Bury Safeguarding Partnership

Safeguarding Adult Review (SAR)

Stuart

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Contents

Glossary

Abbreviation	Definition
MDT	Multidisciplinary Team
COPD	Chronic obstructive pulmonary disease
PCNT	Pennine Care NHS Trust
SAR	Safeguarding Adult Review
BSP	Bury Safeguarding Partnership
A&E	Accident and Emergency
CPA	Care Planning Approach
GMP	Greater Manchester Police
SIO	Senior investigating officer
GMMH	Greater Manchester Mental Health Trust
CVD	Cardiovascular Disease
NCA	Northern Care Alliance (hospital trust)
MCA	Mental Capacity Act
MHA	Mental Health Act

Introduction

1.1. Under Section 44 of the Care Act 2014 there is a duty for Safeguarding Adult Boards (SABs) to arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. If the SAR criteria, are not met but the relevant SAB feels that there are lessons to be learnt, an alternative review may be undertaken.

1.2. The purpose of conducting a review is to enable members of the SAB to:

• Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.

• Review the effectiveness of procedures and their application (both multi-agency and those of organisations).

• Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.

• Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

1.3. The aims of the SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

1.4. SARs are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

1.5. Agencies that have contributed to this review are:

- NHS GM- for specialist commissioning pre-April 2022
- Provider Collaborative
- Northern Care Alliance
- Greater Manchester Mental Health (including Primary Care contact)
- Pennine Care Foundation Trust
- Tameside and Glossop ICFT
- Bury Adult Social Care
- Greater Manchester Police
- MIND

2. Overview of the case and circumstances leading to the review

2.1. The SAR referral was received by the Bury Safeguarding Partnership (BSP) on 17th January 2023, and the case was considered on 15th March 2023 and the review endorsed and commissioned. The panel agreed that the criteria for a discretionary Safeguarding Adult Review had been met, even though the only agencies working with Stuart were organisations under the umbrella of the NHS.

2.2. The information the BSP reviewed concerned information about Stuart who was 54 years old at the time of his death. He had long term mental illness and had been hospitalised for long periods of time throughout his life. He also had several long-term physical health conditions. He died of respiratory failure in August 2022. It was known that Stuart could be self-neglecting of his personal care and his physical health. Concerns were raised in relation to the management of his physical needs and selfcare needs on transfer from Edenfield Unit at Prestwich Hospital to a less secure hospital managed by a different trust (Pennine Care NHS Trust (PCNT)). On admission Stuart was found to be acutely unwell and required transfer to A&E for further assessment and intervention. It was also noted that when he arrived at the new unit, he was admitted quite unkempt, dirty clothes, and wore shoes that did not fit him.

2.3. The panel agreed that Stuart had care and support needs. The care he received potentially constituted abuse (physical, organisational, neglect) and that this possibly may have contributed to his death.

2.4. The SAR Panel acknowledged that there were areas of improvement identified for the planning and coordination for patients with co-existing mental health and physical health conditions.

3. Key Themes Identified by BSCP

The key themes identified at screening that required further review:

- The continuum of care – physical and mental health
- Application of the Mental Capacity Act
- Response to self-neglect by individuals with an impairment of the mind/brain
- How health services are delivered within secure services to meet the physical health needs as well as the mental health needs.
- Care planning/risk assessment/escalation

4. About Stuart

4.1 Stuart' s ex-partner and next of kin has provided the review with Stuart's story and the family's experience of his care journey and provided a sense of who Stuart was. They met when Stuart was 19, they had a child together. Although only together for a few years and had been apart for 25 years at the time of his death, she still cared for him, and she also kept a very close relationship with his parents.

4.2 Stuart was born in Manchester, and he grew up with his parents and one younger brother. It is documented in clinical records that from an early age he displayed behavioural problems. He was reported to be a difficult infant and was an over-active and mischievous child. It was noted that he was first referred to a child psychiatrist because of his behaviour at the age of four, and subsequently re-referred in his teenage years. Stuart was educated at Kingsway High School, Cheadle, and then went straight into the Army. However, he was medically discharged aged 17 and a half, as he kept falling asleep and was diagnosed with narcolepsy[1].

4.3 His ex-partner understands that he was given Ritalin[2], and he had to carry a certificate about possessing this as it was a controlled drug. When he left the Army, his parents bought Stuart a window cleaning round in the local area to them. They got him a car and expressed that he wanted for nothing.

[1] Narcolepsy is a chronic neurological disorder that affects the brain's ability to control sleep-wake cycles. People with narcolepsy may feel rested after waking, but then feel very sleepy throughout much of the day.
[2] This medication is used to treat attention deficit hyperactivity disorder - ADHD. It works by changing the amounts of certain natural substances in the brain. Methylphenidate belongs to a class of drugs known as stimulants. It can help increase your ability to pay attention, stay focused on an activity, and control behaviour problems. It may also help you to organize your tasks and improve listening skills. This medication is also used to treat a certain sleep disorder (narcolepsy).

4.4 Prior to his illness he was described as a lovely, popular person. He was always very well dressed and always smelled of "Tuscany" after shave. He was immaculately presented; he was "clothes mad, and he was always at the barbers getting his hair cut". Although he had a window cleaning round, Stuart also worked as a doorman in the evenings, his ex-partner knew that he used amphetamine whilst they were together, and the people he hung around with were also using it.

4.5 Stuart's pleasures came from football. He was a big 'City' man and used to go with his friends to watch them. He also loved music, particularly reggae, UB40 etc, but lately he used his CD player, that his son got for him, to play Kylie Minogue and Whitney Houston.

4.6 As a couple they separated when their son was aged about two. He started using more drugs, and his ex-partner believes the breakup of their relationship hit him hard. After their separation his behaviour began to deteriorate, he was involved with the police, and was found guilty of a serious assault, and was then detained under the mental health act.

4.7 During their time together, his then partner saw a change in Stuart's ways and actions and as a person. His personality changed and he began to be a bit "paranoid".

4.8 When he became unwell, he lost contact with all his friends and most of his family, however there were around 400 people at his funeral, which the family feel says a lot about the person Stuart had been before his illness.

4.9 Stuart had been a patient at the Edenfield Centre, Prestwich Hospital prior to his discharge to the Tatton Unit, PCNT on the 6 July 2022. He passed away on the Acute Medical Unit at Tameside General Hospital on the 7 August 2022, from physical health concerns, including type 2 respiratory failure. Cause of Death is recorded as:

1a) Respiratory Failure
1b) Infective exacerbation of COPD
II) Essential Hypertension, Type II Diabetes Mellitus and Bilateral Ischaemic Vein Thrombosis

His ex-partner, son and father were with him.

4.10 From clinical records Stuart's mental disorder originated in 1998 when he was thirty years of age. He had an established diagnosis of Paranoid Schizophrenia F20.0.[3] Stuart had been continuously detained under Section 3 of the Mental Health Act since the 19 February 2000.

[3] International Classification of Disease F20.0 - Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition and speech, and catatonic symptoms, are either absent or relatively inconspicuous.

4.11 Stuart was initially managed within a Psychiatric Intensive Care Unit (PICU), but his treatment was stepped up to a medium secure unit in March 2004, and remained at this level thereafter. The Multi-Disciplinary Team (MDT) felt that Stuart continued to require treatment within a medium secure environment due to "his significant premorbid history of criminality dating back to childhood, including multiple episodes of violence."

4.12 His paranoid schizophrenia was noted to have taken an unremitting course, with symptoms evident almost continuously since the time of first diagnosis. Stuart presented with grandiose delusions, persecutory delusions, hallucinations in various modalities, disorganised speech and thought patterns, odd behaviour, and prominent negative symptoms such as self-neglect, lack of motivation, blunted affect, and social withdrawal. He had a history of incorporating nurses into his persecutory delusions and had carried out assaults on staff and peers.

4.13 Stuart moved to the Edenfield Centre (Adult Forensic Service- Medium secure Unit) in January 2019. His mental disorder had proven to be treatment resistant in nature, but his mental state was stabilised on Paliperidone Palmitate [4] monthly injection. At his Care Programme Approach (CPA) meeting on 12 October 2021, it was agreed that he did not require conditions of medium security, and long-term rehabilitation within a low secure setting would be more suitable. In the weeks leading up to Stuart's death, the family were excited and looking forward to him going to the Tatton Unit and feeling positive. Hoping that he may be able to get leave and come home to visit as it was a low secure unit. His ex-partner told his friends things were "looking up".

4.14 The transfer to Tatton Unit[5] did not happen until the 6 July 2022. Delays in transfer were due to ensuring that the right equipment was available. During admission assessment concerns were identified in relation to Stuart's oxygen levels, which required transfer to Accident and Emergency (A&E). He was subsequently transferred to a ward for further assessment where it was suspected that he may have

[4] This medication is used to treat certain mental/mood disorders (such as schizophrenia, schizoaffective disorder). Paliperidone is an antipsychotic drug (atypical type). It works by helping to restore the balance of certain natural chemicals (neurotransmitters) in the brain. Common adverse events associated with treatment include, extrapyramidal symptoms (movement dysfunction such as dystonia (continuous spasms and muscle contractions), akathisia (may manifest as motor restlessness), parkinsonism characteristic symptoms such as rigidity, bradykinesia (slowness of movement), tremor, and tardive dyskinesia (irregular, jerky movements)), sedation, and weight gain.

[5] Tatton Unit is a long-term low secure service for adult males, identified for people in medium secure services who require longer term care, or who cannot be discharged due to their risk profile, who could be cared for safely within a lesser secure environment. Most people supported have spent years, sometimes decades, in secure services. They have not been able to leave secure services because their risks remain, usually as they have been unable to benefit from effective treatment programmes. The unit is committed to rehabilitation, which is about building on existing strengths, and developing skills and coping strategies to maximise each individual's functioning and to minimise the disabling effects of their illness

undiagnosed COPD (Chronic obstructive pulmonary disease) [6] and further suspected he had sleep apnoea[7]. He returned to Tatton ward on the 8 July, with a diagnosis is Obesity hypoventilation syndrome[8], obstructive sleep apnoea and possible COPD. Stuart had been referred for outpatient lung function tests and a review by the respiratory team. A care plan to monitor his oxygen levels was put in place. Concerns about Stuart's oxygen levels persisted, and he transferred back to acute medical services on the 9 July. He then returned to the Tatton ward on the 15 July. Following further deterioration, he returned to acute medical services leading to a period of admission from the 19 -26 July. Following the transfer back to Tatton unit he remained stable until 5 August, when his oxygen saturation dropped significantly, and a diagnosis of chest infection was made. Due to the seriousness of his presentation and in consultation with his family he was placed on end-of-life care and passed away on the 7 August 2022.

5. Engagement with Family

5.1. Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a SAR. A focus on their understanding about how their family member was supported and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.

5.2. The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively.

5.3. Stuart's next of kin, his ex-partner contributed to the review, providing multiple examples, anecdotes, and information. This provided a much wider context to the information that was available. Their contribution provided a rich and meaningful understanding of Stuart's personality and life experiences.

5.4. The contribution made is to be commended given the significant time that they had been separated and the input required by the ongoing coronial investigation that has run parallel to this review. It is a testament to Stuart that he made such an impression that a willingness to care for him lasted over the many years he was detained.

[6] Chronic obstructive pulmonary disease refers to a group of diseases that cause airflow blockage and breathing-related problems.
[7] When the walls of the throat relax and narrow during sleep, interrupting normal breathing.
[8] Obesity hypoventilation syndrome is a breathing disorder that affects some people who have been diagnosed with obesity. Normally, you exhale carbon dioxide, a by-product of breaking down food for energy. Obesity hypoventilation syndrome causes you to have too much carbon dioxide and too little oxygen in your blood. Without treatment, it can lead to serious and even life-threatening health problems.

5.5. The family believe that there is meaningful learning that can be gained from reviewing Stuart's case. They hope that agencies will use this learning to improve practice.

6. Parallel processes

6.1. As part of this SAR, it is important to understand the context in which events took place. The author and panel needed to be clear on the other process that were taking place to establish how they related to the SAR process. The following sections provides an overview of the investigations and processes surrounding Stuart's death and the system in which he was cared for.

6.2. The review identified several parallel processes underway because of Stuart having been an inpatient at Edenfield Centre. The centre has been subject to scrutiny following a BBC Panorama Programme 'Undercover Hospital-Patients at Risk', which is described further below. It is important to note these reviews are taking place to provide the context for this SAR and the systemic issues that surround this case. This SAR touches on the wider system issues but remains focused on Stuart as an individual and the learning that needs to take place in relation to the key themes the BSP identified.

6.3. **Operation Crawton** is the investigation set up to 'investigate the abuse, neglect and ill treatment of patients detained in the Edenfield Centre Prestwich, by staff who were responsible for their care during a 12-month period from 1 Oct 2021 to 1 Oct 2022 and to bring offenders to justice'. This criminal investigation started because of a BBC undercover journalist capturing footage whilst posing as a support worker on varying wards in the Edenfield Centre between April to June 2022. A Panorama Programme 'Undercover Hospital-Patients at Risk' was then aired on BBC1 on 28 September 2022. The enquiry has been running since October 2022, and completion of the investigation was expected by the end of 2023.

6.4. Following the airing of the programme, GMP received over 30 calls, one was from an employee of PCFT, who shared the concerns they had for Stuart on admission in July 2022, which brought Stuart into the scope of Operation Crawton.

6.5. Following allegations made by the BBC Panorama documentary in September 2022 about the Edenfield centre. NHS England has commissioned an independent clinical review of the services[9] provided at the Edenfield Centre. In which they are working closely with local and national partners including NHS England, the Care Quality

[9] https://www.england.nhs.uk/north-west/our-work/publications/ind-investigation-reports/independent-review-gmmh-nhs-ft/

Commission and Greater Manchester Police to ensure the safety of these services. The review is being referred to as the "**Shanley Review"** as Professor Oliver Shanley OBE is leading the Independent Review, as the Independent Chair. The review will provide an independent assessment of what has happened within the Trust's secure services and identify conclusions and lessons learned. The review will aim to provide assurance to patients, families, staff and the broader public regarding the quality and safety of services provided by Greater Manchester Mental Health NHS Foundation Trust. The findings of the review were not available at the time of writing the SAR.

6.6. When Greater Manchester Mental Health NHS Foundation Trust received correspondence from the BBC at the beginning of September 2022, which stated that they were conducting research into the treatment by the NHS of adults with severe psychiatric illnesses, resulting in a Panorama programme. The trust took several immediate actions which focussed on responding to the serious allegations and ensuring patient safety.

6.7. On 22 September 2022, the trust requested an Independent Clinical Review to be undertaken of these actions by clinicians from a neighbouring mental health trust with the aim of providing assurance and advice regarding the effectiveness and appropriateness of the immediate response. This review known as the **"Fernley review"** was published in October 2022. The report made several recommendations in relation to safer staffing levels, improving the profile of safeguarding in the organisation, addressing the use of restrictive practices and leadership.

6.8. The trust has also published its **Governance and assurance review: A report from the Good Governance Institute - March 2023**. In which the Good Governance Institute (GGI) carried out an independent evaluation of the governance and assurance at the Trust between October 2022 and March 2023. To give the board answers the questions:

• why did the trust's governance and assurance system fail to alert them to issues at the Edenfield Centre?

• are there any similar governance and assurance failings across the trust that are not alerting the board to similar issues elsewhere?

6.9. As a summary it states *It is difficult to avoid the conclusion that the Edenfield should be seen as a collective failure, not just of the trust or of specific individuals, but of a system of governance and assurance which had not kept pace with change*.

6.10. There has also been a **safeguarding investigation** under the category of "Organisational or institutional abuse", led by Bury local Authority. The safeguarding investigation has worked alongside GMP's operation Crawton, screening 202 referrals

alongside 100 People in Position of Trust[10] referrals, the subsequent individual investigations although overseen by Bury have been undertaken across 11 other authorities. The allegation of organisational abuse or institutional abuse was substantiated. The investigation is now closed and has accepted as assurance the GMMH Trust action plan that was developed in response to the findings from its internal investigations and reviews. It is to be monitored in response to the safeguarding investigation. The process for investigation of safeguarding concerns raised from GMMH trust to the local authority team has also been reviewed and changes implemented. This is commented on later in the report.

6.11. In the case of Stuart, the "Organisational or institutional abuse" investigation was notified after the referral into Operation Crawton. The decision at this point had been made that a SAR would be undertaken for Stuart, and therefore no additional safeguarding investigation would take place.

6.12. Both mental health trusts have undertaken Root Cause Analysis (RCA) reports as part of the NHS patient Safety framework into the issues raised about Stuart's care whilst at the Edenfield Unit and on the Tatton unit.

7 Key Practice Learning

7.1 In order to address the keylines of enquiry identified the BSP all relevant agencies were asked to complete a Learning Report for the SAR. In which they were asked to analyse the assessment of physical health in the context of current policy expectations; and consider guidance on self-neglect and its use in inpatient mental health settings in the time frame from 1st August 2021 to 7th August 2022. The learning report also asked the following questions.

- *What evidence is there that Mr Smith's needs were assessed holistically whilst under the care of the organisation and what resources and services were utilised to support Mr Smith as an inpatient?*
- *What opportunities were there to raise and escalate concerns regarding his physical health and selfcare?*
- *To what extent was the impact of Mr Smith's mental health considered on his capacity to make decisions about physical health needs and selfcare?*
- *Identify examples of "strong" practice*

7.2 The author notes the period under review encompassed the period of the Covid 19 pandemic. It is acknowledged that the pandemic placed additional pressure on NHS

[10] People in Position of Trust-A person in a position of trust is an employee, volunteer or student who works with adults with care and support needs. This work may be paid or unpaid. Examples of such concerns could include allegations that they have: behaved in a way that has harmed or may have harmed an adult or child.

services- adapting to new ways of working, stress of working keeping oneself and patients safe, redeployment etc. However, this did not detract from the practice concerns identified.

7.3 Within the information provided in the learning review reports the author identified four key areas of practice (KAP). These were further explored at a Practitioner learning event and with the panel. These areas are identified as the underlying issues as to why Stuart's physical health needs remained unmet and he experienced persistent neglect of his personal care needs.

1 Care Planning

- The absence of holistic assessment of health and wellbeing
- Care plans not reflecting both mental and physical health needs
- No clear frameworks for reviewing and reevaluating needs

2 Self-neglect

- No recognition of when low motivation becomes self-neglect and when self-neglect becomes a safeguarding concern

3 Mental Capacity

- How to balance and explore the impact of mental ill health on capacity
- When to consider the use of Best Interest
- Poor legal literacy

4 Organisational oversights of patients with long term admission to acute Mental Health services

- Lack of overarching goals for patients
- Poor advocacy for those in long term detention
- The system not fully utilising the key points of oversight and review

8 Analysis of findings

8.1 Each of the four key areas of practice above will be explored and examined individually. The first three domains of care planning, self-neglect and mental capacity are co-dependent. An improvement in one of the areas would lead to the opportunity to improve practice in the other key practice areas. If for example, in KPA 1 a good quality care plan that is clear in identification of needs; supported with an action plan with a clear process to review and evaluate, would have helped identify a growing picture of self-neglect and deteriorating physical health. Understanding and recognising self-neglect (KAP 2) would contribute to care planning and consideration of capacity to make unwise decisions. Understanding mental

capacity (KAP 3) in the context of mental ill health will support care planning about supporting decision making and identification of self-neglect.

8.2 The fourth KAP compounds the challenges of the practice above, spending twenty-two years detained to secure units under the Mental Health Act, left Stuart isolated from family members with a loss of anyone to champion and advocate for him. There was no overall long-term plan to maximise his quality of life. The sense of the man that entered acute mental health services was lost over the years and there appears to have been a gradual acceptance of his presentation and deterioration.

8.3 The feeling of no one being a champion for Stuart is also expressed by family. His ex-partner describes the last few visits to see Stuart as being terrible at Edenfield, *the last one particularly when he came into the visiting room having had no medication, without his walking frame and barely able to walk. He was not clean. It seemed that they had just got him out of bed, not prepared him properly, and so the visit was very agitated, and we left soon after it started.*

8.4 She also expressed that Stuart did not get any rehabilitation at all whilst at Edenfield. *They say in his notes he socialised, but I know for a fact he didn't as he never came out of his room. Whenever I rang, they got him from his room, or said he was sleeping.*

8.5 The review is cognisant of the culture and quality issues that were highlighted in the Panorama documentary in relation to Edenfield Unit and the focus of the many reviews taking or having already taken place. Practitioners involved in the review felt that there was a long-standing closed culture, driven by performance rather than quality outcomes for patients. They report that changes are now taking place but there is still work to do. The absence of any quality assurance framework did not provide any checks or balances in the system and so continuously perpetuated the findings that follow. Some of the practice issues identified are also replicated across other health organisations that participated in this SAR.

8.6 Care Planning

8.7 Evidence shows that people with a serious mental illness die up to twenty years younger than the average population.[11] Preventable cardiovascular disease (CVD) is the major cause of death, along with endocrine disease and respiratory failure. Evidence also suggests that these individuals receive a lesser standard of health promotion and physical health care and despite national awareness and guidelines early mortality rates have not improved. Therefore, it is essential that staff in mental health settings meet patients' physical as well as mental healthcare needs. The physical healthcare of people with mental health problems features prominently in

[11] National Institute for Health and Care Excellence (NICE)

the “Five Year Forward View for Mental Health” report from the Independent Mental Health Taskforce to NHS in England (2016). It identifies that a good service will ensure that people with mental health problems receive the same standard of physical healthcare as any other member of society. They may deliver this through their own appropriately qualified and experienced staff or in partnership with other providers. There are two main tasks for practitioners in mental health services:
1. Medical assessment to ensure physical illness is not causing the psychiatric presentation.
2. Monitoring for adverse physical effects of antipsychotic treatment or other causes of poor physical health[12]

8.8 The organisations contributing to this review have policies for Physical Healthcare and Wellbeing in place in response to the national findings. On review the content of these does support practice, but the review identified gaps in the implementation of the policies. For context Primary Care services (GP) are provided and managed via a contractual arrangement with Better Health Manchester (previously Robert Derbyshire Practice) and supported by the in-house physical health team within GMMH. In PCFT if the patient is a mental health inpatient primary care services are delivered by the in house Physical Health Team.

8.9 The following findings are almost exclusive to the care planning for Stuart whilst at the Edenfield unit. Once Stuart transferred to the Tatton Unit at Pennine Care Mental Health Trust, he had a holistic assessment of health and wellbeing and seen to some degree “with fresh eyes”. The admission assessment highlighted that that there were some concerns about his physical health presentation. As Stuart’s physical health quickly deteriorated from admission there was always a clear plan of action in place for his respiratory problems.

8.10 Although Stuart did have a care plan about management of low oxygen saturation levels whilst on the Tatton unit, he did not have any other physical health care plans completed, despite him having other physical health conditions, so the following issues around care planning for physical health conditions is evident across both trusts.

8.11 The only other health service Stuart had contact with during the scoping period was the Urology department at Salford Royal Hospital for a retroperitoneal mass that had been discovered prior to the review time frame. This is the only occasion identified when there was consideration of Stuart’s capacity around care and treatment. It is good practice that this was initiated by the clinician at the NCA. The best interest meeting that took place on 15 June 2021 is documented in Stuart’s record. The notes summarised the biopsy of the mass and agreed the best course of action. The best interest meeting held by the urology team was attended by the doctor from the

[12] CQC Brief guide: Physical healthcare in mental health settings

Edenfield centre. It was noted at the best interest meeting that Stuart had Schizophrenia with a long-term admission to a secure hospital. It was not recorded in the best interest meeting, the long-standing concerns with self-neglect and non-concordance with some aspects of his treatment for his other illness, this should have been considered as part of the plan and has been highlighted as learning for the NCA. It was a missed opportunity to make plans for what should happen if Stuart declined to work with the agreed plan. This theme is picked up later in the report.

8.12 There is no evidence of Stuart attending for another scan as part of the agreed monitoring or actions taken because of non-attendance. On admission to the Tatton unit, it was identified that he required further follow up from urology. The Edenfield unit records identify a scan was arranged for the 11 of January 2022, but Stuart declined to attend the appointment, a capacity assessment was completed around this refusal. E-mails were sent to Urology from the unit on several occasions to gain advice if any further actions were required, but no responses were received. It does not appear that any attempts were made to contact Urology by telephone or send a letter, though it was repeatedly documented in records that no response had been received from Urology. The readiness to accept capacity is not congruent with the previous decision to hold a Best Interest meeting as in June 2021 when it was felt Stuart did not have the mental capacity to make significant decisions for himself in relation to the retroperitoneal mass.

8.13 The issues around capacity are discussed under the next KAP. The reasons for the lack of follow-up are considered next as part of the wider analysis of care planning.

8.14 GMMH have been open and candid in their findings in relation to the care planning for Stuart and acknowledge that it fell below standards they would expect. They have undertaken a Concise Serious Incident Review[13] and shared the findings with the author. PCNT also shared the Tabletop Review they undertook following Stuart's death, which have been considered in the following sections.

8.15 The issues in relation to care planning fall under three main categories- care plans not being holistic of all needs; when needs were identified they were not supported by a robust action plan and a lack of clarity around roles and responsibilities within the Multi-Disciplinary Team (MDT) as to who should undertake actions.

8.16 The review has found Stuart's Care plan was not complete whilst under mental health services, so there was not a plan in place to address all his health needs. Stuart had a range of complex physical health issues such as diabetes, high cholesterol, and high blood pressure, and he was prescribed a range of medications for these. The management of these conditions was led by the GP at the Edenfield Centre and supported by the Responsible Clinician and the Advanced Practitioner for Stuart. He

[13] As part of the NHS Serious Incident framework to support learning to prevent recurrence of harm.

was reviewed regularly by the GP, on some occasions he would refuse to be seen by GP, but his care was still reviewed and noted to be good practice. The review identified that there had been concerns raised about the quality of the handover of Stuarts needs between the Edenfield unit and the Tatton Unit. I was raised that the information was not complete at the point of transfer, however he did receive a physical health review on admission to the Tatton Unit which identified several health needs except for Stuart's breathing issues the other health issues did not receive a care planning approach in the Tatton Unit.

8.17 Having no specific care plans around many of his physical health conditions was also the case at the Edenfield unit. Despite the fact Stuart had factors that placed him at increased risk of developing respiratory disorders (history of smoking, obesity). The trust identified there appeared to be limited response to the lowering of oxygen saturation levels dating back to 2019. Despite the system in place to discuss Stuart's care plan (CPA[14] reviews, regular ward rounds) the concerns never transferred into an active management plan or escalation which suggests that the processes within the MDT for communicating concerns in relation to physical health were not effective. Practitioners describe care planning as process driven rather than a person-centred approach. Under the arrangements at the time Stuart had multiple plans that were seen in isolation and not pulled together, or person centred. Therefore, MDT discussion on changing needs or how plans interacted did not take place.

8.18 Practitioners reflected that the system in place sets up practitioners to fail and are not meaningful or helpful for patients as there are several different care plans for one individual and can run to 40-50 pages long, they are rarely updated and when they are the volume of information involved meant that it was unlikely that they were to be used effectively in daily practice. It is reported a new system has been updated and will be more effective in its working.

8.19 In the timeframe of the review there was no one in position to ensure that any quality assurance of care plans took place, as mentioned earlier this allowed poor care planning to go unrecognised and not seen as an organisational priority. Since new posts have been developed dedicated to quality assurance in GMMH, it has been recognised that there have been practices which are ineffective around training and understanding/competency around deteriorating patients. This is now being addressed as part of the action plan following the Panorama investigation. PCNT will include audit of physical health plans as part of the quality assurance programme, as the tabletop review identified the gaps in care planning for Stuart's many physical health conditions.

8.20 There are several other examples of how identified health needs never translated into a care plan. Whilst the retroperitoneal mass was being investigated concerns in

[14] CPA The Care Programme Approach (CPA) is a package of care for people with mental health problems.

relation to Stuart having low oxygen levels were identified. The surgeon believed the problems with his oxygen levels could have been because of undiagnosed sleep apnoea, this was not explored any further by the MDT. There is also reference to Stuart having had a diagnosis of Narcolepsy, but this was not discussed within any MDT meetings which raises the question of roles and responsibilities of the team in responding to physical health concerns. Findings from the national analysis of SARs (2017-2019)[15] identify the theme of the risk of *Parity of esteem, for example mental health overshadowing physical health concerns.* This issue was raised in the practitioner event to explore whether this impacted on the care planning for Stuart. Practitioners did feel that Consultants, Allied Health Professionals and GPs are of equal value, but the problem relates back to not having a "one person, one plan" in place. The author does feel that physical health care was not given the same level of focus as Stuart's mental health.

8.21 As part of GMMH trust policies Stuart had an assessment of his physical health using the recognised assessment tool more frequently than the minimum standard but action was not taken in relation to concerns identified such as low Oxygen saturations, obesity and smoking, it did not result in any additions to his overall care plan. The same findings were made following admission to the Tatton Unit, that identified health needs were not translated into an action plan.

8.22 An underlying factor for some of Stuart's physical health condition was obesity, which appears to have been a longstanding issue over several years, and this pre-dated his transfer to Edenfield. His last weight recorded was in May 2022 and he weighed 172kg with BMI 48.26[16]. There is no evidence to suggest that anything was done to support his continuously increasing BMI by requesting involvement of dietitians or again never incorporating the findings into a personalised plan of care. His weight was also not considered following his admission to Tatton unit.

8.23 The second issue relevant to care planning was the lack of clear actions when health needs were identified. It was not uncommon for Stuart to decline care or address his own self-care so it would be reasonable to anticipate that this would need to be a feature of any care plan. Information provided for the review identified there was no consistent management plan for how staff should manage care refusal. Stuart's mental health diagnosis included that nursing staff were trying to harm him as part of his presentation, this does not appear to have been considered in the care planning for his physical health needs or his capacity to decline interventions. And more importantly there was no recognition as what the long term impact of physical health

[15]https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

[16] The body mass index (BMI) is a measure that uses your height and weight to work out if your weight is healthy. A BMI 30 or over – indicates that a person is in the obese range

concerns remaining unaddressed would be and the next steps to take if the risk of harm was escalating.

8.24 Alongside the need for care plans to include what to do if Stuart declined interventions, there was also a lack of clarity about the specifics of care needed. For example, the care plan for Stuart's wellbeing and physical health had a major focus on managing his diabetes but did not reference how often his blood sugars should be monitored and what to do if they were raised. On transfer from GMMH to PCNT Stuart's discharge letters reported that he should have had weekly blood sugar's taken. There is no evidence that they were taken on Tatton Unit.

8.25 The absence of a detailed care plan with specific actions alongside an underutilised process for holistic review, allowed for drift in the oversight and management Stuart's physical heath and led to continuous deterioration, throughout his admission.

8.26 The poor care planning then led to the third area of concern the lack of clarity around roles and responsibilities within the MDT. Whilst at GMMH who was supposed to do what and when was never clearly articulated. The learning event considered that because of having both a mental and a physical health team created a tendency to think the at the physical health team would be addressing physical needs and therefore physical health not being seen as everyone's responsibility. The issues of Stuart having no care plans around any of his other physical health problems following transfer to the Tatton unit was identified in the tabletop review as may be due to *the structure of Named Nurse duties at Tatton, and gaps in provision around this.* Again, demonstrating unclear roles and responsibilities.

8.27 The above issues were compounded by issues of understaffing and lack or Registered Nurses on the ward at GMMH. This made communicating responsibilities for delivery of a care plan even more important. The Registered Nurse staffing issues impacted on the handover at changes of shift, on some occasions there was no Registered Nurse on shift on the ward to ensure that clinical information was handover accurately. The ward on which Stuart resided was seen as a 'settled' ward and therefore when there were staff shortages across the Edenfield site, nurses on shift at Ferndale were frequently moved to other wards. The author can only imagine that this had a very demoralising effect of staff and patients as their needs were perceived to be lesser.

8.28 Self-neglect

8.29 The review has identified that in Stuart's case there was a lack of recognition of when low motivation associated with his mental health condition became self-neglect and in turn when the self-neglect became a safeguarding issue. Self-neglect is classified in the Care Act 2014 statutory guidance (DH, 2016) as a form of 'abuse and neglect.'

8.30 Self-neglect is the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences

to the health and well-being of the self-neglecters and perhaps even to their community.

8.31 Adults considered to be self-neglecting are unable to or unwilling to provide adequate care for themselves and:

- they are unable to obtain necessary care to meet their needs; and/or
- **they are unable to make reasonable or informed decisions because of their state of mental health** or because they have a learning disability or an acquired brain injury;

and/or

- they are unable to protect themselves adequately against potential exploitation or abuse;

and/or

- **they have refused essential services without which their health and safety needs cannot be met but do not have the insight to recognise this**.

8.32 The criteria in bold are the relevant areas to consider in self-neglect that Stuart fell within. Information provided for the review at no time recognised the persistent noncompliance with interventions for his physical health to be considered as self-neglect whist a patient at Edenfield, Tatton Unit or whilst in contact with NCA. On transfer to the Tatton unit, it was noted that Stuart arrived in an unkempt and malodorous state with dirty clothes on that were also in poor condition, however there is no documentation of this within the patient records, or this being seen as a safeguarding incident. An internal incident report was later completed and following the showing of the Panorama programme when contact was made with Operation Crawton.

8.33 There was a long-standing assumption that Bary had capacity to make decisions to not care for himself, to take medication or attend appointments. Stuart's chronic mental and physical health needs, poor insight and a complex system of delusional beliefs impacted on his mental and physical health as well as his likelihood of addressing his self-care both independently and with the support of staff.

8.34 It is a well referenced issue that whilst at Edenfield that Stuart needed prompts to attend to his self-care and at times documented self-care was poor and he was malodorous. There was strong smell emanating from his bedroom on occasions again this was never considered as self-neglect.

8.35 Reviews on the ward noted that Stuart's self-care remained poor, with no accurate picture as to how often he had showers and changed his clothing. In two clinical team meetings reviews in March 2022 there is references to peers having complained regarding the smell emanating from his bedroom. This created an action for his room to be cleaned by staff at least twice a week including changing his bedding and staff

to offer to assist him every other day to attend to his personal care if he consented. There is no evidence this was undertaken on a consistent basis. There was no consistent or detailed plan to address Stuart's needs to self-care or plan of action to support this or about what should be done if Stuart refused.

8.36 The lack of care planning for the neglect of self-care alongside the lack of care planning for management of physical health needs did not provide opportunity to consider the behaviours as self-neglect. Practitioners acknowledged there is limited understanding of self-neglect across services and therefore goes unrecognised as a safeguarding concern in the organisation.

8.37 There is a well-established safeguarding panel in the organisation where Stuart's case may have been explored but self-neglect needed to be recognised as a safeguarding concern to do this. The practitioner event recognised the need to increase the understanding of self-neglect across the organisation. As part of the learning from this incident a prompt will be added to the new care planning approach to ensure that safeguarding is considered as part of every review. The membership of the safeguarding panel has been strengthened and now occurs twice weekly.

8.38 The self-neglect Stuart was experiencing indicates that a safeguarding referral should have been made this was a missed opportunity to support Stuart in this area and put further safeguards in place. The safeguarding process would have led to a safeguarding strategy meeting. A strategy meeting would have provided an opportunity for a multi-professional review of Stuart's care, to ensure that everything possible was being done to address his wellbeing and physical health care needs, possibly highlighting the absence of physiotherapy, occupational therapy, and dietician in his care. This would have also created the opportunity for advocacy under the Mental Capacity Act to be considered and an external view of the care Stuart was receiving.

8.39 However, in the review period any safeguarding referrals made to Bury Adult social care from any private or mental health hospitals were screened as to whether the criteria for section 42 investigation[17] was met and then delegated to the trust to undertake the enquiries on behalf of the local authority. This meant that there was a "closed shop" in relation to safeguarding investigations led by the trust and therefore no external oversight, scrutiny or challenge. Since the Panorama investigation a new process has been put in place whereby investigations are undertaken by the local authority, to promote openness and quality assurance of safeguarding investigations.

[17] Under Section 42 of the Care Act 2014 a local authority must make enquires where there is reasonable cause that an adult in its area who has needs for care and support whether the authority is meeting any of those needs, is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

8.40 The internal review by GMMH suggests the lack of recognition of self-neglect could have been due to the chronic nature of his needs and led to staff becoming disheartened in terms of offering support and given the length of time Stuart was detained staff may have become desensitised to his needs.

8.41 The NCA also noted that it is unclear if the self-neglect policy was considered by professionals when the issues in compliance with treatment for the retroperitoneal mass were identified.

8.42 Mental Capacity

8.43 Preston-Shoot[18], in reference to SARs related to self-neglect, reports that one-third of them comment on the complexity of balancing autonomy with protection in cases where an adult who self-neglects is deemed to have decision-making capacity. Reviews have commonly concluded that adequate consideration was not given to the significance of individuals' support needs alongside their right to self-determination.

"*Mental capacity was used by agencies to justify not taking action, but that the outcome was neither empowering nor protective*".

8.44 This is true in relation to the issues of self-neglect in Stuart's case. The assumed capacity to refuse treatment and care was rarely explored nor considered in the context of his mental illness. So, neither the use of the Mental Health Act or Mental Capacity Act was considered to balance Stuart's autonomy to make decisions with the need to provide care and services to prevent harm. Capacity was only considered when Stuart required a specific intervention due to the retroperitoneal mass. On this occasion it resulted in a Best Interest meeting as Stuart was considered not to have the capacity to make an informed decision over care and treatment for the mass. There is no rationale as to why this was not transferred to other aspects of his healthcare, or why there was no plan to address refusal for further monitoring.

8.45 To fall within the scope of the Mental Health Act (MHA), the person must have a mental disorder within the meaning of the act, which is defined as "any disorder or disability of the mind". The MHA is mainly focused on the assessment and treatment of mental disorder in hospital settings, which may be provided under compulsory powers if the person is unable or unwilling to consent, and it is necessary to detain them in hospital to protect them and/or others from harm.[19]

[18] Preston-Shoot, M. 2016. 'Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work.' Journal of Adult Protection, 18(3): 131-148.
[19] https://proceduresonline.com/trixcms/media/4395/the-interface-between-the-mental-health-act-1983-and-the-mental-capacity-act-2005-adults.pdf

8.46 To fall within the scope of the Mental Capacity Act (MCA), the person must be assessed as lacking the relevant capacity within the meaning of the act: "For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."

8.47 In Stuart's case the continuous assumption of capacity is questionable as he is detained under the MHA and has a "diagnosed disorder of the mind". There is some evidence that there were attempts to support Stuart to engage in and develop an understanding of several issues, including his abdominal mass. What is less clear is how the MDT would manage the situation if he did not have insight, to ensure that a robust plan was in place for staff to support and facilitate the management of his chronic physical health conditions.

8.48 The practitioner learning event and information provided for the review identified that understanding of the MCA in a mental health setting was limited especially in relation to the complex concepts of "executive functioning" and the ability to weigh relevant information. There was in Stuart's case the added complexity that his mental illness included delusional beliefs about care and physical health treatment. For example, Stuart had not worn shoes for several months prior to his transfer to Tatton Unit on exploration following Stuart's death it seems that he was unhappy with wearing shoes and as he believed they burnt his feet and were covered in urine, this was thought to be delusional. There was no planning or assessment to consider the impact of not wearing shoes (Stuart then started to use a wheelchair therefore further reducing his mobility and contributing to increasing obesity). It was acknowledged by the organisation that capacity assessments should have been considered regarding his physical health and self-care on a consistent basis and that the negative symptoms of Stuarts mental illness should have been considered alongside.

8.49 Organisational oversights of patients with long term admission to acute Mental Health services

8.50 Until the SAR process commenced it was not known to BSP that Stuart had continuously spent over 20 years in a mental health unit. The length of his stay is unusual but not exceptional and stood out as key underlying issue for Stuart. There is no doubt that over such a long period the sense of who Stuart was as a person was lost. It stood out at the practitioner event that a plan to achieve some long-term goals to maximise his quality of life was absent. As stated earlier there is no evidence of utilising services to provide any reablement, to provide activities or enhance motivation as part of a holistic plan of care. As highlighted in the previous section from an organisational perspective, Stuart's deteriorating physical health needs were

not addressed, alongside normalisation of low expectations of care. This gave rise for the review to consider what other opportunities were there to challenge the care he was receiving and to give Stuart a voice. One of the areas identified was oversight by a case manager. Case managers are employed by NHS England and subsequently the Provider collaborative, their role in this case is essential to understand.

8.51 All specialised adult secure service is case managed by clinicians who are employed by either NHS England in their direct commissioning role or by lead provider collaboratives (who took over case management responsibility from 1st April 22). Case managers are responsible for the regular oversight of patients and pathways. At its core, the role of a mental health case manager is to ensure that clients receive the necessary services and support they need. They review and ensure the service delivery to ensure providers are meeting the expected/required standards in their specification and contract- highlighting any issues to the management of the organisation if any are identified.

8.52 During the COVID-19 pandemic, the need to prioritise providers clinical and operational capacity was paramount and included the redeployment of staff to frontline clinical practice. Case Managers roles and responsibilities were amended and delivered remotely concentrating on crisis management of complex patients during this time. Despite the restrictions information that was sourced from the national case management system identifies that there was some degree of oversight recorded on a 2- 3 monthly basis in the review period, expectations in the Standard Operating Procedure for patients in secure hospitals is for oversight every 8 weeks.

8.53 It appears over time due to the capacity of the case managers this became a 10 weekly oversight and on exploration this was the pragmatic view to do the best with the resource available, it was universally accepted across the system as the normal standard. Therefore, before Covid, each patient of the 10 wards of Edenfield received a case management review every 10 weeks. This was typically undertaken by the case manager meeting the ward manager. Then followed by holding a drop-in clinic for the ward patients to attend. Some patients were more regular than others in wishing to discuss their care and treatment within the ward with their case manager. Some patients chose to contact their case manager individually by telephone message outside of these review schedules if they had any issues, they wished to discuss instead of waiting for a face-to-face meeting every 10 weeks. Stuart was not someone who regularly wished to meet with his NHSE case manager. Instead, he preferred to speak to the case manager when undertaking a ward walk through. The case manager acknowledges that the Covid pandemic and the pressures on the case management resource exacerbated the challenge of reviewing the care provided to patients who preferred not to engage as Stuart did.

8.54 From October 2021 there is a gap in recorded contact until July 2022. It is believed that activity did take place in terms of planning Stuart transition as this did take place,

but it was not recorded on the National Case management system. The expectation was that weekly telephone calls took place with the wards for oversight. Immediately before the provider collaborative took responsibility for case management in April 2022 the NHS England specialist commissioning case management resource was under pressure. The case manager covering Edenfield had retired in early January 2022 and replacement cover was limited. The provider collaborative did not go live with case management until 1st April 2022 and in the first three months the few staff available were tasked with undertaking the legacy of mandatory NHS England Safe and Wellbeing reviews for all Learning Disability and Autistic patients. This meant that due to completing the mandated work, the ordinary case management function could not be delivered to the Edenfield patients until the summer of 2022. This delay was compounded by the lack of a comprehensive handover from NHS England to the provider collaborative which resulted in a great deal of work being required by the new provider collaborative in compiling up to date and reliable information about the patients in adult secure units across Greater Manchester.

8.55 The SOP in place for Case mangers[20] identifies that case managers play a vital pivotal role within specialised commissioned services, providing credible oversight and facilitation of care for patients. They support the commissioning function by:

- *providing oversight of patient pathways, identifying potential/actual gaps in provision and barriers to progress*
- *involvement prior to admission with referrals pre and post assessment for specialised services – particularly in managing cases that are escalated e.g. escalation calls, liaison with potential providers (variable involvement across areas)*
- *listening to and talking with patients, their families and carers*
- *ensuring the voices of patients and their families are heard and acted upon*
- *monitoring and reviewing the quality and safety of provision*
- *observing providers in practice, monitoring and reviewing quality information and local intelligenc*e

8.56 The panel reflected that being able to fulfil all elements of the role described above has been a challenge for a long time and likely to remain the case due to ongoing capacity of the team and further organisational changes.

8.57 It is the view of the author that not being able to fully deliver comprehensive case management is a missed opportunity for vulnerable patients like Stuart, to hear their voices and lived experience. The absence of this in Stuart's case meant that again the gaps in his physical health care were not picked up, the focus was on the transition through mental health services and less so on the quality and safety of the care he received. The pressures in the service and then the impact of the Covid pandemic did

[20] Specialised Mental Health Learning Disability and Autism Commissioning - Case Management Standard Operating Procedure (SOP) (NHSE 2020)

not allow for case managers to undertake their own scrutiny or to provide a voice for Stuart but relied on reporting from GMMH and other external organisations such as the CQC. The case manager is responsible for the pathway management and quality oversight of the service and as commissioners expect that at a minimum the ward manager maintains links with their case manager and escalate any issues to their senior leadership team. Despite the reduced capacity NHSE, and latterly the provider collaborative case managers team the quarterly contract monitoring meetings were held. There was a responsibility at these meetings for communication regarding quality monitoring, oversight, and escalation. Given the issues identified earlier in the report that GMMH had not been recognising and responding to the quality-of-care Stuart was receiving and the longstanding cultural issues of the organisation this mechanism appears to be flawed as essentially it was reliant on the organisation raising concerns about itself to the case manager.

8.58 Both the provide collaborative and NHS England have introduced additional quality measures since the findings of the Panorama programme to consider how quality and safety of patients is explored. Case managers feel that to fully achieve this it needs to be ensured that there are adequate numbers of case manager in place as indicated in the NHSE Case manager SOP to deliver the role and function is required and that they are supported by adequately resourced contract, quality, administrative and commissioning functions within the team.

8.59 The case management team and practitioners also feel that there is an impact from the lack of Care Planning Approach (CPA) co-ordinators for patients in forensic units which Stuart would have been entitled to, again the capacity of this services is stretched that their focus is on patients that are in or spending more time in community settings. Again, reducing the opportunity for external overview of Stuart's care and make challenge when necessary.

8.60 As part of the wider consideration of who and how could advocate for Stuart the author met with MIND who provide the IMHA service (Independent Mental Health Advocate)[21] to the Edenfield unit. The IMHA had some involvement with Stuart in an informal way observing Stuart in the day room where he was often just resting on the sofa there during weekly visits to the ward. However, in early 2022 there was a

[21] IMHAs can help people who use services to understand: their legal rights under the Mental Health Act the legal rights which other people (e.g. nearest relative) have in relation to them the particular parts of the Mental Health Act which apply to them any conditions or restrictions to which they are subject any medical treatment that they are receiving or might be given, and the reasons for that treatment the legal authority for providing that treatment the safeguards and other requirements of the Act which would apply to that treatment. IMHAs will also help people to exercise their rights, which can include supporting them to self-advocate and/or representing them and speaking on their behalf. IMHAs can support people in a range of other ways to ensure that they can participate in the decisions about their care and treatment.

request to speak with Stuart as his annual section 3 renewal[22] was approaching and they were asked to gather Stuart's views. Although the conversation was mixed with delusions the IMHA was surprised of the level of understanding about the tribunal Stuart had.

8.61 The use of advocacy for reviews is not routinely undertaken and is something that could be considered, especially when patients become so isolate due to the length of their detention. The IMHA described how the recent introduction of advocacy for patients requiring seclusion showed a clear demonstration of listening to patients, the advocate speaks first at the review making sure the review a more person centre approach. This approach is something that could be considered for other aspects of care or case management.

8.62 As time progressed Stuart became more detached from his family. Stuart refused to see his parents whilst he was detained as his illness meant that he believed they were somehow responsible for him being there. His ex-partner describes how good it was when a social worker became involved following transfer to the Tatton unit, that she felt involved again and that Stuart mattered. She also shares how the absence of having a link person during Stuart's admission made keeping in contact harder and visiting more difficult. She reported that her son was not even allowed to take photograph of his dad, which he found extremely difficult. There is a policy in place that does not permit visitors to bring mobile phones or cameras into the unit due to safety and security within a medium secure unit, however exceptions are made, and this would usually be managed via the individual's clinical team if a request was made to take photographs. It is not clear why there was no social worker or link worker for the family whilst Stuart was at Edenfield that could maintain contact and keep family involved in his care and treatment and support their continued involvement.

8.63 In the information provided by his ex-partner it appears that the presentation of Stuart was upsetting for the family leaving them distressed. They raised concerns at the time but felt they had nowhere else to go as in spite of raising concerns they concerns kept being repeated.

8.64 The family cannot describe a time when they felt supported around contact and visiting Stuart, until he was transferred to Tatton unit and a relationship with a social worker was established. His son who was only a very young child is deeply affected by not being able to form or maintain some kind of relationship with his father.

[22] There are standard timescales for review of patients detained under section 3 of the MHA. Each time the Section 3 is renewed, a review of your current care and treatment is carried out by the Mental Health Act Managers.

9 Summary of findings

9.1

Finding	Key Points
Person centred approach to care planning	During Stuart's time in Mental health secure units, he had multiple care plans in place. The care plans were of poor quality with unclear actions, roles, and responsibilities within the plan. The processes to review care did not consider Stuart's needs holistically and bring his mental and physical needs into one space. Stuart had no identified long term goals to improve his quality of life and the sense of who he was before his mental ill health was lost. Therefore, Stuart did not remain central to planning and his lived experience was not consistently considered. The culture of the organisation on focusing on process not quality and the morale of those working in the unit, provided no checks and balances to intervene in his care. The Case management oversight also provided no challenge to the care delivered. There was limited involvement from family, often through Stuart's choice, and absence of consistent advocacy or anyone to champion on his behalf and challenge the status quo for him.
Legal literacy	The strength of professionals working with Stuart is in the understanding of the MHA but less so in relation to the MCA. Professionals require the development of their knowledge and understanding of which safeguards provided by the acts are more likely to best protect patient's interests.
Self- neglect	Stuart's persistent refusal of interventions for his physical health and personal care were never seen through a safeguarding lens as being neglect. Professionals need opportunities to reflect and be supported to gain greater understanding of self-neglect as a safeguarding issue.
Advocacy	Stuart was detained under the MHA for 24 years before his death. He often declined contact and information sharing with his family. Whilst there is some evidence of advocacy it not usual practice to include at Tribunals and case management reviews. In a person-centred approach professionals need to consider their roles as patient advocates. Develop approaches to include family.
Organisational oversight of long term detained	To be detained for such a length of time enabled a loss of focus on Stuart. Internal and external oversight of care plans needs to be more person centred and the quality of case management to be routinely audited.

10 Improvements Made

10.1 Through the review the author met and spoke with professionals who were passionate about making changes in response to the findings in this and the wider concerns identified across the system.

10.2 All services involved in the review were invited to provide an update on any actions taken in response to the findings of the SAR.

10.3 The trust in which Stuart was predominately cared for now has structures in place now to ensure that there is a focus on patient safety and quality of the care including patients plan and notes/reviews. There were no dedicated quality posts in place at the time of Stuart's admission. GMMH expressed that overall improvements include the investment in Nursing & Quality posts responsible for setting and upholding high standards of quality care and patient safety which include:

- Head of nursing & Quality for Acute Forensic Services (AFS) X3 Matrons for AFS
- Associate director of Infection and Prevention Control (IPC) and Physical health (Trust wide new post)

10.4 Historically there has been several practices identified that were deemed ineffective around training and understanding/competency around deteriorating physical health of patients. Physical health Training has now been strengthened with further reviews and ongoing developments expected.

10.5 Plan your day meetings are currently being implemented to wards at the Edenfield centre so there is a record of any changes or concerns that can be raised daily as this was not happening previously.

10.6 Provision of staffing of the ward on which Stuart was placed had significant and long-term issues. A robust and accurate daily reporting mechanism has been established for the reviewing and reporting of safer staffing across the Service, with twice daily safety huddles and daily situation reports. Data is now available and measured to identify which wards are persistently short of staff and where particular wards are used to repeatedly drawn on staff to support other areas. The Service have recently undertaken their comprehensive safer staffing establishment review. This safer staffing review included clinical and professional discussion with ward managers, operational managers and matrons, and analysis of quality indicators. All the wards completed the Mental Health Optimum Staffing Tool (MHOST)[23]. The findings from

[23] The Mental Health Optimal Staffing Tool (MHOST), was created with the support of Health Education England, it calculates clinical staffing requirements in mental health wards based on patients' needs (acuity and

the MHOST data collection have been triangulated with other key metrics and Telford Model (Professional judgment tool)[24]. This is in accordance with National Quality Board (NQB)[25] requirements.

10.7 There is work underway to look at the pathways and the clinical model of the unit, and how the voices of the patients are heard through person centred approaches to care planning. To strengthen person centred approaches, a Mental Capacity Act 2005 awareness audit has been undertaken which, although highlighting areas of good practice including detailed analysis of the decision to be made and involvement of the individual and others, evidenced gaps in terms of documentation. In particular, the audit highlighted that the Trust's Best Interest Decision Balance Sheet and Best Interest Meeting Record form were not being used in accordance with Trust policy. As such, a training programme has been developed to enhance skills and knowledge for staff and to ensure that MCA and Best Interests practice and procedures are understood and adhered to. Introduction of new ward round procedure had been introduced which highlights capacity and safeguarding as key considerations during review.

10.8 IPC audits have led to the introduction of "bedroom of concern audits" alongside the introduction of the self-neglect toolkit and assessing (using a rating scale) for when someone's room is untidy. Then depending on outcome actions are taken. There has been a focus on educating the workforce in recognising self-neglect via several mechanisms such as 7-minute briefing and further training.

10.9 There has been a drive to improved staff knowledge and competency relating to management of diabetes through additional training. Development of new diabetes care plan and audit of existing framework. A pathway has been developed for service users who are deemed obese and require support regarding weight management.

10.10 An audit undertaken to review the quality of the care plans. Introduction and Use of patient status "at a glance board" to alert staff to any Physical health needs. Physical health overview in ward rounds is now taking place.

10.11 A Patient Advice and Liaison Service (PALs) officer[26] has been recruited to and based at the Edenfield centre 3 days per week to strengthen the patient voice.

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dependency) which, together with professional judgement, guides chief nurses and ward based clinical staff in their safe staffing decisions.

[24] Telford's professional judgement method (Telford, 1979), first formally described in the UK in the 1970s, provides a way of converting the shift-level staffing plan, decided using expert opinion, into the number of staff to employ.

[25] The NQB provides advice, recommendations and endorsement on matters relating to quality, and acts as a collective to influence, drive and ensure system alignment of quality programmes and initiatives.

[26] The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

10.12 Introduction of weekly patient safety panels which provide oversight and assurance of patient safety and quality issues including safeguarding. All Physical health equipment used has been reviewed.

10.13 New Safeguarding process has been introduced following the Panorama incident by Bury adult social care.

10.14 The provider collaborative has a programme of unannounced quality visits to the wards in the secure setting and greater emphasis on gather in the voices and experience of service users.

10.15 NHS England are also developing the ways the voice of the service users is gathered as part of quality surveillance.

11 Summary

11.1 In summary Stuart was a gentleman who endured long standing mental ill health which met the requirements under the MHA to be detained to a secure unit. This detention lasted until his death, a total of 22 years. Prior to his admission he is described as proud of his appearance and popular person. Over the 22 year he spent in hospital he developed several long-term health conditions; he became morbidly obese and self-neglecting of his personal care. He became lost as person.

11.2 The care required to manage his deteriorating physical health needs was not supported by adequate care planning. The basic components of nursing care Assessment/Diagnosis/Outcomes and Planning/Implementation/Evaluation were not evident for all his needs. This prevented the presenting issues being brought together in a single person-centred care plan.

11.3 The absence of care planning, accompanied by a lack of consideration of Stuarts capacity to make decisions about his physical and selfcare needs facilitated the continuous deterioration of his physical health. The lack of awareness of self-neglect as a safeguarding issue did not prompt any consideration or reflection of the care he needed. Parallel investigations and reviews support that mechanism were not in place to oversee and challenge the quality-of-care Stuart was receiving.

11.4 The systems in place for a patients detained for a long period, like Stuart, did not include a consistent approach to provide advocacy or ways to hear his voice and understand his lived experience. This was accompanied by the family becoming more distant, as it was deemed Stuart had capacity to make the decision to decline family

involvement in his care. There appears to have been no attempts to foster that relationship with his family in alternative ways. It appears that ultimately there was no one to be a champion for Stuart and advocate on his behalf.

11.5 It is difficult to state categorically the care Stuart received lead to his death. But the findings of this review identify that the care he received did not promote best health nor prevent deterioration, it did not lead to improvement in his quality of life.

11.6 The application of the MHA Code of Practice appears to absent in this case. The Code which was first created to help professionals and others working in services to interpret the MHA as it applies to decision-making in day-to-day practice, and to provide safeguards for involving and protecting people in mental health services. One of the purposes of the Code is to help local services to support the empowerment and involvement of patients and carers, and to make sure that safeguards are in place to support and protect the dignity and respect of people. Going forward there needs to be consideration as to how those patients who are not proactive in their own care, isolated from family and external services are supported to ensure they receive safe services.

12 Conclusion

12.1 This SAR Report is the Bury Safeguarding Partnership response to the death of Stuart to share learning that will improve the way patients, with long an enduring mental and physical health conditions can be cared for safely.

12.2 All those involved in the SAR spoke openly and honestly about the case and showed humility to accept the standard of care and service delivery in this case were not what they would expect and a desire to improve as they move forward.

12.3 The findings of this review identify that Stuart experienced a continuous downward spiral of self-neglect and poor health. Accompanied by the findings of parallel reviews that as an organisation GMMH and wider system did not have sufficient quality oversight of patients in their care. The additional case management oversight afforded to patients in secure hospital also did not pick up the deteriorating physical health of Stuart, challenge or escalate concerns or champion on his behalf, due to the capacity and resources within the service.

12.4 Following the identification of gaps in knowledge around self-neglect and Mental Capacity, poor care planning and the absence of advocacy, it is important that

assurance and oversight of these areas is robust. Patients that have very length periods of detention need additional levels of scrutiny due to their isolation.

12.5 That evidence of the effectiveness of the changes made since Stuart's death need continuous oversight to ensure improved standards of care for future patients in long term hospital detention.

13 Recommendations for BSP

13.1 Both Greater Manchester Mental Health Trust and Pennine Care NHS Trust identified gaps in the care planning for physical health needs whilst in Mental health settings. They should provide regularly updates the BSP on the progress specifically around care planning for physical health and person-centred approaches to care in Mental health units.

13.2 Mental Health settings should provide assurance to the BSP that practical education on MCA is in place and the impact of the education on practice.

13.3 Information and/or data on safeguarding incidents, referrals and enquires from mental health trusts to be shared with the relevant subgroup of the BSP to monitor the impact of the actions taken following this SAR and to provide partnership scrutiny of the information provided.

13.4 The BSP should be provided with assurance from GMMH and PCFT that education on self-neglect for patients with a diagnosed mental illness is in place and this is reflected in the safeguarding data of the organisations.

13.5 Organisations caring for patients with a diagnosed mental health disorder, that are detained for long periods of time should establish the following and provide the BSP with the assurance that improvements are being made and it impact

- what is best practice for advocacy and hearing the voice of patients through their journey through services
- how to ensure the voice include families and how those relationships are supported

13.6 Internal and external organisations that are responsible for oversight of care planning and case management ensure that this is person centred and routinely audited for quality. Assurance to be provided to the BSP that improvements have been made .