Richmond
Safeguarding Adults Board

Safeguarding Adults Review

(Sophie)

Lead Reviewers:
Mary Burkett and Eliot Sullivan-Smith

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Contents

1. Introduction

1.1 Why this case was chosen to be reviewed

This case was chosen to be reviewed because it met the statutory criteria for a Safeguarding Adult Review (SAR) under section 44 of the Care Act 2014. This case involves issues related to the impact of a provider unilaterally changing its mode of delivery, and subsequent death by suicide[1] of a young vulnerable female adult. This case illustrates the complexity and inherent risks in placements, specifically for young adults just through transition, the need for effective communication between agencies and the number of agencies involved in working with young adults.

The Richmond SAB decided to use the SCIE *Learning Together* systems methodology to undertake this review in order to gain the broader systems learning from the case. (Fish, Munro & Bairstow 2010).

1.2 Succinct summary of the case

Sophie was a young woman who had been known to mental health services from the age of 14. She formally entered care when she went to Thornbury Hall, a residential setting. This review covers the period of her care from transition to adult services at the age of 18 through to her death at 19 when she was living in a residential setting in Richmond.

From her teenage years, Sophie suffered from mental health problems and at a young age received a diagnosis of bipolar affective disorder and social anxiety disorder. A diagnosis of atypical autism was later made in an attempt to capture the social communication difficulties demonstrated by Sophie, and ensure that these would be appropriately attended to. Sophie had a history of self-harming and it was well known that she found change particularly challenging, she had difficulty in expressing her feelings, and displayed disproportionate behavioural responses to interruptions in routine or stressful situations. As might be expected Sophie was unsettled for her first few months at her new home, but the structured environment and support she was receiving helped her to flourish, her self-esteem and confidence grew. She started volunteering and developed strong friendships with the other residents. Profound unilateral changes were made to the way care was delivered in the home. Over January 2016 the staff group changed dramatically and very quickly numerous concerns were raised with the Care Quality Commission (CQC), who liaised with the Lead Borough for Safeguarding (London Borough Richmond upon Thames). Over the next few weeks Sophie became more unsettled, other friends were moved out of the home, or were admitted to hospital. Sophie remained in the home with only one other resident. In May 2016, she took her own life.

[1] A formal cause of death has yet to be confirmed by the Coroner's court

1.3 Review timeframe

The SAB decided that the critical time period to review in this case was from March 2015 when Sophie was first placed at the provider until the time of her death in May 2016.

1.4 Organisational learning and improvement

Statutory guidance to support the Care Act 2014 states that:

> "The Safeguarding Adults Board (SAB) should be primarily concerned with weighing up what type of 'review process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. Safeguarding Adults Reviews (SARs) may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases". (DoH[2] 14:135)

The use of research questions in a *Learning Together* systems review is equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of systems Findings.

Richmond Safeguarding Adults Board (SAB) identified that the review of this case held the potential to shed light on particular areas of practice including addressing the following research questions:

1) How effectively are transition arrangements from children's mental health services, and 'settling' in to adult services, managed to support service users and their families?
2) How do services and practitioners respond when service users in crisis are also undergoing periods of change?
3) How do placement authorities respond to concerns/changes in provision of care, and when these are also expressed by service users?

1.5 Methodology

Statutory guidance requires SARs to be conducted in line with the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability. In addition, advice states that:

- "there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

[2] Statutory Guidance to support the Care Act 2014, Chapter 14

- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively." (DoH,14:138)

It also gives SABs discretion to choose a review methodology that suits particular circumstance: "The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected". (DoH, 14:141)

1.6 Reviewing expertise and independence

The SAR has been led by two people who are both accredited by SCIE and experienced in the use of the SCIE *Learning Together* model. Eliot Sullivan-Smith and Mary Burkett are independent health and social care consultants and have no previous involvement with this case, nor any current relationship with Richmond SAB or partner agencies. The lead reviewers have received supervision from SCIE as is standard for *Learning Together* accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

1.7 Methodological comment and limitations

<u>The 'shape' of the review</u>

The SAB asked that the review process should be based around a one-day *Learning Together* Workshop, which was used to engage with the front-line practitioners and line managers, and generate the qualitative data needed to inform the review process. This was followed by a separate meeting with members of the Review Team (managers of local agencies) to support the process of analysis of the practice within the specific case, and to move beyond that to draw out the broader systems learning that has been highlighted by the case, and produce the generic findings. The reliability of the findings is strengthened by the involvement of local managers who considered local service issues, however as this review did not involve any individual interviews (conversations) with front line practitioners or managers it is important to recognise that there is necessarily a slightly reduced level of case specific detail. Further detail of the review methodology and process is contained in the appendix of this report.

<u>Participation of professionals</u>

Due to the time since Sophie's death and criminal proceedings being considered there were not as many staff available to attend the Learning Together Workshop who knew

Sophie personally as the Review Team would have liked. However, all agencies were represented and where staff who were involved in her care were not able to attend their managers participated. The Lead Reviewers were also able to use information by staff that was provided to the police as part of their investigation. Senior agency managers from across a number, but not all, agencies formed the Review Team, which supported the analysis work. The input of the 'right' people at the Review Team and the Learning Together workshop are key to supporting meaningful conclusions being drawn.

Perspectives of the family members

One of the Lead Reviewers was able to meet with Sophie's parents in 2017. The parents were clear that they considered there to be organisational and individual culpability for their daughter's death. They were complimentary about the quality of working relationships between Sophie and her key worker at the provider, and Children's health and social care practitioners, prior to her transition. They recognised the inherent difficulties that adult services might have had in communication with them given Sophie was an adult who had stated she did not wish her parents to be involved in decisions about her care.

1.8 Structure of the report

Statutory guidance requires that SAR reports "provide a sound analysis of what happened in the case, and why, and what needs to happen in order to prevent a reoccurrence, if possible (DoH, 14:149)

- The Appraisal of Practice section provides an overview of what happened in this case in terms of the professional practice that took place. It clarifies the view of the Review Team about how timely and effective the interventions were, including where practice was above or below expected standards.

- A short transition section highlights the ways in which features of this particular case are common to work that professionals conduct with other adults and therefore provides useful wider organisational learning to underpin improvement.

- The Findings section forms the main body of the report, and explores and tests out the key areas of generic learning that have emerged from the case. These are the systems issues that are not only specific to this one case but have a broader application.

2. The Findings

2.1 Appraisal of professional practice in this case: a synopsis

The appraisal sets out the view of the Review Team about how timely and effective the interventions with the service user were in this case, including where practice fell below or above expected standards and why. This synopsis of practice is a link from the specific case to the wider findings about the local safeguarding system, between April 2015 and May 2016.

Judgements of practice are made in light of what was known and what was knowable by practitioners involved in the care and treatment of Sophie during the identified review period. The Reviewers also rely on records of actions being taken. Sometimes the lack of a record is referred to in the appraisal of practice; the reviewers recognise that the lack of a record does not necessarily mean that an action did not happen. For some aspects of the case, the explanation for why these judgements have been made will be further examined in numbered findings for which a cross-reference will be provided.

Appraisal of practice

In 2015 Sophie moved from a specialist adolescent placement, with Looked After Child status, to Lancaster Lodge (LL), an 11-bedded 'therapeutic residential service' for adults aged 17-40 years old, part of Richmond Psychosocial Foundation International (RPFI). Her placement, geographically within the London Borough of Richmond upon Thames (LBRuT), was funded by London Borough of Wandsworth Social Services and Wandsworth Clinical Commissioning Group. Ideally, placing authorities should offer a 'variety of providers to choose from'[3]. However, it is recognised that nationally, placing authorities find difficulty in offering a variety of placement options to people with quite complex needs. With her diagnoses, and in recognition of her status as a Looked After Child with additional needs, she had robust transitional planning by the Looked After Child Team. However, although she is recorded as having met the manager of the home prior to her transfer, there is no evidence of a visit to the placement prior to her move, which would have been good practice. The Pathway Plan by the Leaving Care Team was robust and during the first month and onwards Sophie had continuity of contact with the Professional Advisor from this team. This was only ongoing contact with a professional who knew her from her previous placement.

Sophie's placement review was carried out on 3rd June 2015. This was not well-planned, as in the two days preceding she had met with her Leaving Care worker (1st June), on the 2nd June she met with a member of staff from Thornbury Hall for lunch. The failure to coordinate these visits was a missed opportunity for information sharing and joint working; for agreement as to how Sophie's needs would be met, how placement reviews would be conducted and who would lead on day to day support, including the role of LL, and local mental health services. **Finding 1**

[3] S5 (1) (a) Care Act 2014

explores how well placing authorities (commissioners) maintain an active relationship with providers through formal and informal oversight.

A few days later Sophie experienced a relapse in her mental health, she was hearing voices and was very agitated and anxious. She was assessed by the Hospital Psychiatric Liaison Service, before being discharged back to LL with support from Richmond Mental Health Crisis and Home Treatment Teams. This could have been another opportunity to further explore with Sophie and the professionals involved in her care if there were further steps which could be taken to support her with the transition to adult provision. Services focused predominantly on symptom-management; given her symptomology a period of instability was predictable however there is no evidence that consideration was given as to whether she might benefit from further support, and whether the relapse was a response to anything specific other than the move.

The following day LL reported Sophie missing. She returned on her own stating she was being stalked, and experiencing anxiety and fear regarding her safety at LL. Staff were required to restrain Sophie, the police were called, and she was taken by ambulance to Hospital, where following an assessment, she was admitted. After six days Sophie was discharged back to LL with some changes to her medication. The medication changes were later considered to have been a positive change.

Sophie continued to exhibit paranoia, confusion and hallucinations. She was seen at LL by the Home Treatment Team, but over this short period, there is limited evidence of communication between LL and South West London and St George's NHS Mental Health Trust (SWLStG), to support a well-integrated and informed view of Sophie's progress. The focus of LL staff remained on symptom management and medication responses over psychosocial approaches or discussion about what triggered the relapse. Sophie's crisis care was reactive, there was no evidence of a discharge plan consistent with the Care Programme Approach (CPA) or any care planning process to review her holistic social care, placement, and mental health needs. **Finding 2 explores how well organisations work together to protect individuals and predict and manage crises**.

At the beginning of August Sophie made a request to her Leaving Care Team to move out of LL. This request was discussed between the Leaving Care Team, the placement review officer, and LL which was good practice. They concluded that Sophie was too unwell to move (Sophie was kept under constant observation and not allowed out unaccompanied), and recognised that she changed her mind frequently about leaving and might well change it again. The placement review officer made a commitment to look for alternative placements if that was what Sophie wanted, which again was good practice. However, this decision was communicated through LL – rather than by direct contact, which would have been more appropriate. There is no record of the LBW Placement Team following up her request to move at a later date, which would have been good practice. Understandably there might have been a reluctance to endorse another move, given Sophie's known reactions to changes in circumstance, however, given her level of vulnerability some follow up would have been appropriate.

A friend of Sophie's from a previous placement died in early August. Despite awareness of the affect that this major event might have on Sophie there is no evidence that any discussion took place with LL staff or of any follow up referral for additional support bereavement support. Good practice would have been to more actively support Sophie through her period of loss.

Sophie's mental state continued to deteriorate and, following a suicide attempt she was admitted to hospital. Whilst in the hospital the Home Treatment Team initially refused a gatekeeping assessment[4] on the grounds no bed was available. This is not good practice and the Trust expected all requests to be responded to and assessments made the same day. A comprehensive holistic mental health assessment, following the recovery model, was undertaken the following day.

Family relationships were important to Sophie and she repeatedly expressed a wish to return home. However, as many an 18 year old might, she refused her consent for information to be shared with her parents. Given her age and vulnerability, how to keep her parents informed and involved would have posed a dilemma for practitioners.

Once again, there is no evidence of a discharge CPA or other care planning review process by the Trust. This was another missed opportunity to involve Sophie, her family, and social care mental health team, and LL. As well as discharge planning this could have looked at strategies to prevent future admissions to hospital. Instead Sophie was simply returned to her placement.

September 2015 through to January 2016 was a period of relative stability, over which Sophie's mental state improved. There had been a change in her medication, she had received therapy and psychological interventions and her familiarity with the staff and other residents at LL and their expertise would all have contributed to this. There were a stable group of residents who she bonded well with – they were a supportive group who "looked out for each other". In September 2015 LL were rated Good by the CQC.

During this period, Sophie was supported by LL and the Leaving Care Team to build more structure into her life. She attended the Recovery College where courses included 'Taking Control'; this helped her to understand herself better, develop confidence and assertiveness skills. She sought employment and voluntary work and hoped, longer-term, to go to University. These practitioners illustrated providing sound person centred support to Sophie.

Around the end of 2015 RPFI initiated significant and unilateral changes at LL. These changes involved the review of external staff supervision and the proposal to deliver all the therapy by in house staff, rather than source these to meet the specific needs of residents. Senior staff at LL were not happy with the changes which were likely to profoundly adversely impact on residents. **The way these changes were**

[4] An assessment for suitability for admission to a psychiatric hospital bed. The assessment takes place to ensure that all appropriate community options have been explored.

unilaterally imposed was not good practice and is discussed further in Finding 3.

Sophie's period of stability and progress towards recovery continued almost until February 2016 when changes at LL began to have a very visible impact on the residents. Sophie stated at the time that she was concerned and troubled about the changes in staff at LL, the loss/end of therapy, and a feeling 'that she is going backwards'. **Finding 4 considers the precariousness of Sophie's recovery and questions how services may develop a culture of understanding of what recovery looks like, not just avoiding what relapse looks like**.

In January, the long standing manager of LL resigned with immediate effect, the Clinical Lead (the next most senior position) having already resigned in November. The reviewers understand these resignations were a result of the changes being brought about by the RPFI Board at LL and lack of consideration that was perceived by them to have been given to the welfare of residents. Given the sudden and dramatic nature of the manager's leaving, being walked off the premises in front of residents and other staff, the Review Team would have expected RPFI to have directly communicated with the CQC and placing authorities, but no such communication is evidenced as having taken place.

RPFI view the staff and service changes they made as introducing stronger governance to LL and bringing services into line with the RPFI ethos, and their other provider, albeit for a different client group. They believe they had appropriate staffing in place, although given the short term nature of their first appointment to the Registered Managers position, and the background (i.e Youth Worker) of the second appointment this belief is difficult to understand. The new 'Clinical Lead' (who, following the initial resignation was promoted to the Registered Managers position, had recommended that, to be consistent with the ethos of RPFI, all therapeutic input should be provided by in-house staff; the idea was that staff would be trained to undertake the therapy provision, this was planned to take place in February 2016. There is no evidence the new Lead had the appropriate knowledge and experience to make this decision in relation to the needs of this particular group of residents. It is questionable whether this level of support could always be sourced internally or indeed if this is what placing authorities would consider appropriate. It is the view of the Reviewers that a significant change of this nature fundamentally altered the nature of provision offered (and contracted for) and should have been discussed with the CQC and with placing authorities.

Following the manager's resignation all but one staff member left within the next 4 weeks. RPFI assert that there was sufficient continuity of staff with appropriate skills and experience following this resignation, but this is not the experience or understanding of Sophie's family, or the Review Team. Given the degree of service changes it would be expected that the Board at this point would inform their placing authorities and the CQC, at least to reassure them about the safety and wellbeing of their residents. **Finding 3 considers the impact of unilateral provider redesign and transformation decisions in the context of the provider commissioner relationship.**

Over the preceding few months there had also been significant changes in the Board of Trustees at RPFI and the Board were operating ultra- vires. These changes were known to residents and their families but were not known to either the regulatory bodies (CQC and Charity Commission, or the placing authorities). Finding 1 explores how a closer oversight both formal and informal is exhibited in placements and Finding 3 about the lack of safeguards in the system to prevent or identify unilateral changes.

It does not appear that the impact of change on Sophie and, given her diagnosis of atypical autism, the predictability of change-related crisis was taken into account by agencies working with her. Reviewing agencies, when considering changes to an individual's home environment, should always seek to understand how change is perceived by that individual, and evaluate the likely impact of change on their wellbeing. This was especially important for Sophie for whom relationships were fundamental, and for whom change was a considerable stressor and potential relapse-trigger. **Finding 5 explores how Wandsworth practices person centred care to understand and record individual needs**.

In a meeting with her Care Coordinator it was recognised that Sophie was finding the changes at LL very difficult. It was also noted that the routines and structure provided by education / college had been beneficial and that Sophie was attempting to put more structure into her life. This was validated by the Care Coordinator, but no steps were taken by statutory services or LL to support this approach by providing more structured input themselves, which would have been good practice. In fact, as residents left LL activities in the home were reduced.

From February 2016, and following service and personnel changes, concerns were repeatedly raised by staff and families to the CQC in relation to the care at LL. At the beginning of March the CQC made an unannounced inspection visit, in line with their best practice. LBRuT initiated a Provider Concerns Meeting, in line with the London Multi-Agency Adult Safeguarding Policies and Procedures, which was held at the end of March. Due to staff holidays and a subsequent misunderstanding about whether the meeting had been cancelled LBW missed this meeting. Misunderstandings can happen, but, given the nature of the concerns some follow up by LBW would have been expected, and good practice. Immediately following the meeting, all placement authorities initiated placement reviews, with the exception of Wandsworth, who were contacted on several occasions by LBRuT regarding meetings and concerns. A month later, LBRuT distributed minutes of the meeting, this is longer than would be expected.

In a case of provider failure it might be expected that the host authority, through the Safeguarding Adults Manager (SAM), would liaise closely with the provider management team/ Board to ensure that any care and safety issues were being communicated to placing authorities. This did not happen here, neither does it appear that the role of the SAM was made explicit to all placing authorities. The tensions inherent in ensuring clients' safety and the environment within a failing provider are significant, and excellent communication needs to occur between regulatory bodies, placing authorities and the host authority to successfully manage

moves from the home. **Finding 2 explores how organisations work together to protect individual residents and predict crisis and relapse**.

A strong bond had formed between the residents, all of whom were affected by the changes at LL. However, the residents' friendship group became more unstable as some residents moved away, and two residents were admitted to hospital after attempting suicide. None of the services involved in providing or commissioning Sophie's care explored the impact of this on her, nor was additional support offered. It would be the responsibility of the provider to ensure this support, however there is a strong argument that at this point LBW, and ultimately responsible for Sophie's care, as the placing authority should have been far more proactive in their management of the placement.

The Review Team were in agreement that it is reasonable to expect that when a placement is in such a state of flux and vulnerable clients are involved, commissioners/placing authorities would take steps to ensure people's safety, physically and emotionally. A placement review officer was allocated to Sophie in February and visited at the beginning of March. Given LBRuT's safeguarding team were in touch with LBW's adult mental health services concerning the changes and concerns relating to LL, it is not clear why, given her needs and vulnerability, there was not more explicit consideration to whether other actions could be taken to ensure her wellbeing.

Communication within Wandsworth Adult Mental Health Services and between other agencies was poor, Sophie's Social Worker from Wandsworth appeared unaware of the Safeguarding processes. Sophie's family were notified first of the need to move, and plans were suggested and agreed before involving her. Given the context this was understandable however there was no multi agency conversation to agree a strategy for the move and who might be best placed to support her on different aspects, either at this point or later. This would have been expected and would have been good practice. This lack of consultation was challenged by Sophie's care coordinator from SWLStG. Sophie's father made numerous attempts to speak to the front line practitioners, eventually speaking to a manager and later the Placement Review Officer herself. He was emphatic with both about the risk to moving Sophie and the need to manage this extremely carefully, Despite his interventions and attempt to influence the way the move was managed Sophie found out about her move during a MDT meeting held by SWLStG. She was understandably distraught; if there had been multiagency conversations this could have been avoided.

Sophie was well known to be vulnerable to change and she was losing her close peer group relationships, as well as experiencing significant uncertainty about her placement. Predictably the process to find a new placement for Sophie was difficult. She was upset by the move, and did not feel well enough to visit a placement when it was agreed. At this stage there was no evidence of communication between the Review Officer, the care coordinator and the Leaving Care Team. The Review Officer visited Sophie, however a relationship did not exist between them and the impact of this on Sophie does not appear to have been explored. Sophie's family

report that Sophie was not happy to travel to a placement with her due to this unfamiliarity.

From 27th April 2016 Sophie was recorded as presenting low in mood and tearful, she reports that 'no one was listening to her'. Following a home visit Sophie's parents raised concerns about her mental state to LL. Lancaster Lodge, LBW, and SWLstG emailed each other about LL concerns that Sophie was becoming more poorly. Communication illustrated the dilemmas for staff; recognising that mentioning a move to Sophie would be distress her, that Sophie was angry that her family had been consulted and had agreed a plan for her to move, prior to her knowing. Sophie stated she wanted to move, but to a semi-independent accommodation. Staff at LL were concerned about the extent of her deterioration, recognising rightly that an urgent clinical assessment was needed and that a professionals meeting should be called.

On 28th April despite this deterioration, and Sophie's expressed wish to consider semi-independent living, arrangements continued for her to visit an alternative placement. It was curious that the provider that was being considered did have a step down facility but it was not recorded that this was explicitly explained to Sophie, which might have alleviated some of her anxiety. No mention is made of an advocate to support Sophie during this time which would also have been good practice. Visits to two placements were planned for the following day. Later on that day Sophie expressed feeling in a 'dark place' and the wish to take her life. Sophie had a history of self-harming and a potential ligature was removed from her room.

The SWLStG mental health team responded the next day to follow up the incidents of the previous day. A crisis plan was set up and a medical appointment brought forward to 9th May. The professionals 'meeting' requested by LL took place (involving the mental health team, the Social Worker (who had visited Sophie), LL staff, and the Psychiatrist), and it was agreed to review the situation after the weekend. This was expected and reasonable practice based on what was known.

The planned visits to the placements on 29th April were cancelled because Sophie was not sufficiently well enough. Lancaster Lodge requested additional funding from LB Wandsworth to increase care and observations with additional waking night cover. LB Wandsworth's view was that this was already included in the contract and suggested that LL should provide the necessary extra support to Sophie until she moved, and that they should make use of A&E if they had concerns. The request by LL should have alerted LBW to the fact that LL were potentially not coping with Sophie, and at this stage good, person-centred practice would have been to have reassured themselves that Sophie was safe, rather than focusing on service terms. LL increased their observations, conducting room sweeps and keeping Sophie's door open at night for observation. Over the weekend Sophie continued to be anxious about her move and feel suicidal. Concurrently arrangements for placement visits continued. Although staff recognised the impact the changes were having on Sophie there is no record that sufficient time was taken to discuss this with her, to attempt to better reassure her, although a conversation was held between LBW and LL about slowing the process down and not discussing the move further. At a

meeting with the placement officer the focus was on the visits to other homes, there does not appear to have been discussion around Sophie's wellbeing and the effectiveness of any support mechanisms. There was limited contact between the placement review officer and LL at this point too, due to the perception by the placements review officer that conversations with LL were aggravating the situation. Given this, LBW could perhaps have found other sources of support for Sophie. Despite previous recent conversations that the move could be slowed down a decision was made that the move would take place the coming Friday, 7 days later. There is no record in the notes that this decision was communicated to Sophie, nor is it clear why the decision to take things more slowly was then reversed so abruptly. Sophie lets her LL Keyworker know that she is happy for the Leaving Care PA to be her advocate; it is not known if this conversation was initiated by a staff member or not, however it would have been good practice to do so. This decision was relayed to her LBW social worker. There was no record that this was followed up by the placement review officer, which would have been good practice.

Visits to possible placements planned for 2nd May were aborted due to transport problems. Lancaster Lodge called the crisis team as they were very concerned about Sophie's health. Transcripts of this conversation demonstrate LL were advised to take Sophie to A&E, notes made by LL at the time state LL staff understood that they were being asked to manage the situation, and an A&E visit was not necessary. This confusion on the part of LL is hard to reconcile, specifically as they were concerned for Sophie. The Lead Reviewers were informed by Sophie's family that residents overheard staff talking about the Board's wish to change the focus of the client group of LL to Learning Disabilities, and an assumption was made by them that they would not be allowed to return to LL if they went into hospital. This was seen by them for the reason that an ambulance was not called. Although staff were conducting bedroom searches to remove items that Sophie could use to harm herself and she was on close observations, other rooms were not made safe for her. During the evening, Sophie excused herself from staff to use the bathroom. Whilst there she tied a ligature, the injuries caused by which she subsequently died from two days later.

2.2 In what ways does this case provide a useful window on our systems?

Sophie's case is unique, however the style of care delivery and challenges presented to service providers is typical for young care leavers, and young people generally through transition and in ongoing need of adult social care. Much knowledge exists around transition illustrating how difficult this period of time is for all young people. Young adults with no adult social care needs are usually supported through to adulthood by family and friends, and major decisions talked through with loved ones. For young people who have been in residential care, there is likely to be a level of institutionalisation, which will create an added dimension of dependency. It could be expected therefore that for a young person with the complexity of need exhibited by Sophie that the level of support needed would be considerable. For a young person like Sophie to then be placed in a home for adults with the 'rights' of adults is a very steep change and challenge for them. The support and care

provided to children is very different and more intense than for adults, and different legislation about rights and decision making, encapsulated in the Mental Capacity Act, means that vulnerable young adults can be left inadequately supported. There are often deficiencies in communication between the agencies supporting children, as well as in those supporting adults, but in these transitional situations communication between the two (adult's and children's) is also important. Various policies and procedures support this transition but it is still the case that young people are expected to function with a considerably reduced level of support. Whilst resources might make it difficult for a universally different approach there appears to be no attempt to work with those young adults for whom the transition is easily predictable to be severely challenging, and likely to fail, if they are not provided with more support than would otherwise be the norm. The challenges for adult social care services are for it to be truly person centred, responding to the needs of those clients who very vulnerable. Vulnerable young people who come into the care of adult social care requires them to work in a sophisticated way, working extremely closely with transition services, family and others to support the client through this difficult change, whilst respecting and working within the legal framework for adults. This is likely to mean a different style of service provision and possibly closer oversight of the care being delivered than would be usual for other adults. The alternative is a very sharp, abrupt loss of support for young adults at a time when they might need it most. There are also links between this SAR and another one recently done by LB Richmond.

2.3 Summary of Findings

The review team have developed five findings for the SAB to consider. These are:

	Finding	**Category**
1.	How effectively and flexibly do commissioners maintain an active relationship with out of borough placements through the operation of formal and informal processes of oversight?	Management Systems
2.	How well are organisations, regulators, providers and commissioners, working together to protect individual residents and predict crisis and relapse?	Management Systems
3.	There is no safeguard in the commissioning contracting system to prevent unilateral service decisions being made by a provider, meaning that compliance with any contract is over-reliant on trust and good practice	Management systems
4.	To what extent can Richmond & Wandsworth provide a personalised care planning process that reflects the precariousness and complexity of what good looks like for adults with mental illness**?**	Professional norms and cultures in longer term work
5.	How effectively does Wandsworth practice person-centred care for adults in placement both in relation to efforts made to	Professional norms and cultures in longer term work

	understand individual needs and how those needs are then recorded?	

2.4 Finding 1 How effectively and flexibly do commissioners/ placement authorities maintain an active relationship with out of borough placements through the operation of formal and informal processes of oversight?

MANAGEMENT SYSTEMS

This Finding looks at the the presence (or not) of mechanisms for oversight of placements that exist for commissioners, their quality and flexibility.

2.4.1 How did the issue manifest itself in this case?

When the initial placement was made the contact by LBW adult mental health services was only with the provider, as is standard practice. LBW adult mental health services allocated a placement review officer for the discreet period of the placement review. There were two other key agencies who were to have ongoing involvement in Sophie's care. The Leaving Care team and SWLStG. The 'receiving' NHS and social care partners (SWLStG) are not routinely contacted even when a client with high needs is being placed as the emphasis is on the contract and funding of the provider. In this case, the placement cost was very high.

There was no ongoing or periodic contact between all these agencies which meant that sometimes full use was not made of the knowledge and experience of those who regularly worked with and had a relationship with Sophie.

In this case when SWLStG had CPA meetings, neither LBW nor LBRuT social care were invited to the review meetings. This was not usual or good practice at the time. Additionally a placement review meeting was held with no other agency present, and outcomes of the Leaving Care meetings were not routinely shared with other than LL.

2.4.2 How do we know this is an underlying issue and not something unique to this case?

The Review Team and Case Group confirmed that no special consideration is given to young adults entering the care of adult mental health social care; a social worker is not allocated to them and placement reviewers operated for the discreet period of any one review. The Review Team confirmed it was not unusual for there to be no additional communication between teams on a routine basis when undertaking reviews/meetings to try and coordinate these in order to both maximise information sharing and planning to the benefit of the client. The Review Team considered that a similar pattern and issues applied to young adults with a learning disability.

2.4.3 What is known about how widespread or prevalent this issue is?

In Wandsworth, during 2015-2016, 8 young adults left children's mental health services, 7 of whom were placed out of borough. There were more young adults with a learning disability, 20, who were placed in an out of borough placement. The practice that was followed with Sophie is standard practice for all these placements, and the Reviewers do not consider this to be unique to Wandsworth.

2.4.4 What are the implications for the reliability of the system?

The placing authority have a duty to their residents to make decisions consistent with their wellbeing, and to promote service-user led life outcomes. Without an active relationship with their resident, or contact with a local service fulfilling this role, placing authorities are less able to fully respond to the changing needs of their service user. The needs and experiences of younger adults may fluctuate greatly between review periods. The implication for the system is that as changes occur service users may be seen to still be at the level of ability seen at the last placement review.

Post-placement, the long-arm and sometimes inflexible nature of review mechanisms can mean placing authorities may not capture the changes in presentation of their clients. Different, perhaps more regular contact with these 'devolved' agencies could ensure a more holistic view of the setting.

Finding 1 How effectively and flexibly do commissioners/ placement authorities maintain an active relationship with placements (out of borough and more widely) through the operation of formal and informal processes of oversight?

QUESTIONS TO THE BOARD

- How would the Board like the future oversight of the transitional and medium term care in adult services of young vulnerable adults in out of borough placements to take place in order to aspire to the best outcome for the young person, that takes into account their changing needs.
- How does the Board gain assurance that when commissioning and contracting care agencies are discharging their duties under the Care And Statutory Support Guidance 2017 to 'regularly assuring themselves of the safety and effectiveness of commissioned services (para 4.19)

2.5 Finding 2. How well are organisations, regulators, providers and commissioners working together to protect individual residents and predict and manage personal crisis

MANAGEMENT SYSTEMS

For vulnerable young adults it is not unusual for several organisations and agencies to be involved in their care with different responsibilities. By working together they can better protect the young person and be in a stronger position to be able to predict times of crisis. This Finding focusses on the degree to which agencies and practitioners work preventatively to predict and alleviate personal crisis in service users, rather than simply react once it has happened. It links to findings 1 and 4

2.5.1 How did the issue manifest itself in this case?

An important part of effective mental health care is the assessment of risk and development of crisis and contingency plans that seek to understand signs and symptoms of relapse, and to predict and prevent relapse and personal crisis. At different stages in her life Sophie experienced relapses of illness, including paranoia, anxiety, and depression; which she exhibited through challenging behaviours, and acts of self-harm. Despite this risk management plans to both minimise the way unavoidable change/challenges were presented and discussed with her, or how she could be best supported in a crisis, were not developed.

Amongst the agencies and services supporting Sophie there was significant knowledge of the way she responded to challenge and change. In the early months of her stay at Lancaster Lodge staff had responded appropriately at times when she self-isolated or was feeling unwell. They were all working toward a mental health qualification and had regular clinical supervision where approaches could be considered. However, there was no record provided to the Review Team that indicated there was a risk management plan in place that specifically addressed moments of crisis, nor when and if information should be shared with others or escalated to LBW.

The placement review was a 'snapshot' based on previous patterns and history, there was no evidence of a comprehensive assessment undertaken; neither were there other agencies present at the review meeting; the Review Team considered this was usual, but poor, practice. This was a missed opportunity to identify the lack of comprehensive risk management plans that responded to Sophie's behaviours, and the specific and complex nature of her mental health and social communication difficulties.

It was predictable that when the need for her to move was identified due to the concerns raised about LL that this was going to be a difficult and challenging period for her. Despite this, there was no plan amongst the agencies about how the information should be shared and how she might be immediately supported. This resulted in her finding out at a multi-disciplinary team meeting; predictably she was distraught at the news and immediately called her parents. Despite her clear distress there is no record of agencies trying to mitigate some of the impact that this had, or plan together how her move could be taken forward.

In a provider failure, the risk of relapse is very real, and the need for a proactive and anticipatory response could be predictable. The multi-agency network did respond to quality failings and complaints about LL. This same network could have anticipated that both the failure of the provider, and the coordinated action taken by agencies would have an impact on the service user group, and on their mental health. This was another missed opportunity of behalf of LBW to understand Sophie's needs and behaviours and predict and manage the risk that should would likely pose to herself.

Following on from the changes, other residents experienced crises and two were admitted to hospital following suicide attempts. The group had been a strong peer group and at this point there was only one other resident in the home; the impact of the loss of her friendship and support group was again predictably going to have an adverse impact on Sophie's mental health. Again, no discussion or planning took place around her likely support needs.

2.5.2 How do we know this is an underlying issue and not something unique to this case?

The tools used by LBW practitioners to conduct assessments do not routinely cover known behavioural risks and how these can be managed and mitigated, suggesting this is likely to be an underlying issue across all client groups in receipt of care, not just those most vulnerable, unless a particular professional thinks and behaves differently.

2.5.3 What is known about how widespread or prevalent this issue is?

What happened in this specific case was not considered to be unusual by the Review Team. As such, it can be predicted that the same issue could be presented for any service user

who struggles with stability, for example people with dementia, experience of mental health problems, a learning disability, or young vulnerable adults. The numbers of residents who rely on support to function with more stability are difficult to predict but are likely to be large.

2.5.4 What are the implications for the reliability of the system?

The lack of a systematic multi-disciplinary individualised risk strategy for residents places them at unnecessary risk. Situations will inevitably arise that trigger crisis, if these are not explicitly discussed then are less likely to be responded to in a timely and appropriate way; in a worst case scenario, they can be inadvertently made worse in the way they are handled.

SWLStG Mental Health Trust were in the process of developing crisis collaborative plans that cover predictable risks and there management; this is now in place and would have been of use in this case.

Finding 2. How well are organisations, regulators, providers and commissioners working together to protect individual residents and predict and manage personal crisis

QUESTIONS TO THE BOARD

- If there is a value in individual risk analyses for every vulnerable adult how might such analyses be conducted and most effectively shared?
- How can the Board be reassured that health and social care providers apply crisis intervention theory and reflect on crisis experiences learning for future situations, putting in place a management plan that covers relapse and crisis management for vulnerable adults that is co-created with them and others of their choosing?
- What measures would the Board like to see in place that attempts to respond at the earliest possible stage in cases of provider failure?
- Where day to day risk management is delegated to residential or nursing providers how can statutory agencies be reassured that prevention of crisis and risk are key goals of longer term therapeutic interventions?

2.6 FINDING 3. There is no safeguard in the commissioning/contracting system to prevent unilateral service decisions being made by a provider, meaning that compliance with any contract is over-reliant on trust and good practice

(MANAGEMENT SYSTEMS)

Placing authorities (in this case LBW) have care placement agreements in place with the provider of care for their clients. Such agreements cover the nature of care to be provided and how it will be reviewed and managed. In placing clients, an authority attempts to best match a client with the provision and, due to the specialist nature of the need, placements can be made out of borough. This is often the case for young adults with mental illness and adults with a learning disability.

In LBW placements are not made with providers rated ‘Inadequate’ by the CQC. The CQC are the national regulatory body responsible for monitoring the overall organisational governance of providers.

2.6.1 How did the issue manifest itself in this case?

What happened?

Changes made by the RPFI Board of Trustees at Lancaster Lodge resulted in profound changes to the nature of care delivery. The changes related to provision of internal therapy and staff supervision, and resulting staff changes. RPFI's rationale was to ensure consistency with the ethos of service delivery espoused by RPFI. Neither the proposal to make changes nor the actual changes in care delivery were communicated to placing authorities, nor did any consultation take place about the potential impact on residents. In this case residents and families were aware of changes being proposed as there was discussion in the home but this was not relayed elsewhere, and other agencies did not have the degree of closeness to the clients that could have meant they would also have been aware of the changes and able to alert placing authorities. The Reviewers considered that the changes resulted in LL not being able to deliver on their service offer to the placing authorities.

Additionally, there were changes in the RPFI Board of Trustees, and for part of the period under Review the Board operated ultra-vires. It is not customary, or feasible within current resources, for placing authorities or regulators to continually check provider Board governance and this leaves potential malpractice going unnoticed; additionally, no staff members were aware of the changes to alert more senior staff to them.[5] There was discussion by staff in front of residents that there was an intention by the Board to change the focus of LL to a facility catering for the needs of people with Learning Disabilities. The placing authorities and other providers engaging with LL were unaware of these proposals.

What was the consequence?

The series of changes ended in a manager, highly respected by residents and families, leaving; within 4 weeks all but one staff member had also left. Although not required to, the leaving registered manager informed the CQC of the change, but not local commissioners. Within the next 5 weeks two managers had been appointed (the first leaving within 4 weeks); there is no evidence either had the skills or experience to manage the home, nor to deliver the necessary care to what was an extremely vulnerable group. The way the changes were implemented by RPFI, with no regard to the vulnerability of the residents, and no apparent comprehensive risk assessment, plus the lack of any safeguards in the system by the placing authorities, meant a vulnerable group of residents were left in an increasingly vulnerable state. Residents became anxious and stressed, there were 2 attempted suicides and Sophie took her own life.

How was this able to happen?

This was perhaps the biggest question the Reviewers were left with and the answer seems to be that the current governance process for contracts in LBW contains nothing procedurally to prevent a provider going ahead with a major change in direction. Rather, communication of such decisions is assumed to happen – there is no formal mandate within the contracting process to make sure that it does, making the system reliant on other kinds of practice safeguards.

- Every placement is reviewed: the process that LBW had in place for reviewing placements was (and is) an initial review, 6-12 weeks' post placement, and then

[5] Following the events at LL the CQC have begun to review if stronger safeguards can be put in place; The Charity Commission are now aware of the changes.

yearly. In this case, the initial review took place at 12 weeks and a date for the yearly review set for the spring the following year (2017). Significant deterioration can happen within this year; in this case, the deterioration happened over two months.

- Concerns about a placement might also be communicated by members of staff from the placing authority who visit a client in a placement, both formally and more informally. LBW did not assign a social worker to Sophie in this case. Given the lack of an allocated Social Worker there were few instances of informal communication at an organisational level (with other organisations involved or the provider) or communication around Sophie that would potentially have offered an insight into workings of a placement. The Review Team understand it is standard practice not to assign Social Workers to residents in specialist high-cost placements, despite these being the most vulnerable clients in their care.

- Some placements might have outcome focussed care agreements. In these cases, the provider might feel they have the 'right' to change a method of delivery without recourse to the placing authority's knowledge or agreement. This was not the case in this situation.

- The ultimate arbiter of the quality of care being provided by a setting is the Care Quality Commission, but both regulatory and commissioning systems work to a routine and predictable pattern of contact with providers. Within the broad system of regulation and contracting there is nothing in place which provides an early warning system of when a provider is failing in such a dramatic way. In September 2015, the CQC had inspected Lancaster Lodge and rated them Good. Although RPFI managed other homes these catered for a different client group and, as there were no concerns about them, and in the absence of the knowledge of the significant failings of the Board, there was not the perceived need to make any additional checks. The failings of the Board have since been the focus of a CQC investigation.

In this situation, it was not until complaints were made to the CQC that LBRuT and subsequently placing authorities, including LBW, were made aware of the changes.

2.6.2 How do we know this is an underlying issue and not something unique to this case?

That such sweeping changes were able to be made by a provider without reference to or consultation with LBW as commissioning authority, service users or families is not something that is particular to this case. Different approaches can be taken - the Review Team noted that LBRuT have published procedures for managing safeguarding at an organisational level, including specific actions as part of outcome meetings to consider actions to monitor the safety of service users. In general, however, organisations follow standard practice around corporate risk. Once areas of poor practice or failure are identified agencies work together to share information, but there is little in the system to identify risks and manage these to pre-empt failure. The style of communication between commissioners (placing authorities), and providers consists of a standard formal contractual mechanism with no built-in relationships that might foster closer, more informal communication between the organisations. Neither is there a mechanism to access informal information about a provider in an ongoing way. The contractual process for spot placements is the same for all placements regardless of care group or registration activity; there is no discernment in the

system to highlight those who are more vulnerable (or whose needs may be more complex or subject to greater variation) and who may therefore benefit from additional or more frequent oversight. Service users are involved to provide intelligence and feedback on their experience.

Additionally, within placement agreements (contracts) there is nothing stating what should happen when a provider changes its operating model, rather there is an implicit expectation that providers inform commissioners/placement agencies of any changes to service delivery.

This is not helped by procedures around placement reviews which typically take place in isolation of other agencies or organisations.

2.6.3 What is known about how widespread or prevalent this issue is?

Commissioning arrangements are geared towards standard rather than exceptional circumstances, and toward placing people with less volatile and complex needs. Brokerage teams routinely exist to focus knowledge and skills of contracting and placements within one team rather than being dispersed amongst placement and review officers. At the time, LBW did not use a Brokerage service. There is an additional complexity in the system due to the shared funding of some placements between the NHS and LAs, as in this case. In cases such as these the governance arrangements between the relevant statutory agencies needs to be clear to identify communication and feedback in situations like this.

Out of borough arrangements are more likely for people with complex needs, who by definition can be more vulnerable and may require non-standard input. LBW contract team report that the number of out of borough placements made for adults aged 18-25 with mental illness in 2015-2016 was 7, out of a total of 8 out of borough placements. The number of out of borough placements made for people with a learning disability in 2015-2016 was 20, out of a total of 25 placements. These figures do not change substantially year on year.

The pattern of placements is not different in Wandsworth than in other local authority area in England therefore it is likely that this has a wider significance.

2.6.4 What are the implications for the reliability of the system?

The absence of safeguards preventing unilateral change allows practice that is primarily driven by organisational needs, at the expense of person centred care. This situation might be able to occur more easily where providers are out of borough as there could be fewer informal channels of communication, nonetheless is arguably pertinent to all placements. This presents a huge challenge to commissioners, who need to ensure that their clients receive services that are both in their interests and lawful, while at the same time being aware of the very real financial pressures that exist on all forms of service delivery. Under these circumstances, we would argue that discussion and consultation between all parties is desirable to ensure any needed changes are in the clients' best interests and maintain the integrity of the service offer

FINDING 3. There is no safeguard in the commissioning/contracting system to prevent unilateral service decisions being made by a provider, meaning that compliance with any contract is over-reliant on trust and good practice

QUESTIONS TO THE BOARD

- How can Health and Social Care commissioners gain intelligence about the organisational circumstances of local providers, in order to better gain advance notice or warning as they enter periods of organisational or service change?
- How can the Board be assured that contracting arrangements contain robust safeguards that prevents providers from unilaterally changing the mode of service delivery?
- How can the Board be assured that the procedures for managing safeguarding at an organisational level taken into account the additional risk presented to residents from provider failure and actions of the multi-agency safeguarding system?
- How does the Board want to assure themselves that host authority responsibilities are sufficiently understood and shared in cases of provider failure?

2.7 Finding 4: To what extent can Richmond & Wandsworth provide a personalised care planning process that reflects the precariousness and complexity of what good looks like for adults with mental illness?

PROFESSIONAL NORMS & CULTURE in LONGER TERM WORK

Effective person-centred transition planning is essential to help young people and their families prepare for adulthood. Effective person-centred planning should support relapse prevention and crisis contingency planning, seeking to understand what 'good looks like' for the individual. The aim is to support individuals to identify and pursue their goals, while being self-aware about crises and periods in their life when they are 'unwell'.

2.8.1 How did the issue manifest itself in this case?

This case offers two contrasting examples of personalised care being provided to Sophie, one in a period of organisational stability and the other in a period of organisational crisis. There was a good Pathway Plan in place for Sophie however there does not seem to be a comprehensive care plan that covered all areas of Sophie's treatment and care during times when she was well and in relapse.

During her time at LL Sophie experienced times of stability and achievement as well as times of emotional adversity.

During her stay in LL Sophie did well when she was 'held' in a structured environment. She formed close bonds with the other women at the placement. Her Pathway Plan provided her with access to support and an environment tailored around her resulting in a rise in her self-esteem and confidence. Her parents reported that she was doing things that they didn't ever think she would be able to do. Her family were part of her life and she spent successful nights away with them, as well as day outings. 'Good' for Sophie was characterised by structure and routine, personalised-care, and empowerment and control over her life, choices and decisions.

When life was harder for Sophie she self-isolated and at times self-injured, or had suicidal, thoughts and urges. These occasions were picked up by LL staff who then changed the risk rating, and a record made in the daily log. The plans in place did not state how Sophie would like to be supported during difficult times, emotional crisis or in the event of relapse in her mental health condition. The approach taken to risk management often appeared disempowering and paternalistic, rather than collaborative and person-centred. Two examples of this are:

On one occasion when the LL team thought she was 'tonguing' her medication they crushed her pills. This ran contra to the Mental Capacity Act 2005, and the legal framework for dispensing medication.

It was also recorded that Sophie did not go out without being accompanied by a staff member as she was sexually vulnerable. Although it is not clear from this whether she was ever prevented from going out (directly or through behavioural consequence) if this had been the case it would again have been a violation of her rights.

In both these situations staff clearly thought they were doing what was in Sophie's best interest, however, they did not have a documented discussion with her agreeing to this, nor, if she lacked capacity in this area, the comprehensive assessment of her mental capacity and Best Interests decision-making required under the Mental Capacity Act 2005.

These two situations could have been helped if prior to a crisis arising staff had discussed with Sophie, and, given her young age, ideally her family.

When the staff in the home were seriously concerned about her mental state a phone call was made to the emergency team who advised that she be taken into hospital; this was misunderstood and she remained in the home. Again, if a plan had been agreed between the treating team and provider about how a relapse like this should be responded to (how and when to escalate concerns) then the course of action would have been absolutely clear and not open to interpretation.

2.7.2 How do we know this is an underlying issue and not something unique to this case?

The Review Team did not consider that practice in this case varied from usual practice, neither was LBW practice around care planning unusual or specific to this case. Many young adults with mental illness or a learning disability will have complex presentation that needs a flexible and well planned response for periods when they are well and when in crisis. The care planning, therefore, should cover in advance both of these situations explicitly for when the client might be in extreme stress and not able at the time to fully articulate their wishes. In this way preplanning with clients would provide providers and practitioners with the information, knowledge and permission to work in ways that differ from occasions when the client is well.

Material put forward to the review by LL suggest that they considered that the staff in post were sufficiently skilled and knowledgeable to manage and support the level of need being presented. Given Sophie's ultimate death and the attempted suicide of two other residents could suggest that they either under-estimated the skills required, or the level of client need. This is the only therapeutic home for adults with mental health illness that RPFI run.

The Leaving Care team report that a frequent issue for leaving care clients is what agencies might need to share with family and they record this in the pathway plan; a routine part of the plan is to discuss strengths and concerns and how to respond to these. It appears that neither the Leaving Care Team nor adult social care routinely discuss with residents the nuances surrounding decisions to involve family and loved ones.

2.7.3 What is known about how widespread or prevalent this issue is?

In a recent study of 27 Safeguarding Adult Reviews across London, the lack of personalised care was drawn out as a learning theme, including in one case the focus on the operation of organisational systems over personalisation (Braye & Preston-Shoot, 2017). The same report highlighted significant learning about the failure to properly deploy the Mental

Capacity Act 2005 framework, with assessments being omitted or poorly performed, and best interests decision-making lacking. Good practice was identified when agencies worked together with the individual firmly at the centre of decision-making.

The numbers of LAC in transition are very small and Sophie was one of a very few young people leaving care with mental health issues in 2015. Therefore, although the numbers are small, the impact of faults in the system on these residents is extremely significant.

2.7.4 What are the implications for the reliability of the system?

By its nature treatment and care delivery for young adults with mental health illness are complex and precarious. The lack of a comprehensive care plan that covers all aspects of a resident's needs, for when they are both well and in relapse, can result in their vulnerability being increased due to inappropriate decisions being made and or left to chance. In the absence of a clear plan decisions and actions can be taken which can be contrary to the clients wishes and or outside any legal framework.

Finding 4: To what extent can Richmond & Wandsworth provide a personalised care planning process that reflects the precariousness and complexity of what good looks like for adults with mental illness?

QUESTIONS TO THE BOARD

- How will the Board be assured that there are comprehensive processes in place to support residents when they are in times of crisis and when they are well in order to provide an all-round 'good' experience of care?
- How can the Board and member organisations best support and work with young people to reflect the nuances around family members' involvement in their care and life?

2.8 FINDING 5 How effectively do Richmond and Wandsworth practice person-centred care for adults in a placement, both in relation to efforts made to understand individual needs and how those needs are then recorded?

(PROFESSIONAL NORMS/CULTURES – LONGER TERM WORK)

This Finding picks up a number of issues identified in the previous one and elaborates on the implications for person-centred care for individuals receiving care in formal placements.

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 concerns the provision of person-centred care; it is one of the things that the CQC look for when they inspect a provider. The intention of the regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. Providers must take action to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences. They must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves.

2.8.1 How did the issue manifest itself in this case?

The quality of care provided to Sophie when she was under 18 and legally a child was good: her needs were well documented by LBW Children's Social Care; the diagnosis of atypical autism was made and evidenced to ensure her communication needs were considered. The Leaving Care Team worked with her to develop Pathway Plan which was comprehensive and tailored to her needs including vocational work and Recovery College. This was good practice. The degree to which the quality of her person-centred care changed once she became an adult is best illustrated by focussing on two events:

a) Her transition to adults' services

Sophie moved to Lancaster Lodge without prior visits to the placement before her moving date, or, other than her Leaving Care PA, continuity of contact from professionals who knew her during the first month of her placement. Despite the clear notification of her diagnosis of atypical autism, LBW adult mental health services reported being unaware of this as commissioners of her placement. It is not clear why they were unaware as the Review team confirmed it is routine practice for a summary of a client's needs to be provided during the transition to adults' services. Usually, it would be the social worker's role to coordinate information from all sources, however, Sophie was not allocated a social worker, although she was allocated a care coordinator through the SWLStG NHS trust. There is no record of contact between agencies to build a picture of her progress and wellbeing through transition to her life in Lancaster Lodge, neither did there appear to be a care plan, separate to her Pathway Plan, which could have provided a reference point to include all aspects of her care. The benefits of a CPA approach were not fully utilised through the development of a shared plan, incorporating or referencing the Pathway Plan, to support Sophie and the agencies that supported her to deliver comprehensive and coordinated care.

At the first placement review meeting held by LBW neither the Leaving Care team nor the care co-ordinator from SWLStG Mental health trust (who provided her mental health care) were invited, thus missing an opportunity for LBW, as commissioners, to gain from the experience and insight of other's knowledge of her. In the days either side of the review meeting she received visits from the Leaving Care PA, and separately a staff member from Thornby Hall – her previous placement as a 'child'. Her Leaving Care PA particularly would have been an important person to have included in any review a she had been working with Sophie for some months.

b) The point at which concerns about Lancaster Lodge became known; February 2016 onwards

This was the stage at which the decision was made for Sophie to move without her being involved in this, told about it before her family, or being discussed with other agencies which were working with her and knew her well. The placement review officer spoke with her parents, against her previously expressed wishes, and at no point was an advocate offered to her to help her better communicate her wishes and needs.

The lack of communication at this point between the provider, mental health trust care coordinator, Leaving Care PA and placement review officer meant that insight and knowledge about Sophie within the system was not maximised as would be good practice for a vulnerable adult. It would be more essential than ever that at this time great care was taken to get to know Sophie and ensure that she was at the centre of her care plan, involved in its production and delivery. Although this did appear to be the case for her Leaving Care Pathway Plan there did not appear to be a separate care plan developed by LBW adult social care and therefore no communication took place between the two.

Finding 2 also raises the more general concern about the requirement to provide person-centred care to every individual in the placement given the organisational decisions that were able to be taken.

2.8.2 How do we know this is an underlying issue and not something unique to this case?

In the context that most service users struggle with child to adult transitions it is not surprising that the most vulnerable children/young adults find this time even more difficult, specifically those who have been in residential care for a few years. The Leaving Care team told this review there are a number of people in their care who go on to 'get lost' in the system as they move to adult services; this applies to both young adults with learning disabilities and mental health needs.

The Review Team confirmed that it is not standard practice to offer formal advocacy to young adults like Sophie despite the inherent challenges with informal/family advocacy for young adults trying to gain independence from their parents and family. If formal advocacy through a commissioned organisation was not available then informal advocacy, through a worker who she had a strong relationship with, could have provided her with extra confidence and support to engage with other agencies. The Leaving Care team offer advocacy leading up to the placement, however this is not continued with post placement.

2.8.3 What is known about how widespread or prevalent this issue is?

This pattern of practice is not unique to Wandsworth and therefore it can be assumed that it occurs elsewhere.

The numbers of children in care who transition with MH or physical disabilities in a year and the numbers of children with physical disabilities who transition to adult services per year are few. Although these are not 'large' numbers they do represent some of the most vulnerable young adults within the state's care.

Chapter 16 of the Care and Support Guidance (Department of Health, 2017) provides guidance on transition to adult care and support. Paragraphs 16.1 and 16.2 emphasise the importance of effective person-centred transition planning, recognising the stresses of change, and stating that this period of a person's life "should be full of opportunity" (Department of Health, 2017). Transitional assessments are legislated for in section 58 of the Care Act 2014 and are a legal requirement for Local Authorities under certain circumstances.

Chapter 10 of the Care and Support Guidance to the Care Act 2014, provides guidance on when and how to undertake care and support planning. Central to this approach is the involvement of the person and the existence of a plan that provides detail about what needs are to be met, and how they will be met. The Care and Support Guidance also recognises that the issue of failure to provide effective planning has historically been widespread (Department of Health, 2017).

2.8.4 What are the implications for the reliability of the system?

When delivered appropriately a person-centred care plan offers young people like Sophie the best opportunity and chance they have to function to their full potential. Operating in an environment where care delivery is devolved adult social care must ensure that the care plan is clear and providers are held accountable for its delivery. Conversely where this is not present, as in this case, this opens up the dangers and risks in the system.

FINDING 5 How effectively do Richmond and Wandsworth practice person-centred care for adults in a placement, both in relation to efforts made to understand individual needs and how those needs are then recorded?

QUESTIONS TO THE BOARD

- How can the Board support Local Authorities to complete transition assessments that are as robust for young people transiting from institutional care to institutional care, as they are for children living independently?
- How can Health and Social Care Authorities support person-centred care planning for vulnerable individuals in residential or nursing care?
- How can the Board support a standardisation of assessment process that supports personalisation and a recovery approach to care planning for individuals receiving residential home care and encourages learning and sharing across agencies?
- How can the Board explore the barriers to the use of advocates with young people transitioning to adults services, what they are and how they might be overcome?

3.0 Appendices

3.1 How the *Learning Together* review process was undertaken in this SAR

The *Learning Together* methodology can be used flexibly to provide bespoke proportionate reviews to gather and analyse the data and then develop the appraisal of practice and the findings. How the key components of the methodological heart were undertaken in this SAR:

- Generating the 'View from the Tunnel' – from the data provided by front line staff to reduce 'hindsight bias' and generate a more complete understanding of what happened and why. In this SAR that phase of the process was undertaken by front line staff who were directly involved in the management of the case (including practitioners and commissioners) and their immediate line managers at the one day *Learning Together* Workshop.

- Analysing the data using 'Key Practice Episodes' to 'chunk' up the timeline, to appraise the practice of the professionals and to understand what the contributory factors were. In this SAR that phase of the process was undertaken by front line staff, their managers and members of the Review Team at the one day Learning Together Workshop. The analysis and appraisal work was then developed further by the Lead Reviewers and written up in the Appraisal of Practice, with input from the Review Team.

- The 'Window on the System' – the generic findings which provide a window on the local safeguarding system, is generated through the analysis of learning from the specific case, in order to tease out which pieces of learning have a broader application. This phase of the review was undertaken by the Lead Reviewers and the Review Team. It was begun during the one day workshop and then developed further in a separate meeting of the Lead Reviewers with the Review Team.

Richmond SAR Process – Key Meetings		
Date	**Key Activity**	**To achieve**
27.09.17	SAR training session for SAB members, local front line staff and managers	Familiarity with the SCIE Learning Together model
10.10.17	Learning Together SAR Workshop for frontline practitioners and managers directly involved in the case	Gather and analyse case data
07.11.17	SCIE independent supervision session for Lead Reviewers	To quality assure and support development of appraisal of practice and emerging findings
13.11.17	Meeting of Lead Reviewers and Review Team	Verify developing analysis of practice and input to emerging generic findings
tbc	Lead Reviewers facilitate SAB Findings Workshop	To share findings with SAB and facilitate development of SAB action plan

3.2 Members of the Review Team

Role	Agency
Lead Reviewer	Independent
Lead Reviewer	Independent
Head of Safeguarding and Professional Services	LBRuT and LBW
Head of Safeguarding Adults	LBRuT and LBW
Chair and Trustee	Richmond Psychosocial Foundation International Institute (RPFI)
Lead Nurse Adult Safeguarding	South West London and St Georges Hospital NHS Foundation Trust (SWLStG)
Registered Manager	RPFI (Lancaster Lodge)
Sector Manager	Care Quality Commission (CQC)
Service Manager Adult Mental Health Services	LB Wandsworth
Head of Planning and Quality Assurance	LBs Richmond Upon Thames, and Wandsworth
Senior Contacts Manager	LBW
Team Manager, Future First, Leaving Care Team	LBW
Detective Sergeant, Specialist Crime Review Group	Metropolitan Police
Head of Service, Adult Mental Health Services	South West London and St Georges Hospital NHS Foundation Trust (SWLStG)
SAB Coordinator	Richmond and Wandsworth SAB

3.3 Members of the Case Group

Role	Organisation
Safeguarding Manager	LBs Richmond & Wandsworth Council
SAB Coordinator	LBs Richmond & Wandsworth - SAB
DS Specialist Team	Metropolitan Police
Inspection Manager	CQC
Service Manager	Richmond & Wandsworth Council – MHT
Social Worker	LBW Mental Health Team
Assistant Team Manager	LBW Mental Health Team
Manager	CQC
Senior Contracts Manager	LBs Richmond & Wandsworth– Commissioning Team
Quality Assurance and Contract Monitoring Officer	LBs Richmond & Wandsworth
Trustee	RPFI
Registered Manager	RPFI (Lancaster Lodge)
Safeguarding Adults Lead	South West London & St George's Mental Health Trust
Head of Social work Associate Director/AMPH	South West London & St George's Mental Health Trust Previously associate Director CMHT – Local Authority
Social worker (Locum)	Previously LA – Adult Services

Role	Organisation
Acute Care Coordination Centre Manager	South West London & St George's Mental Health Trust
Team Manager	LBW Children's Service
Root Cause Analysis author	South West London & St George's Mental Health Trust
CAMHS Consultant	South West London & St George's Mental Health Trust
	South West London & St George's Mental Health Trust
Specialist Crime Review Group	Metropolitan Police

3.4 Summary chronology of key events

DATE	KEY EVENT
10th April 2015	Sophie moves in to Lancaster Lodge
1st June 2015	LL cancels a placement review meeting they have with the Leaving Care PA and Sophie. The Leaving Care team discover she has self-admitted and contact LL to find the reason for the relapse; they complete Sophie's Pathway Plan.
3rd June 2015	Sophie's mood fluctuates, the LA placement review takes place with no one from the Leaving Care team present or people who know her well.
6th June 2015	Sophie is taken to A&E with chest pain and later discharged with advice. A GP later takes her back to LL after seeing her asking for cigarettes and alcohol.
8th June 2015	Sophie's mood and behaviour deteriorates over a week and she is taken into Kingston Hospital A&E; she reports auditory and visual disturbance, although denies suicidal thoughts. Sophie is deemed to have capacity to make decisions about her care plan and is discharged home to be followed up by Richmond HTT.
9th June 2105	Sophie is reported missing from LL, she returns inebriated at 1am, highly anxious and paranoid. The police pre-assessment check is shared with LBW adult social care
10th June 2015	Sophie is aggressive and disruptive and is informally admitted to Kingston Hospital. It is suggested that a twice daily dose of her medication would be more effective. She is discharged a week later (17th June)
June to beginning of August	These few weeks are difficult ones for Sophie, she self isolates, sleeps poorly, is paranoid and hallucinates. Sophie is not totally compliant with her medication and LL request a medication review at which her medication is changed. At the beginning of June her placement is reviewed by LBW, with a further review in one year's time. At the end of July the NHS care coordinator asks the doctor to review her, saying that her parents are also concerned. At the beginning of August Sophie discovers that a friend of hers from Thornby Hall has died, understandably she is very upset Sophie contacts the Leaving Care PA to ask if she can be moved to a non-therapeutic setting. The PA and LL manager discuss this and it is recognised that it is not unusual for her to change her mind about this, and also that as she makes herself vulnerable when she goes out alone.
12th August 2015	The care coordinator finds out that Sophie is again expressing a desire to leave LL. The placement review officer confirms that if Sophie does settle on

DATE	KEY EVENT
	deciding to want to move then she will start looking for other placements for her.
August 2015	During the month Sophie's mood varies. She makes a decision to stop Facebook for a while as she feels this affects her. On the 28th August she is in a lot of distress and calls her mum
30th August 2015	Sophie overdoes on paracetamol and ibuprofen and is taken by ambulance to hospital; Sophie reports she won't attempt suicide again
31st August 2015	Sophie is found with a cord around her neck; she states this was not premeditated but that she felt low
1st September 2015	During her gatekeeping assessment Sophie confirms she intended to attempt suicide. Sophie is assessed as high immediate and long term risk for self-harm and suicide. The Leaving Care PA attempts to visit her at home, however finding she is in hospital sends her a card. Sophie remains in hospital and is stable for the next 4 days. On the 6th she puts the handle of a bag around her neck.
8th September 2015	After a consultant ward round Sophie is discharged to LL. She reports she is happy to be back. The next week is a positive one, she engages with others in the home and starts at Recovery College. On the 19th she doesn't return home by her curfew time and is reported missing. She returns home drunk having missed the last train and using the night bus.
October 2015	Sophie continues to function well and attends Recovery College
November and December 2015	On 1st November Sophie meets with her Leaving Care PA and an updated Pathway Plan is developed with her. Sophie has not required PRN medication for 8 weeks and continues to manage herself well; her self-esteem and confidence grows. There are a couple of days when she feels low but generally engages with others and outside activities. Sophie returns from spending Christmas with her parents. Her mum reports that she struggled a bit at home, particularly with eating.
1st January 2016	Sophie tells her Leaving Care PA that she going home every couple of weeks or so and this is going OK, she talks of an interest in studying social care at college
7th January 2016	Sophie's psychology support is ended by LL as they feel she no longer needs this
12th January 2016	Her Leaving Care PA visits again and they cook together; Sophie is still in a positive frame of mind
15th January 2016	The registered manager of LL is seen off the premises in front of residents. Sophie enrols on a college course. The rest of the month is positive with outings and visits home.
1st February 2016	During a prearranged visit with the Leaving Care PA Sophie queries how long she might stay at LL; the PA agrees to raise this with Sophie's LL Key worker
5th February 2016	The CQC receive a letter of concern about LL and a decision is made to visit on 1st March. From this point forward they receive numerous complaints and concerns from ex and current staff, residents and their families.
9th February 2016	LBW allocate a placement review officer to Sophie
19th February 2016	Sophie self-harms although she doesn't report this to staff until a week later (24th)
24th February 2016	Sophie has her last session with her psychologist which she feels sad about
25- 27th February 2016	LL are concerned about Sophie, she feels paranoid about the house management and is confused about her therapy being taken away. Sophie self isolates again.
1st March 2016	Day 1 of unannounced CQC inspection

DATE	KEY EVENT
2nd March 2016	Day 2 of CQC inspection. LBRuT initiate an embargo on LL and an organisational safeguarding meeting. They contact all placing authorities (Including LBW) to attend this.
3rd March 2016	Day 3 CQC inspection, and they continue to receive complaints about LL. The LBW placement review officer arrives to undertake a placement review meeting with Sophie who is not well enough to engage with her. The review officer discusses contacting her family but Sophie refuses to give her consent Sophie refuses to go to a prearranged review meeting at the Recovery College Sophie misses her CPA review. LL has stopped structured group programmes and therapies. LL monitor Sophie's food intake and as she is very low, they predict a manic episode. Sophie reports the staff changes at LL have left her feeling unsupported and she wants her medications reviewed. LL contact the mental health team and they are reminded of their duty of service if Sophie deteriorates
7th March 2016	Two residents are admitted to hospital.
8th March 2016	LBRuT again alert LBW to the concerns, LBW confirm they are already reviewing the placement.
11th March 2016	LBRuT contact LBW letting them know that the SAM will be in touch regarding the investigation. They are also informed that 2 other authorities will not be returning their residents there
14th March	LBW Placement Review Team become aware of the concerns re LL
11-20 March 2015	Sophie reports being upset about the other residents hospitalisation and wants to visit them. Sophie engages in different activities, spends time at her parents, and has some positive time at the Princes Trust, but starts to becomes withdrawn.
22nd March 2016	LBRuT inform LBW that an embargo will been placed on LL and there will be a safeguarding meeting on the 29th March
23rd March 2016	SWLSG Care Coordinator visits Sophie at LL. They hear of her fight to get therapy reinstated and that she feels the new staff do not respond to her emotional needs, so she goes to them less frequently for support.
23rd March 2016	Internal LBW email conversation about the need to find a new placement for Sophie
24th March 2016	The Review Office speaks to Sophie's father alerting them to the need to find a new placement for Sophie The Review Officer also emails the Community Housing Therapy group to see whether a placement there would be suitable for her Sophie is given the news that 3 of her friends, other residents, would not be returning to LL, also that her key worker has left. Sophie and her family subsequently were informed by the key worker she had been sacked.
24th March 2016	LBRuT place an embargo on LL
25-28th March 2016	Sophie stays with her parents. The visit goes well and she has a good time
28th March to 12th April 2016	The Review officer is on leave, her out of office gives her managers details – he is also on leave 25th March to 3rd March
29th March 2016	Initial safeguarding meeting was held. LBW are not present
30th March to 6th April 2016	Over these few days Sophie is generally positive; she enjoys attending the Princes Trust, goes shopping with staff, walks with the other 2 residents and spends a day with her family and appeared in a good mood
4th April 2016	The safeguarding manager calls Sophie's father to discuss her move. Mr Bennett informed them of the need to handle the move extremely carefully to ensure Sophie's well being. The care coordinator expresses concern that the move had not been discussed with Sophie and meets with Sophie who seems settled

DATE	KEY EVENT
7th April 2016	Sophie has her MDT review, where she learns in an unplanned way of the proposed move; she is deeply distressed by this and calls her mother in distress. Sophie says she wants a step-down facility, not Dainton House (Dainton House is however a step down facility). It is agreed to review her diagnosis at the next appointment as it looks as if her Atypical Autism is the more visible presenting condition.
12th April 2016	Sophie is assessed by Community Housing therapy group (that manages Dainton House and Lilias)
13th April 2016	The care coordinator and Review Officer agree to meet together with Sophie on the 18th to discuss the move
14th -15th April 2016	LL staff discuss Sophie's low mood, they do not feel she is 'up to advocacy
15th April 2016	The care coordinator expresses concern to the LL manager about information about the move not being passed to Sophie making her subsequently more anxious. Community Housing confirm that Sophie is accepted for a place in Dainton House or Lilas.
16th -17th April 2016	Sophie is very low, distressed in her room. Her mum calls LL expressing concern about her; staff undertake regular checks. Staff report her as paranoid again.
18th April 2016	The care coordinator and review officer meet with Sophie who is anxious but seems pleased at the step down potential of Dainton House. A visit is arranged for the following week (25th). During the meeting LL staff are asked to leave; Sophie is upset at this and later tells her key worker she feels stuck in the middle. LL ask LBRuT to mediate with LBW to slow the move down to give Sophie more time to adjust.
19th April 2016	Sophie again mentions to her keyworker that she feels stuck in the middle. The key worker contacts Sophie's mum and reports she is self-isolating and not speaking Sophie's father speaks to the manager of the placement review team recommending a transition plan is put in place given Sophie's response. The Review Officer confirmed that they would work closely with the care coordinator.
22th April 2016	Sophie's low mood continues. She meets with her care coordinator and LL key worker, she is very distressed and leaves the meeting but with the help of her key worker returns. Sophie is not able to articulate what she wants and agrees to visit DH and another home
25th April 2016	The planned visit to Dainton House doesn't take place as Sophie isn't well enough. The review officer asks LL staff to not talk about the move to avoid more distress
26th April 2016	Conversations take place between LBW and LL, and the care coordinator and Sophie's mother. Later in the day the care coordinator visits Sophie at LL. Concern is expressed that discussion between Sophie and LL staff are exacerbating the situation. It's agreed that, in order to offset any more uncertainty a date for the move should be set and a plan to work toward this put in place. The care coordinator visits Sophie at LL to discuss people's concerns about her but she is unable to have this conversation. She later agrees with the care coordinator to move the following week. The care coordinator asked the LL staff to monitor her overnight The therapist also sees Sophie and expresses her concerns and view it is the speed and lack of notice that is causing the distress

DATE	KEY EVENT
27th April 2016	The LL deputy manager also requests a multiagency meeting to discuss the planned move on the 29th, the review officer responds and agrees a meeting on the 28th. They also request a psychiatric assessment Sophie became very agitated, angry and upset during a home visit, her parents call LL who pick her up.
28th April 2016	Sophie reports to LL staff that she is in a dark place and wants to commit suicide, they find superficial cuts and remove a potential ligature from her room. The review officer meets with Sophie and a LL staff member, after encouragement Sophie agrees to visit Dainton house the following day. Sophie is to be accompanied on the visit by a LL staff member as Sophie feels anxious about using public transport. A request is made to have transport re-imbursed and costs for another worker as LL cannot leave the remaining female resident alone with a male member of staff. That evening Sophie reports feeling suicidal, observations are increased and another room sweep is carried out. The SWLSG crisis team is called and they advise that Sophie be taken to hospital, this was misunderstood and Sophie remains at LL.
29th April 2016	The care coordinator follows up the events of the night before; a crisis plan is agreed. The care coordinator informs LBW LBW agree to pay taxi costs to visit Dainton House, Sophie asks to postpone the visit to Monday as she has not slept well and feels tired. This is agreed LL manager contacts LBW and asks for additional funding for them to meet Sophie's needs for 121 care and waking night staff. This is not agreed and LL are informed that if they have concerns they should support her to attend A&E.
29th April to 1st May 2016	Sophie is often tearful, she is under close observations and room sweeps are done twice a day.
1st May 2016	LL contact the Leaving Care PA as Sophie indicates that she would like her to advocate for her. The Leaving Care PA tries to contact Sophie but as there is not answer so she leaves a message. Sophie reports being anxious and stays in her room. She says she is suicidal.
2nd May2016	The planned visits didn't happen due to a mix up with the transport. The Clinical Lead at LL advised Sophie that she needed to try and stay engaged, she was escorted to the shops. On her return she says she is going to the bathroom As she is on close observations a staff member follows her and after a few minutes asks if she was OK, she responds and the staff member goes away. After 5 minutes staff call Sophie again and find she has attempted to hang herself her. The ambulance is called, she is resuscitated and taken to hospital.
3th May 2016	Sophie is in an induced coma, tests are undertaken to see if her condition is survivable
4th May 2016	Sophie is pronounced dead