Bath & North East Somerset
Community Safety & Safeguarding Partnership

Safeguarding Adult Review: Mr Swaby

Independent Overview Report Author: Deborah Cohen

June 2022

Contents

1. Introduction & Acknowledgements

This SAR was commissioned by the Bath & North East Somerset Community Safety & Safeguarding Partnership (BCSSP) following the death of Levi Swaby. The SAR covers the time span from September 2018 to the date of Levi's death on 19th November 2019.

The information in this Report has been received from the following agencies who had contact with Levi:

- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- B&NES Safeguarding and Quality Assurance Team
- B&NES Adult Social Care
- Options for Living (Supported Living service provider)
- Department of Work & Pensions – Southwest (DWP)
- Avon & Somerset Constabulary (the Police)

The Reviewer was also able to draw on the written views of Levi's family that had been given to AWP and the Reviewer met with Levi's family. Their comments and observations have been interwoven into the report.

In addition, although not involved directly or indirectly involved with the care of Levi, thanks are due to Drug & Alcohol services who contributed to an understanding of how they are organised and how they work within Bath & North East Somerset.

Finally, thanks are due to Kirstie Webb, BCSSP Business Manager, for her assistance in coordinating the work behind the scenes.

All opinions are those of the author only.

Deborah Cohen, Independent SAR Reviewer, December 2021

2. Summary & Recommendations

2.1 Levi Swaby a 36 year old man of Black African Caribbean heritage, died unexpectedly on 19th November 2019 following a cardiac arrest. He left family including his mother, who was involved in his support, and a sister. He also had children with whom contact was variable over the years.

2.2 Levi had been known to mental health services, intermittently, since 2007. He had care and support needs arising from his mental health challenges. A Coroner's Inquest took place and the Coroner's Report stated that the cause of death was accidental overdose, likely triggered by a previously unknown underlying health condition.

2.3 This review identifies a mental health system that was reactive rather than proactive, responding to the immediate presenting problem, but without any indication of learning from Levi's history. It is hard to find evidence of reflection on, and identification of, patterns or cycles of repeat behaviours that a person with chronic, long-term mental health problems might exhibit and how this might impact on the future.

2.4 The delivery of services to individuals with long term, chronic mental health problems is always going to be challenged by more pressing, "urgent" needs. This means that procedures, policies, training, and staff support should be in place which enable practitioners to stand back, review, and reflect on what is really going on, and to construct strategies for recovery. These procedures should include how the CPA framework is applied, how information is recorded, how information is transferred between practitioners, the approach taken in team meetings and supervision, and how services are organised to ensure that individuals with the appropriate professional backgrounds are involved in an individual's care. An effective system which is supportive of its staff enables them to be energised and promotes staff working with someone with chronic needs to remain curious and proactive. It goes to the heart of how mental health services are organised and delivered.

2.5 This Review is a deep dive into the experience of a single person, Levi Swaby. If there was a single stand out missed opportunity or moment when a different course might have been taken, it was the Medical Review on 8th April 2019 when a doctor went to see Levi, carried out an assessment, wrote in the notes not just about his mental (medical) state and capacity, but also about environmental and social issues that were having an impact on his care: suspicions of cuckooing and the state of his flat. Yet these issues were not followed up.

2.6 These comments are not about the individuals who supported Levi: they all acted in good faith and worked hard to support him, rallying around him each time his mental health started to breakdown. These are comments about how the system manages and oversees the care and support provided to individuals with long term conditions, to individuals who self-neglect, and to individuals who engage in "risky behaviours".

2.7 It is important that the BCSSP surfaces how typical the experience of Levi and his family was in reflecting the operation of local mental health services. This Review makes several recommendations.

2.8 The Review has identified eight themes with the discussion structured as follows:

- what should happen,
- what did happen,
- findings, and
- recommendations.

2.9 In addition, the recommendations are brought together in a single list below for ease of reference. It should be appreciated when developing action plans that the themes, findings and recommendations are interconnected.

2.10 The Reviewer has used the generic term “practitioner” to refer to clinical staff of any professional background including social workers. The term “recovery” is not about “getting better” in the medical sense. The word is used in this report in the mental health specific context as being about a personal journey rather than a set outcomes, whereby the individual is enabled to develop a sense of self and supportive relationships, empowerment and coping skills, and meaning, that are personal to each individual’s set of circumstances.

Levi’s Family’s Wishes

2.11 Support has been provided throughout to Levi’s mother, a cousin and aunt. Levi’s cousin, has a background in Adult Safeguarding. She is the author of the family’s report into the experience of Levi in the services.

2.12 The family was very clear when meeting with the Reviewer that it is of the utmost importance to them that services must learn from what happened to Levi for the benefit not just of other service users but also for the benefit of the families of those using services. Families must be included if there is to be an holistic approach and all staff need to understand safeguarding and their responsibilities.

2.13 The Family have offered to present to a workshop of practitioners and/or present to the AWP Board about the experience of Levi and their experience.

2.14 The family has asked that Levi be named in the report in his memory.

3. Background & Summary Timeline

3.1 Levi grew up in Bath with his mother and younger sister and he was in contact with some extended family. He attended local schools and after briefly attending Bath College, Levi worked in various jobs including in shops and as a painter and decorator. His ability to maintain long term employment seemed to be impacted by his mental health.

3.2 He was described by many of the practitioners who worked with him as a kind and friendly man but intensely private.

3.3 Levi had been known to mental health services since 2007. He had an enduring psychotic illness “which contributed to social decline and self-neglect” (quoted from the Trust Patient Safety Report). The clinical records record that Levi had a number of criminal convictions. In July 2011, Levi was referred to and assessed by the West of England Forensic Mental Health Service. The assessment provided feedback on risk management to the community mental health services and noted that some of his offending behaviour was in all likelihood driven by mental illness. Levi was detained under the Mental Health Act between May and June 2011 and in 2012 Levi was diagnosed with schizoaffective disorder. The records seen by the Reviewer do not indicate how or where Levi lived and supported himself during this earlier period. At the point of his admission in 2018 he was living in temporary supported accommodation.

3.4 Levi was subsequently admitted to psychiatric hospital on 2 further occasions: the first informally from: August - September 2018 and the second under the Mental Health Act from April - May 2019.

3.5 This Review considers matters that took place from the date of Levi's discharge from hospital in September 2018 to his death in November 2019. The term "practitioner" is used throughout to refer to clinicians of any discipline including social workers.

3.6 The Review focusses on Levi's mental health care and support needs. Levi's physical health needs and how they were addressed are covered comprehensively within the Patient Safety Report, and not repeated in this report.

Summary Timeline

Date	Event	Activity
Period 1		**Discharge from hospital in September 2018 to readmission on 24th April 2019**
Sept 2018	Hospital discharge	Levi was discharged to his mother's address on 5 September and then given emergency accommodation on 7 September in a Bed & Breakfast (B&B). He was not able to return to his previous accommodation at 'The Paragon'.
Oct 2018 – Jan 2019	B&NES Community support	Support for Levi from the B&NES Recovery Team and the Intensive Team. A Care Coordinator is allocated to Levi. A Housing Support Worker assisting Levi to find accommodation.
Jan 2019	New tenancy	Levi signs a tenancy agreement on 31 January 2019 for a flat in Parsonage Lane, owned by Sanctuary Housing Association. Commencement of package of care provided by Options for Living comprising 6 hours a week, with 3 visits a week, not to be on weekends at request of Levi. Agreed at the first meeting with Levi that Options for Living will support Levi with his Universal Credit claim and his benefits generally.
Feb 2019 to Apr 2019	Care coordination	Levi supported by his Care Coordinator and Options for Living who record working to support Levi in maintaining adequate cleanliness, self-care and help with budgeting. There is one incident when the Police record that "….Levi has been attending the Bank [one of the local high street banks] over the last few days accusing a staff member of breaking into his house in the night. The bank is concerned about Levi due to him appearing erratic/confused".
8th Apr 2019	Medical review	Levi's Care Coordinator contacts B&NES Intensive Service with concerns regarding the deterioration of Levi's mental state. An urgent medical review takes place on 8 April and one of the doctors from the service carries out this review in Levi's flat. It is decided to recommence LS' medication and refer him to the Intensive Service.
9th Apr 2019	Intensive Service	The Intensive Service carries out an assessment. Levi is taken onto their caseload for monitoring of medication, his mental state and risk to self and others.
24th Apr 2019	Assessment - Mental Health Act	MHA assessment is held at Levi's address. Levi is detained under section 2 of the MHA for assessment on Sycamore Ward, acute inpatient unit in Hill View Hospital.
Period 2		**Admission to hospital on 24th April 2019 up to discharge from hospital on 21st May 2019**
24th Apr 2019	Hospital admission	Levi admitted to Sycamore Ward, under Section 2 (treatment order) of the MHA. The assessing team find the lock to the

		door of Levi's flat superglued to prevent the locking of the door.
29th April 2019	Ward review	Ward Review held and it is agreed to grant 1.5 hours a day of unescorted leave.
21st May 2019	Hospital Discharge	Discharge CPA and Levi leaves hospital and returns to his flat with support of the Intensive Service.
Period 3		**Discharge from hospital 21st May 2019 to death 19th November 2019**
21st May 2019	Return to flat	Levi returns to his flat with resumed support from his Care Coordinator, Options for Living, and the Intensive Service.
12th Sept 2019	Visit to GP	Levi attended his GP without appointment, complaining about chest pains and black outs. Levi insists on cycling himself to hospital but did not go to hospital.
18th Sept 2019	CPA review	CPA review in the Community
4th Oct 2019	Discharge form Intensive Service	Levi discharged from the Intensive Service. Services made aware that Levi has received a significant sum of money as back payment of benefit arrears. Ongoing support from his Care Coordinator and Options for Living. GP is to continue to review Levi's physical health at routine appointments and to continue to prescribe Levi's medications.
14th Nov 2019	Employment and benefit issues	Levi meets one of the Individual Placement and Support (IPS)[1] workers in Bath to explore how he can be supported towards regaining paid employment. Later on that day, a visit from Care Coordinator and Options for Living at Levi's home. Levi talks about feeling let down that he has spent all his back dated benefit money. Discussions about Levi starting cookery classes and finding activities to do.
18th Nov 2019	Research opportunity	Levi meets with a research assistant from AWP about participating in a research programme.
19th Nov 2019	Death	Options for Living Support Worker arrives at Levi's flat at around 13.00 to find a large police presence. Ambulance attends. Levi is found in cardiac arrest and dies shortly afterwards.

4. Analysis & Findings by Theme

Theme 1: The Delivery of Care

4.1 The delivery of services to individuals with long term, chronic mental health problems is always going to be challenged by more pressing, "urgent" needs. This means that mechanisms are needed to stand back and review and reflect on what is really going on, and to construct strategies for recovery. These procedures include how the CPA framework is applied, how information is transferred between practitioners, the approach taken in team meetings and supervision, and how services are organised to ensure that practitioners with the appropriate professional backgrounds are involved in an individual's care. This theme is about Levi's care and support in the period under review.

4.2 Levi was supported by the following services:

[1] IPS is an employment support service integrated within community mental health teams for people who experience severe mental health conditions. It is an evidence-based programme that aims to help people find and retain employment.

- the B&NES Recovery Service and a Care Coordinator allocated to him from this Team. This team is an integrated mental health and social care team, providing care, treatment, and support to people over age 18 with secondary mental health needs. The multidisciplinary……support provided is under the overarching frameworks of the CPA and the Care Act 2014. "[The Team] will help you work out possible reasons for your difficulties and give support and treatment to promote your recovery. This will include looking at ways to stay well. When you are discharged, you will have a plan to support this"[2].
- The B&NES Intensive Service offers home treatment for people aged over 16 years experiencing a mental health crisis as an alternative to hospital admission. The Team operates 24 hours a day 7 days a week. "We are a team of mental health workers, with a broad range of specialist skills and experience. Our aim is to work closely with you, and your carers, relatives, and friends where appropriate, during a period of home treatment. We want to help you identify possible reasons for your difficulties. We want to help you to find the best ways to recover and stay well. This may include both planned and emergency visits and contact by phone". Involvement with the team is usually short term and, on average, up to six weeks[3].
- Inpatient Services at Hill View Hospital.
- 'Options for Living, a local independent provider of support services to vulnerable adults, working to help clients maintain tenancies, participate in the local community, and develop a range of independent living skills. This type of support is often referred to as "floating support" in the sense that it is separate from the person's accommodation and was commissioned by the Council.

4.3 The Reviewer was told by one member of AWP staff that Levi was the type of patient that "in the old days would have been supported by the Assertive Outreach Team".

Holistic assessment of need, and care and support planning on discharge from hospital in September 2018

4.4 Discharge planning should start as early as possible following the admission of a patient to hospital to allow for difficulties in putting in place arrangements for safe transfer out of hospital. In mental health services this is carried out under the Care Programme Approach (CPA) by a Care Coordinator who will be based in the community services, working with inpatient staff. In addition, local authorities have the duty under Section 9 of the Care Act 2014 to carry out an assessment where it appears that an adult may have needs for care and support.

4.5 Best practice is that there is a single assessment and a single support and care plan and that these plans can be seen by all staff working in the mental health services with the individual in question.

4.6 Care and support plans should be reviewed at least annually if not more frequently and a new assessment carried out if needs are felt to have changed. Care and support plans should cover all of the patient/ service user's needs.

4.7 Assessment, and care and support planning in B&NES was carried out by the mental health services in AWP who undertake the Care Act responsibilities on behalf of the Council. AWP's patient information system is Rio and all assessments including Care Act assessments should be found on Rio.

4.8 Levi's needs had been assessed under the Care Act on 21st March 2018. The assessment identified five outcomes where Levi had needs for support – to be provided by "supported accommodation Clyde Avenue owned by Arch Care". Levi's accommodation was key to his recovery being the sole action recorded against each of the outcomes relevant to Levi. The author of the assessment wrote: "I am of the opinion that his [Levi] mental health will continue

[2] http://www.awp.nhs.uk/media/425037/recovery-service-banes-leaflet.pdf
[3] https://bathnesshealthandcare.nhs.uk/wp-content/uploads/2017/03/Intensive_Service_BANES.pdf

to decline or worsen further if he [is] without an increase in support and a move to somewhere more appropriate to meet his needs".

4.9 It might be expected that there would either be a fresh assessment at the time of discharge or if not required that this assessment would inform the planning of Levi's discharge from the Applewood Acute Adult Inpatient Unit in September 2018. However, the CPA discharge plan did not reference the earlier Care Act assessment described above and the discharge plan was silent on Levi's housing needs. A document entitled "Your Personal Housing Plan" dated 2nd November 2018 has been seen but it should be noted that this was completed nearly two months after Levi's discharge from hospital.

Findings

4.10 Attention to Levi's housing and accommodation needs was undertaken nearly two months after discharge from hospital and did not seem to take into account the reasons why Levi had not been able to return to his previous accommodation, and that he was therefore effectively homeless. Instead, he was discharged to his mother's home and after 2 days he moved to emergency bed and breakfast accommodation. This was despite the clearly identified need in the Care Act assessment carried out in March 2018 for supported accommodation, and that he had been admitted from temporary supported accommodation that would not take Levi back from hospital on the grounds of his high level of needs. There is no further mention of "Clyde Avenue owned by Arch Care".

This is important because this arguably put Levi into accommodation without the support that he needed to maximise his independence outside hospital, albeit with six hours a week of floating support.

Adequacy of Assessment and Care and Support Planning from September 2018 onwards

4.11 Under the CPA, the discharge plan from hospital would be reviewed and a care and support plan to support the patient/service user to live in the Community would be put in place. This would be carried out by the recipient community team – teams have different processes to accept and allocate incoming cases to Care Coordinators. The assessment and approach will be based on knowledge of the service user, of their history, including past involvement with the services.

4.12 In this case Levi was known to his allocated Care Coordinator who had carried out the Care Act assessment in March 2018 - from before his admission to hospital (referred to above). In January 2019 Levi went into a private rented flat as a tenant and his Care Coordinator arranged for Levi to receive six hours a week support from Options for Living. The support was commissioned and funded by the Council's Adult Care Services.

4.13 Following Levi's second admission to hospital in 2019, there was a CPA review in May 2019 and an updated care and support plan was put in place in August 2019. This plan includes the social care package – Options for Living – and it records as an unmet need "suitable supported accommodation". This plan is in the Rio notes, and it is formatted as a series of drop-down menus rather than in a document format.

4.14 The Care Assessment from March 2018 remains the last assessment of Levi's needs seen on the Rio records. No updated assessment has been seen by the Reviewer in the Rio records at the point of Levi's discharge in May 2019, nor at subsequent CPA meetings.

Findings

4.15 A CPA support plan for the period between hospital admissions (September 2018 to April 2019), setting out how Levi was to be supported to live in a private rented flat, what the risks were of this sort of accommodation, and how they might be mitigated, did not seem to have been put in place. It is not clear what the expectations of Options for Living's six hours a week involvement was. It should be said that the Options for Living internal support plan was comprehensive and included risk assessment and risk management.

4.16 The completion of an holistic care and support plan by the Recovery Team would have provided a baseline against which the fluctuation in Levi's mental state and self-care could have been tracked and linked to his compliance/ non-compliance with his medication and to his drug taking. Instead care and support from the Mental Health Services centred on responses to the periodic crises when the Intensive Service stepped in, and a longer term more sustainable plan was not put in place.

4.17 When Levi was being supported to take his medication by the Intensive Service, his wellbeing improved and when they stopped supporting him his compliance and mental state declined. This pattern did not seem to be considered which meant that an assessment of his ability to sustain compliance without this level of support was not made. This pattern of behaviour together with the knowledge that Levi was from time to time taking street drugs and the impact of this on his mental capacity (discussed further below), and the risks of cuckooing (discussed further below) was not brought together in a case discussion. This is discussed further below.

4.18 Clear objectives within a care and support plan, would have considered the ability of Levi to sustain his intentions and outlined what support he would need to remain well.

4.19 Following Levi's second admission in April 2019, there was no fresh assessment of Levi's care and support needs, which might have been expected given the difficulties that had led to the second admission, which was under the Mental Health Act. However, it is noted that efforts to expedite access to appropriate supported accommodation were stepped up following Levi's discharge in May 2019 and that the support hours from Options for Living were increased from six to ten hours a week, although there was not written plan on Rio about the plan for how these hours were to be spent.

4.20 There was no plan B accompanying the care and support plan on discharge: as to what might happen if Levi continued not to take his medication: for example, moving to depot medication, changing his medication from Olanzapine if that was not suitable for administration by depot, and, if appropriate, the use of a Care & Treatment Order.

Coordination and Oversight of Levi's Care and Support: A Reactive Approach

4.21 The Care Programme Approach (CPA) has until now been used as the framework within mental health services in England in which care and support for individuals with severe and enduring mental health needs is coordinated. The intention is to ensure that individuals do not get lost between different services that might be working with them in parallel and that there is a joined-up approach.

4.22 Patients who meet the criteria for CPA are predominantly individuals with chronic mental health problems, that is they can be considered to have a long-term condition. The patient/service user be stable for long periods or as in Levi's case may relapse frequently and need crisis intervention.

4.23 As noted at the start of this report, the delivery of services to individuals with long term, chronic mental health problems are always going to be challenged by more pressing, "urgent" needs. This means that mechanisms are needed, that include management oversight to stand back and review and reflect on what is really going on and to be able to construct strategies for recovery. These procedures include how the CPA framework is applied, how information is transferred between practitioners, how information is recorded, the approach taken in team meetings and supervision, and how services are organised to ensure that individuals with the appropriate professional backgrounds are involved in an individual's care.

4.24 Systems in place to help practitioners in this complex work include clinical supervision, team case discussion, and CPA reviews. Where relevant, MARM and Safeguarding procedures can be useful.

4.25 The care and support that Levi received was dominated by his periodic relapses, probably caused by a combination of non-compliance with his prescribed medication and his drug taking.

4.26 The pattern or cycle of what was going on was not noted in any CPA review. The suspicions of cuckooing were not brought into any case discussion, nor consideration of Levi's mental (executive) capacity. Both these areas are discussed further below.

Findings

4.27 The Reviewer was not able to find any evidence in the clinical records of an occasion where there was a review of Levi that included reflection or look back on what was going on. This might have surfaced key issues: Levi's pattern of behaviour with respect to compliance with medication, Levi's ongoing drug taking and its possible impact on his executive capacity, the cyclical self-neglect related to either non-compliance with medication or drug taking, and the reports of suspicions of cuckooing.

4.28 This meant that the pattern of care was reactive to Levi's periodic crises rather than proactive and there was little learning from what had and was going on as a guide to future planning of care. Levi's family felt that this meant that his care "drifted" and that there was an absence of "professional curiosity" on the part of the practitioners working with Levi.

4.29 This type of reflection or case management approach could have taken place in supervision. The Reviewer did not look at supervision records but has read the AWP Clinical Supervision Policy (version Jan 2020) and was not able to find in the policy, supervision being used to look for patterns or cycles in responses to clinical interventions or in service user behaviours that might guide a clinician's future approach. This type of reflection or case management could have taken place in a Team Meeting.

4.30 Management processes, for example a system to highlight individual patients who "revolved" on and off the caseload of the Intensive Team within a short period of time, as was the case with Levi, would have provided an opportunity for review and reflection. There is nothing in the records provided to the Reviewer that indicated that this happened. This type of reflection or case management approach could have taken place through calling a Multi-Agency Risk Management meeting (MARM) which was not called. This is discussed further below.

4.31 Without these supports the individual practitioner can be left unsupported and can be too close to the service user to be able to see what might be going on. This encourages a reactive approach that is based on crisis intervention. In this case each time Levi started to relapse, the Intensive Service responded to his immediate needs without delay. However, this illustrates the point being made here, that care was reactive rather than planned.

Continuity of Care between Community and Inpatient Services

4.32 Procedures should be in place for handovers between community services and hospital services on admission and discharge.

4.33 On 8th April 2019 a medical review was carried out by a doctor from the Intensive Service with the Care Coordinator present. The notes made by the Doctor carrying out the review said: "Levi does not believe he is unwell… from the discussion today I do not believe that [Mr] LS has capacity to make decisions about his mental health and its management, decision will need to be made in his best interest".

4.34 The findings in the medical review on 8th April did not seem to have been considered in the Intensive Service MDT meeting on 11th April, at which the doctor who had carried out the review on 8th April was not present, in that there was no consideration of mental capacity issues, nor possibility of cuckooing mentioned in the notes. It was not clear how information about patients/ service users was communicated between staff other than by reading of clinical notes.

4.35 A further example is how the suspicions of cuckooing held by community and inpatient staff, even though recorded in the clinical notes, were not connected up or discussed (see section below) and no action was taken.

Findings

4.36 There did not seem to be any one person or place where the totality of Levi's experiences was held and mapped that enabled the question to be asked "where are we going?" and "what are the underlying issues?". What does Levi's recovery journey look like and what is the strategy to get there?

Theme 2: How well did Services know Levi?

4.37 Knowing the individual patient/ service user is more than recording in the patient's notes, their past psychiatric history. As well as including information on medical history (psychiatric and physical), their family and social networks, and their activities (education, work, etc), this is an opportunity to find out the background of an individual and to situate them in their environment. This will include an appreciation of an individual's ethnic and cultural heritage, and religious / spiritual beliefs. This should enable an understanding of the strengths and resources that the individual brings with them that can be built upon as well as identifying any risks and barriers to care (for example illicit drug taking).

4.38 Knowing the individual patient/ service user includes awareness of that person's health beliefs which may help practitioners identify gaps between their own and the individual's understanding of his or her situation and consequently, this should lead to care and support plans that are acceptable to the individual service user meeting not just their needs but also their expectations. For example, this may include beliefs about how medication should be administered.

4.39 Levi's past psychiatric history is documented in the notes referring to his intermittent contact with services in 2007, 2008, 2011, 2012, and 2017. In addition, there is a brief account of his personal circumstances, but the account seen in the notes gives scant attention to his family networks and his relationships with his family, nor is there an up-to-date account of wider social networks that Levi may have had. Consideration of his cultural and ethnic background is absent.

Findings

4.40 The services had a shallow knowledge of Levi and his situation: including his cultural and ethnic heritage, his beliefs, the nature of his family and other relationships with individuals or community-based groups with which he might have engaged.

4.41 This was discussed by the Reviewer with Levi's family. They did not understand why practitioners had not asked Levi about the meaning of the words that he would use from time to time, that they did not understand, rather than just assuming the words were meaningless or part of his unwellness. It never occurred to any of the practitioners that some of these words might have been Jamaican slang or patois.

4.42 Two days following Levi's death a manager from the Mental Health Service contacted Levi's mother, to ask to meet her and go through some questions with her. At the time she had a house full of family and friends marking the 'Nine-Night', a traditional Jamaican way of marking the death of a loved one, whereby the immediate relatives are comforted by their family and friends. So, it was not a good time to speak. A few days later a letter was received from the Mental Health Service that commented on the fact that she had not responded to their telephone call and the letter noted that at the time of calling she "had had a house full of people". His mother felt the letter was insensitive and blaming of her failure to be in contact, while she was able to have people around in her house when in fact she was within the mourning period. This is recounted here as an example that captures the lack of cultural awareness: after all most cultures have their own practices especially at a time of bereavement.

4.43 The service that was closest to Levi was Options for Living but they did not seem able to raise with Levi the impact of his use of substances on him, nor the cyclical nature of his compliance with his medication.

4.44 A further example are the many references in the Options for Living notes during the period following discharge from hospital in 2019, to Levi's flat door being open or unlocked and Levi not being in, for example: 10th June, door ajar, LS in, 27th Jun, door ajar, LS in, 25th Jul, door ajar, LS out, 19th Aug, door ajar, LS out, 30th Sept, door unlocked, no response. While individual instances might have been mentioned, the repeated pattern was not drawn to Levi's attention by Options for Living nor by any of the other professionals working with Levi. There was no discussion with the landlord (Sanctuary Housing) about security of the flat. It is not clear what the purpose was of recording this, if no action was to be taken.

Despite having been instrumental in securing for Levi the back payment of benefits, Options for Living did not seem able to probe Levi on how he had spent the money.

4.45 There is little evidence of services "getting alongside" Levi; instead, Levi was described as "not engaging" or "difficult to engage". The importance of this is that the opportunity to develop a relationship whereby the pattern of self-neglect when he did not take his medication, and how this might relate to his taking of street drugs, was not explicitly discussed with him when he was living in his flat, nor at the time that he was an inpatient in 2019. Getting alongside Levi meant at least attempting to talk frankly with Levi about his risky behaviours. It meant attempting to discuss depot medication with an understanding as to why Levi was reluctant to receive medication by depot. There are no records of any attempts to have these difficult conversations.

Theme 3: The Relationship with Levi's Family

4.46 AWP recognises the importance of family and carers and is a signatory to the Triangle of Care initiative. This seeks to "achieve better collaboration and partnership with carers in the service user and carer's journey through mental health services".

4.47 AWP has a published "Family, Friends and Carers Charter" which states that in "AWP we use the term carer to mean people who may be a family member, friend or neighbour who supports or helps someone who has mental health problems". The Charter makes a number of commitments including:

- We will value the experience and expertise that you have and work with you as equal and expert partners, in order to give the best possible care.
- We will identify you, the person/primary carer, who gives most support, either at first contact, or at the earliest opportunity, in the community or in the hospital. We will make contact with you as soon as possible.
- We will make sure any identified needs that are our responsibility will be followed up. We will look at the broader family or support system and recognise their role, acknowledge the impact on them and offer support.

4.48 On the part of the Council, under section 10 of the Care Act 2014, local authorities are required to carry out an assessment of carers needs for support, wherever there is 'an appearance of need'. The identification of carers of individuals under the care of AWP is delegated to AWP to carry out on behalf of BaNES.

4.49 During the period covered by this Review, Levi's mother was a constant, even when the relationship between Levi with his mother fluctuated (in his eyes) or was challenged by Levi's behaviours.

4.50 The first time Levi's Care Coordinator met Levi's mother, was in March 2019 when they were both present at Levi's flat. Following that, the notes recorded a phone call from his mother on 11th April 2019 to the Care Coordinator in which she told her that she felt strongly that Levi was "breaking down" and that "he needed to be in hospital". He was admitted to hospital under the MHA a week later on 18th April 2019.

4.51 Levi's mother attended the CPA discharge meeting on 21st May 2019 and the notes record her account of how her son had been up and down over the last two years.

4.52 On 15th June Levi's mother reported to the Services that "her son had come to her house that day, demanded money…… became aggressive and then left". She expressed the view that her son should go back into hospital as he was unable to look after himself. This was recorded in the Rio notes.

4.53 Throughout this period Levi's mother continued to express concern about the state of his flat and at one point Levi's family took photographs of the level of disorganisation and chaos in Levi's flat.

4.54 Levi's mother attended the discharge CPA meeting on 21st May 2019. At this meeting she asked the ward consultant what would happen if Levi relapsed. The response was that "he would likely be readmitted, and considered a depot in lieu of Olanzapine, with a CTO if necessary". As stated under Theme 1 above, this was not formalised as a "plan B" and was not referred to again in any subsequent interactions with the Intensive Team who were called to support Levi's compliance with his medication.

Findings

4.55 There is very little written in any of the clinical notes or care and support plans about Levi's family and his relationships. These are not mapped out. No attempt is made to consider the contact Levi might have with either of his sons.

4.56 Levi's mother, was not formally identified as a "carer" and not offered a carer's assessment.

4.57 The views of Levi's mother did not seem to be considered (even if rejected) in formulating the plans for him and this would seem contrary to the spirit of the Triangle of Care.

4.58 The Options for Living written support plan included in the section on social, cultural, and religious needs: "to encourage L to maintain positive family relationships". However, it is not evident what was done to put this into practice.

4.59 In the spirit of the Triangle of Care and in an attempt to "get alongside" Levi, a different type of relationship with Levi might have enabled the construction of an alliance with Levi's mother to the benefit of Levi. This is not to gloss over the ups and downs of the relationship, but to note that no attempts were made.

Theme 4: Accommodation

4.60 There is the old 'MIND' adage that all anyone needs is "something to do, somewhere to live, and someone to love". Levi was effectively homeless at the point of his discharge from hospital in September 2018 and suitable accommodation was undoubtably a key factor in his recovery journey. This was recognised by the Services seeking to support him. The Care Act assessment carried out in March 2018 (discussed above), referenced the importance of supported accommodation.

4.61 Levi had been asked to leave the supported accommodation that he had been admitted to hospital from in September 2018 because the provider of that accommodation had felt his needs were too great for them. Despite this Levi was discharged from hospital without plans for his accommodation. He left hospital and went to his mother's house and after 2 days was not able to continue living there, and moved to emergency, temporary accommodation in a B&B. The discharge CPA had not addressed his living arrangements.

4.62 A Personal Housing Plan dated 11th September was developed by the Housing Options Worker with Levi. This recorded that before his admission Levi had been living in 'The Paragon', which at that time was temporary self-contained supported accommodation for men and women. In this facility residents have access to an emergency on call facility (from Bath Homeless Guide 2011-12)[4].

[4] https://www.bathnes.gov.uk/sites/default/files/siteimages/Housing/bath_homeless_guide_2011-12.pdf

4.63 Following Levi's discharge, he was not able to return there because after a fire his room was no longer habitable, and Paragon said that Levi's support needs were too high for them, and he was asked to leave. It was necessary to find new accommodation for Levi, and under the Council's Homesearch Allocation Scheme 2019, he was placed into Band B (for applicants who are "in high medical, welfare or hardship need" compared to Band A for applicants who are "in urgent medical, welfare or hardship need"). Levi was able to bid weekly under the Homesearch scheme for social housing and to look for private rented accommodation. He was also advised as an optional but recommended action to make an application for supported housing which "Levi's mental health workers can assist him with". It is not clear if this application for supported housing was made.

4.64 On 31 January 2019 Levi signed a tenancy for a one-bedroom flat in Parsonage Lane in a property owned by Sanctuary Housing Association. This flat was located in the centre of Bath, in a block of flats with a communal front door, with an intercom into the flat.

4.65 On 12 June 2019 Levi's Care Coordinator raised with Levi that he might view supported accommodation. He agreed to visit 'Mulberry House' which took place on 19 August. This accommodation was run by the charity 'St Mungo's'. Levi liked this accommodation however a response was sent to Levi a month later on 15 September saying that they were not able to offer Levi a place. The manager told the Care Coordinator that "Mulberry House is not able to keep medications or prompt service users to taken them, due to not being CQC registered and also having too many any service users to remind them every time". There was no push back against this response in the light of the fact that CQC guidance states that "A scheme might support people to administer their medicines but not provide personal care. The medicines administration is not an 'ancillary activity'. It does not fall into the scope of regulation by CQC"[5].

4.66 The alternative was a project at 82 Lower Oldfield Park run by the local MIND which was a registered care home. They were able to offer Levi a room, but Levi was less enthusiastic as it would have meant moving from his own flat to a relatively small single room. It was not clear if a plan could have been put in place for Levi to take the smaller room on a temporary basis, pending the availability of something.

Findings

4.67 Levi was discharged form hospital without appropriate accommodation. There is no evidence of any consideration of his needs nor of the risks of him being discharged to inappropriate accommodation at this time.

4.68 Despite the earlier Care Act assessment, and the fact that Levi had been living in supported accommodation, Levi moved into an independent flat in January 2019. It is not clear what had changed since the assessment in March 2018 to make this acceptable.

4.69 Efforts to find Levi supported accommodation are stepped up in June 2019. Given his difficulty in sustaining his living environment and the suspicions of cuckooing (discussed below), more intensive efforts should have been made earlier on to find Levi more appropriate accommodation. This should have included challenging the response from St Mungo's with respect to the availability of accommodation at Mulberry House.

4.70 The Reviewer was told many times that there is a shortage of supported accommodation in Bath, and it is acknowledged that Levi was clear that he did not want to move to Bristol where there was a much greater supply of such accommodation. This is a point for Commissioners of supported accommodation in the Council.

Theme 5: Drug Taking by Levi, Self-neglect and Mental Capacity

4.71 Assessing mental capacity is one of the most complex areas of work for practitioners. Whilst there is a growing literature about mental capacity and impairment through the excessive use of

[5] https://www.cqc.org.uk/guidance-providers/adult-social-care/supported-living-schemes-managing-medicines

alcohol there is to date little written about impairment through the misuse of substances. However, this does not mean that the Mental Capacity Act (MCA) cannot and should not be used to help individuals who misuse substances.

4.72 The MCA provides a statutory framework for people who lack capacity to make decisions for themselves. It sets out who can take decisions, in which situations, and how they should go about this. A person who lacks capacity means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. The MCA can apply to people who are substance dependent – 'impairment' includes symptoms of alcohol or drug use (MCA Code).

4.73 Information on the MCA is quoted at length in Appendix 1 of this Review because of its relevance to the learning from this SAR. Areas specifically pertinent to Levi have been highlighted in italics by the Reviewer in the Appendix.

4.74 Notwithstanding Levi's MHA assessment, Levi's mental capacity in relation to his executive capacity to make and carry out his decisions was never formally assessed in the period covered by this review.

4.75 The only specific reference to mental capacity is in the notes of the medical review carried out on 8th April 2019 which recorded that the flat was "chaotic and messy– for example: "the mattress was covered in rubbish, cigarettes, and biscuits……. kitchen chaotic, bags of rubbish…… no electricity". It was recorded that Levi told the doctor that other people are sleeping in his flat – recorded in the notes under risk "reported other people using his flat? Reality? Delusion – he is certainly vulnerable and would be high risk of being exploited". There is a question mark over whether Levi had been taking his medication. "[Levi] does not believe that he is unwell currently. He was agreeable to restarting Olanzapine, but there appeared discrepancy between when he believes he last took medications… and what [the Care Coordinator] established" (from Rio).

4.76 The notes made by the doctor carrying out the review said: "Levi does not believe he is unwell… from the discussion today I do not believe that [Levi] has capacity to make decisions about his mental health and its management, decision will need to be made in his best interest". This is not taken forward and there is no mention of any assessment of Levi's mental capacity on his admission under the MHA to hospital, nor in the meeting of the Intensive Service on 11th April 2019.

4.77 Discussion with Levi by the ward consultant about the use of illicit drugs was held, and this should have resulted in at least consultation with the Drug and Alcohol Services about how to work with Levi.

4.78 The Care Coordinator and support workers from Options for Living throughout the period covered by the Review record the state of Levi's flat, his appearance and demeanour. They also record concerns about access to Levi's flat and this is discussed below in the section on Cuckooing. The state of his flat is pointed out by Levi's mother to the services on a number of occasions (for example the discharge CPA in May 2019) and in photos taken by Levi's family. This should have indicated the level of self-neglect.

4.79 While Levi is in hospital his capacity is not formally assessed although it is noted that Levi "lacks insight, doesn't think he is unwell thinking he is fine".

4.80 The Recovery Team and Options for Living knew that Levi was taking street drugs but neither considered the impact on his ability to carry out his stated wishes. Both the Rio notes and Options for Living notes recorded Levi's wishes, but he seemed unable to put into action these intentions on a sustained basis on account of misuse of substances and non-compliance with prescribed medication.

4.81 The Options for Living comprehensive support plan and risk assessment identifies Levi's vulnerability, his use of illicit drugs, and the risk of cuckooing. It does not consider his mental capacity – there is no box for mental capacity in the proforma.

4.82 At no time was a referral made to the local drug and alcohol services, nor any contact made to seek advice from these specialist services about how to work with a service user who is declining support for his substance misuse issues.

Findings

4.83 An assessment of Levi's mental capacity including his ability to put a decision into effect (executive capacity) was not made. The relevance of the mental capacity legislation to individuals who misuse substances is set out in Appendix 1 due to the specific relevance to the care and support of Levi.

4.84 The Patient Safety Report author asked one of the practitioners who had worked with Levi about assessment of Levi's capacity and the report records the following: "[there] had not been any concerns surrounding Levi's capacity and explained [they] were considering his capacity throughout his care. Capacity is decision specific, and a formal capacity assessment would only occur when concerns about a person's capacity were raised with reference to a specific scenario". This portrays a limited (albeit common) understanding of mental capacity.

4.85 The discharge CPA meeting held on 21st May 2019 is a further illustration of lack of consideration of Levi's executive capacity even though mental capacity had been raised at the point of Levi's admission. The notes record that Levi "plans to go into the building trade……and he said that "he [Levi] feels that he could tell people in his flat to leave if he does not want them there…. He would now lock his door, and he has a fob". It seems that this and more (not quoted here) was taken at face value unquestioningly by the practitioners present despite the concerns raised by Levi's mother "that no one [should go] into his flat" and "the state that Levi's flat was in prior to his admission".

4.86 Levi struggled from early on to maintain his living environment: it was quickly being reported that "his flat is chaotic and messy ….no electricity, no food" (recorded on Rio). This was not identified as "self-neglect" and the Team had not identified any concerns about his mental capacity. There was no reference or use made of the "Revised Self-Neglect Policy and Best Practice Guidance" (first issued in 2015 and updated in March 2019), nor consideration of calling a Multi-agency Risk Management Meeting (MARM). [The Patient Safety Report notes that "concerns surrounding Levi's self-neglect had been raised since 2011, the severity of his self-neglect appeared to directly link with his mental health. When Levi's mental health deteriorated his self-neglect increased"].

4.87 The Options for Living risk assessment proforma does not include consideration of mental capacity.

Local drug and alcohol services were not consulted:

- for guidance about working with someone who would not agree to a referral to their services - this cannot be uncommon
- about local issues in the area that Levi was living
- if they knew what Levi's repeated references to "body fluid" and "nanja" were.

Critically, the linkage between mental capacity (executive capacity and compulsive behaviours), Levi's self-neglect, his use of street drugs, his cyclical pattern of compliance/ non-compliance with his medication, and the possible "cuckooing" of his flat (see below) was not made. And conversations about this were not held with Levi by any of the agencies or professionals working with him.

Theme 6: Cuckooing

4.88 Cuckooing is defined as a form of crime, in which drug dealers take over the home of a vulnerable person in order to use it as a base for drug dealing. The crime is named after the cuckoo's practice of taking over other birds' nests for its young. See Appendix 1 of the Safeguarding Adults Multi – Agency Policy (June 2019) ref

https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/20190625-FINAL-Joint-Safeguarding-Adults-Policy-Somerset.pdf is about Criminal Exploitation (including Cuckooing).

Common signs of cuckooing according to Crimestoppers include:

- An increase in people entering and leaving the property or doing so at odd times
- An increase in cars or bikes outside
- Possible increase in anti-social behaviour
- Increasing litter outside
- Signs of drugs use
- Lack of healthcare visitors.

4.89 The Reviewer would add that any situation where the vulnerable adult is using substances/ street drugs that brings them into contact with drug dealers should trigger a heightened awareness within professionals of the risk of cuckooing. This was the case for Levi.

4.90 The Options for Living support plan and risk assessment identifies Levi's vulnerability, his use of illicit drugs, and the risk of cuckooing. There is no reference in the plan about what should be done if any evidence was seen of cuckooing, nor what to look out for.

4.91 The notes record that on 19 April 2019 Levi told his support worker that he "gives someone about £150 when he gets his money and that they sometimes come round". No action was taken.

4.92 By the time of Levi's second admission in April 2019 suspicions of cuckooing had been recorded three times: by the AMHP, by the assessing team on leaving the flat (April 2018), and by the ward junior doctor. This includes the observation that the lock on his front door had been superglued to prevent closure of the door. It is noted that during Ward rounds, Levi denied being vulnerable to exploitation from others. Levi felt his accommodation was secure despite concerns being raised by professionals that his flat was not secure.

4.93 An email from health care to ward doctors on the 1st May 2019 details that Options for Living had the same concerns as the Recovery Team Care Co-ordinator regarding the safety of Levi in his flat. They were almost certain he was being Cuckooed and stated that on certain visits 'Levi looked very worried at the door and wouldn't let (him) in'. the lock was glued open so Levi could not secure the flat and Levi could not say why this was. The Move On Worker raised this with the nursing team and they questioned whether or not a safeguarding referral would be appropriate.

4.93 There are many references in the Options for Living notes during the period following discharge to Levi's flat door being open or unlocked and Levi not being in, for example:10 June, door ajar, LS in, 27 Jun, door ajar, LS in, 25 Jul, door ajar, LS out, 19 Aug, door ajar, LS out,30 Sept, door unlocked, no response".

Findings

4.94 Despite having an awareness of what cuckooing is, practitioners did not use Safeguarding procedures to raise a concern.

4.95 The Early Analysis meeting discussed why it was that nobody from the admitting team when Levi was admitted in April 2019 had raised a safeguarding concern. It was speculated that this was because practitioners felt that Levi would be safe in hospital. This may have been the view – there is nothing noted in the clinical records – but there was no follow through plan regarding safety on discharge. The AMHP notes from this period reflect that upon Levi's admission to hospital, they unblocked the lock on his front door which had been glued or forced into a permanently open position. Everything in the flat was turned off and the property secured. The housing provider was notified.

4.96 A number of people at the Early Analysis meeting felt that truly recognising the signs of cuckooing was not deeply embedded in Services as cuckooing was a relatively new phenomenon in Bath.

Theme 7: DWP & Benefits Payments

4.97 It is not unusual for individuals with mental health problems to look to their support workers to assist them with their benefits and to help with the interface with the DWP. This is more often than not done on an informal basis compared to formal appointeeship.

4.98 In recognition of this, the DWP in recent years have developed new policies and procedures to assist vulnerable adults. In addition, approximately a year ago, in recognition of the importance of safeguarding, the DWP reached out to Safeguarding Adults Boards, allocating senior officers to sit on local Boards. DWP have membership of the BCSSP since its inception.

4.99 The new guidance relevant to this Review, although published after Levi's death, is:

- Consent in Universal Credit (published in September 2020). This is about explicit consent to have someone represent a claimant in their dealings with the DWP – "whether that be a friend, family member, or voluntary sector worker, it is recognised that this is essential for many claimants….. explicit consent does not last forever, it usually lasts until either the specific request is completed or the end of the assessment period, after the one in which the consent was given" (from the guidance). Consent can be given through a tab on the universal credit journal.
- Spotlight on handling larger payments (April 2021). This is about the support available to claimants who may benefit from additional support to manage a lump sum payment being made to them as part of an underpayment of past entitlements.

4.100 Levi was supported with his benefits by Options for Living whose support plan for Levi included: "support workers to investigate LS benefit claim and ensure he is in receipt of all entitlements. To offer support to [Levi] to manage his universal credit claim". During this period with help from this service, rent arrears of Levi were paid, and the ongoing payment of Levi's rent was put onto a direct payment basis. In fact, Options for Living were effective in sorting out Levi's benefits and Levi received a back payment of £9,897 in September 2019 (which was the net amount of a total back payment of £18,652 part of which had already been paid via Universal Credit).

Findings

4.101 It is not clear why nobody in Options for Living anticipated that their claim on behalf of Levi would result in a significant back payment and what safeguards should be put in place. None of the records seen by the Reviewer indicate any awareness of a back payment being due and any action to work with Levi in advance of the money coming through being carried out. In fact, all of the agencies seem to have been taken by surprise by the receipt of the back payment.

4.102 It is noteworthy that Options for Living, building on their relationship with Levi, were not able to obtain full consent at the outset from Levi to have access to his journal and to communicate on his behalf with the DWP. It is not clear from the notes to what extent efforts were made to gain this consent, and of course, Levi would have been within his rights to refuse to give this consent. Instead, Options for Living accessed Levi's journal using his log in and sometimes, it appears from the language used in the journal, wrote on his behalf, in his presence. This "dipping in/ dipping out" made of Levi's benefits management did not in the end result in the support that Levi needed.

Theme 8: Notification of Levi's Death to his Family

4.103 Under Police procedure: "Sudden, Unexplained and Suspicious Deaths" (Avon & Somerset Constabulary April 2020), Levi's death would have been categorised as a "unexplained death" meaning that an initial investigation would indicate that the death was not suspicious, and that

there was no third-party involvement. This initial assessment will often be passed to the coroner.

4.104 This procedure says that "the investigating officer is responsible for informing the next of kin as soon as possible after death. This should always be done in person".

4.105 From the Options for Living records, it would seem that the Police were already on the scene at 13.00 that day which was the time the support worker arrived at Levi's flat. Police records say that "the officers were at the home address of the deceased [when] his mother contacted the Police at 14.45 hours, asking what the police activity was……She was directed to meet an officer at a bus stop on Newbridge Road which I believe is nearby. The officer informed her in person of the death and took her back to her home address where he waited for the deceased's sister to arrive before leaving". She recounts that this was after 16.30 that day.

4.106 Being aware of the distress caused to Levi's family by the way in which they found out informally through social media of Levi's death, before being informed by the Police, the Reviewer asked the Police about this. Their records say that two friends of Levi had been looking for him in town and they turned up at his flat "to find him". They found him unconscious on the sofa and called an ambulance who commenced CPR on arrival but pronounced Levi dead. The ambulance paramedics called the Police. The individuals gave their names to the Police. It is assumed that these individuals regrettably posted Levi's death on social media, but it must be stressed that this is speculative.

4.107 The Reviewer put it to the Police at the Early Analysis meeting that this must happen fairly frequently. The Reviewer was told that it is standard practice for police officers at the scene of a death to ask others present to respect confidentiality to allow them to inform nearest relatives and not to put postings on social media. In his experience people do respect this and to date this has not been an issue. It is regrettable that in this instance that Levi's death was put onto social media. The distress that this caused Levi's mother and wider family was acknowledged.

4.108 There are no recommendations for this theme.

5. Recommendations

Recommendation 1

It is recommended that the Mental Health Services with the Council put in place a review of professional practice and support of individuals with long term, chronic mental health problems, chaired by an independent mental health practitioner/ consultant from outside AWP. This should include how services are arranged, what mechanisms are in place to promote reflective practice and a questioning approach, that promotes an ethos of working alongside the patient/service user and knowing/understanding the individual's recovery journey.

The Community Mental Health Framework[6] removes the requirements to use CPA and introduces new pathways. The findings in this SAR should be used to test out new services and arrangements from the perspective of supporting complex individuals with long term, chronic mental health needs.

This Review should include experts by experience who have long term mental health problems and have current experience of the mental health services and should invite Levi's family to contribute.

Recommendation 2

Training for leaders in the system on identification of those service users who are "hardest to reach" and on supporting and enabling front-line staff to be effective in working with individuals who live chaotic lifestyles and/or are self-neglecting. This should be accompanied by training for front line staff.

Recommendation 3

[6] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

Training for staff across all services in race and culture in the world of mental health should be undertaken from the relative perspectives of users, carers, and practitioners.

Recommendation 4

Renewed training should be put in place about the role of carers and what the Carers Charter[7] and Triangle of Care[8] requires of practitioners.

Recommendation 5

Assessment and care and support planning documentation is reviewed to ensure appropriate prompts are in place for practitioners together with renewed training for staff in BaNES Recovery Team on the Triangle of Care

Recommendation 6

The identification of carers, the offer of carers assessments, and the take up of the offer, should be audited by ethnicity against the ethnic make-up of the patient population to inform the approach to the Triangle of Care.

Recommendation 7

Audit standards, specifically concerned with carers, are put in place for use in case audit.

Recommendation 8

Commissioners need to continue to address the shortage of supported accommodation in Bath, but it is acknowledged that this is not an easy nor quick issue to address.

Recommendation 9

Commissioners should work with providers of supported accommodation to ensure that they are able to meet the needs of individuals without need of personal care but who require support with their medication.

Recommendation 10

It is recommended that the BCSSP continues its programme of training and development about mental capacity and ensures there is a focus on assessing individuals who self-neglect and who misuse substances (and alcohol).

Recommendation 11

See recommendation 2 above regarding working with individuals who misuse substances and are therefore hard to reach.

Recommendation 12

Information should be provided across the BCSSP in the support that is available from local Drug and Alcohol Services to practitioners who are working with clients who are reluctant to address their misuse of substances.

Recommendation 13

Options for Living review its support plan proformas to include consideration of mental capacity and ensure that staff are appropriately trained to complete this.

Recommendation 14

A separate policy be developed on Cuckooing to sit alongside the Safeguarding Adults Multi – Agency Policy (June 2019).

---

[7] http://www.awp.nhs.uk/media/877061/carers-charter-explained-1-.pdf

[8] https://www.england.nhs.uk/wp-content/uploads/2017/11/case-study-supporting-well-carers-included.pdf

Recommendation 15

A training programme on Cuckooing should be rolled out across the Partnership.

Recommendation 16

Options for Living should put in place a standard operating procedure for supporting clients with their benefits and for managing significant back payments that reflects current DWP policies and procedures regarding working with third parties who are acting on behalf of vulnerable adults.

Recommendation 17

It is recommended that the DWP be asked to hold a workshop with BCSSP partners to update practitioners on the support that is available for vulnerable adults to safeguard them and that partners update their policies accordingly.

6. Methodology

A hybrid approach has been taken to this review, that combines the earlier stages of the usual SAR process with the latter stages of the newer SCIE[9] "SARs in Rapid Time" methodology[10] (SCIE was commissioned by the Department of Health to develop this). The end product for BCSSP is the Systems Findings Report. The Rapid Time methodology produces findings only however it has been requested that recommendations be included.

The process being followed is set out in the table below. This report is the final stage 6 of the process.

Stage	Action
1	Agree approach and key agencies and individuals to be contacted
2	Meetings with key individuals and reading of background documentation and records, integrated chronology
3	Early Analysis Report written to structure the multi-agency discussion
4	Participants read Early Analysis Report in preparation for the meeting
5	Structured discussion within a multi-agency meeting
6	**Systems findings report with recommendations**

Breaking Down the Timeline into Useful Time Periods for Analysis

The timeline was broken down into three distinctive time periods for the purposes of the early analysis multiagency meeting. The purpose of this was to focus the analysis on the key areas of concern and to then aid identification of common themes that run across the whole of the time period.

The time periods are:

1. Discharge from hospital in September 2018 to readmission on 24th April 2019
2. Admission to hospital on 24th April 2019 up to discharge from hospital on 21st May 2019
3. Discharge from hospital 21st May 2019 to death 19th November 2019

[9] SCIE = Social Care Institute for Excellence

[10] https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time

Early Analysis

The Reviewer, who facilitated the meeting asked the participants to consider each of the three periods under the following four questions:

1. Looking back: How usual, standard, typical were the different aspects of the responses at the time?
2. Looking forward to current time: Would the same response be likely now?
3. Looking back: What were the respective supports, constraints, and barriers for different aspects?
4. Looking forward to current time: Do these contributory factors still hold?

The approach is to encourage minimise hindsight bias, and to promote system level thinking in responses to the narrative of what happened during each episode in comparison to what good practice might have been.

Systems Findings Report

This document forms the final output of the SAR for Levi. It provides the systems findings that have been identified through the process of the SAR.

The discussions in the Multi-Agency Early Analysis Meeting, held to discuss the early analysis, very much inform the contents of this report and there are references to this meeting in the Themes section of this report. These findings are future oriented. The findings focus on organisational and systemic factors that impacted on practice in Levi's case. This systems findings report is presented as a vehicle for change and improvement in services across the Partnership.

7. Detailed Account of Period Covered by the SAR

Episode 1: Discharge from hospital on 5th September 2018 to readmission on 24th April 2019

Levi was discharged from Applewood Acute Adult Inpatient Unit following an informal admission the preceding month, on 5 September 2018. His CPA discharge plan referenced Levi's past psychiatric history and recorded under personal history that Levi "has little contact with his family…. ". However, on discharge he goes to stay with his mother for two days, which does not work out (the notes do not record why this was the case) and Levi is then given emergency temporary accommodation on 7th September in a B&B (Roman City). The Personal Housing Plan, dated 11 September, records that before his admission Levi had been living in 'The Paragon', which at that time was temporary self-contained supported accommodation for men and women. In this facility residents have access to an emergency on call facility (from Bath Homeless Guide 2011-12). Following Levi's discharge, he is not able to return there because after a fire his room is no longer habitable, and Paragon say that Levi's support needs are too high for them, and he is asked to leave. It is necessary to find new accommodation for Levi, and under the Council Homesearch Allocation Scheme 2019, he is placed into Band B (for applicants who are "in high medical, welfare or hardship need" compared to Band A for applicants who are "in urgent medical, welfare or hardship need"). Levi is able to bid weekly under the Homesearch scheme for social housing and to look for private rented accommodation. He is also advised as an optional but recommended action to make an application for supported housing which "Levi's mental health workers can assist him with". On 31st January 2019 Levi signs a tenancy for a one-bedroom flat in Parsonage Lane in a property owned by Sanctuary Housing Association. This flat is located in the centre of Bath, is in a block of flats with a communal front door, with an intercom into the flat.

Levi receives support from the Intensive Service from discharge to 5 October 2018 hospital. Support is then taken over by his Care Coordinator and the Recovery Team. His Care Coordinator knows Levi from before his admission to hospital. She arranges for Levi to receive 6 hours a week support from Options for Living a local independent provider of support services to vulnerable adults, working to help clients maintain tenancies, participate in the local community, and develop a range of independent living skills. This type of support is often referred to as "floating support" in the sense that

it is separate from the client's accommodation. The support is commissioned and funded by the Council's Adult Care Services.

The Options for Living written support plan includes the following - relevant to the discussion below:

- the plan references the likelihood that Levi uses unknown illicit substances "which will impact on his mental health. L is reluctant to talk about this or receive support"
- Under "Benefits" "support workers to investigate LS benefit claim and ensure he is in receipt of all entitlements. To offer support to [Levi] to manage his universal credit claim"
- under Daily Living Skills – to work with Levi "to maintain his living environment to a reasonable standard and …to develop his cooking skills"
- Under social, cultural, and religious needs: "to encourage L to maintain positive family relationships".

Accompanying the plan is a risk assessment. This states in two different sections that Levi is potentially vulnerable from cuckooing[11]. The risk proforma does not include a section for Mental Capacity.

On 14 March Levi's Care Coordinator is with Levi when his mother visits. This is the first time the Care Coordinator has met LS' mother. The Care Coordinator gives Levi's mother, her contact details.

During this period Levi's mental state starts to deteriorate. On 5 April a visit is made together by the Care Coordinator and a social worker in the Recovery Team. The notes record the messy state of the flat, that Levi was "obviously psychotic, and the Care Coordinator wrote that she "ponder[ed] afterwards whether [LS} would be better on a depot or/and Options support him with his medication".

On 8 April the Intensive Service, at the request of the Care Coordinator, reengages with Levi and a medical review is carried out on 8th April. Present at the medical review as well as a doctor is the Care Coordinator. The flat is described in the notes as "chaotic and messy– for example: "the mattress was covered in rubbish, cigarettes, and biscuits……. kitchen chaotic, bags of rubbish…… no electricity". Levi tells the doctor that other people are sleeping in his flat – recorded in the notes under risk "reported other people using his flat? Reality? Delusion – he is certainly vulnerable and would be high risk of being exploited". There is a question mark over whether Levi has been taking his medication. "[Levi] does not believe that he is unwell currently. He was agreeable to restarting Olanzapine, but there appeared discrepancy between when he believes he last took medications… and what [the Care Coordinator] established" (from Rio). The notes made by the Doctor carrying out the review say: "Levi does not believe he is unwell… from the discussion today I do not believe that [Mr] LS has capacity to make decisions about his mental health and its management, decision will need to be made in his best interest".

The Intensive Service take Levi back onto their caseload on the following day (last on their caseload in December 2018) for medication monitoring, monitoring of mental state and risk to self and others. The Intensive Service multidisciplinary team meeting is held on 11 April where they record Levi as "medium risk". Under the Safeguarding heading "none acute" is recorded. The Care Coordinator, support worker and doctor who carried out the medical review the day before are not present at this meeting, and it is not clear from the notes if the findings in the medical review have been considered. Levi's mother separately calls the Care Coordinator on the same day to tell her that she feels strongly that Levi is "breaking down" and that "he needs to be in hospital". There is a discussion about the Intensive Service tyring to support Levi at home but that if they start to share similar concerns to those of Levi's mother then they would consider readmission to hospital".

Levi continues to deteriorate and on 18 April, the support worker tells the Intensive Service that in his opinion, Levi's presentation is the worst he has ever seen. On 19April there is a discussion by the support worker with Levi at his flat. The Options for Living records say "asked LS if he owed anyone money. LS answered yes. Given how chaotic Levi is, its difficult to ascertain how factual LS is being

[11] Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds.

but he told me that he gives someone about £150 when he gets his money. He said they sometimes come round".

On 24 April a Mental Health Act assessment is held at Levi's flat. The admission is discussed further under the analysis of period 2 below.

What needed to happen during this period? How do we know what 'good' would have looked like?

Good practice would have been for planning for discharge from the hospital admission that ended in September 2018 to have started as soon as possible after Levi's admission, noting that Levi was not able to return to his previous home, and that he was therefore effectively homeless. Options would be explored as part of discharge planning as to how realistic a move to Levi's mothers house was, and whether Levi could maintain independent living given that he had been admitted from temporary supported accommodation who could not take him back on the grounds of his high level of needs.

The Options for Living comprehensive support plan and risk assessment identifies Levi's vulnerability, his use of illicit drugs, and the risk of cuckooing. It does not consider his mental capacity – there is no box for mental capacity in the proforma. The mitigation actions would have included raising a safeguarding concern if any evidence was seen of cuckooing. In that context, following the discussion on 19 April, in which Mr Swaby told his support worker that he "gives someone about £150 when he gets his money and that they sometimes come round" a safeguarding concern would have been raised, triggering Police involvement. This would be recorded on the clinical (Rio) record for staff subsequently carrying out the Mental Health Act assessment on 24 April 2019 to see.

There would have been evidence of continuity between the doctor carrying out the medical review on 8 April 2019 and the Intensive Care Multidisciplinary meeting 3 days later. This is not about the doctor being present at the meeting on 11th April but about those present on that day, reading the clinical notes and picking up and discussing the clear issues being flagged – namely LS' mental capacity and his ability to comply with his medication and arguably his self-neglect. A mental capacity assessment would have been carried out in relation to Levi's ability to carry out his agreements with staff/ decisions to comply with his medication. This is discussed further below.

Episode 2: Admission to hospital on 24th April 2019 up to discharge from hospital on 21st May 2019.

On 24 April a Mental Health Act assessment was held at Levi's address "due to continued concerns about his presentation, and difficultly consistently treating him at home due to chaotic behaviours". The AMHP's report says "The concerns for Levi have been around self-neglect and vulnerability. There are real concerns that [Levi] is being cuckooed by drug users and dealers. His door to his flat is not locked – giving access to anyone. Food parcels are delivered by the Intensive Service, but this food soon disappears...".

As the assessment team is leaving, they notice that the door lock to the flat appears to be glued preventing closure of the door. Levi is unable to explain this. Levi is admitted to Sycamore Ward, Hill View Lodge on 24 April 2019.

Levi is clerked in, and the notes record that Levi "had an informal admission to Applewood Ward in August 2018, for a similar presentation where he became psychotic and vulnerable where he was living with background drug use". This knowledge is not referred to again in the notes nor in considering Levi prospects.

On 29 April a ward review is held, and the plan is to continue Olanzapine and to grant 1.5 hours unescorted leave every day. The impact of continuing to use illicit drugs is discussed by the consultant with Levi. The patient is deemed to have "no insight into his mental health". Following a home visit with an occupational therapist on 8 May, a further ward review is held on 9 May where unescorted leave is increased to 3 hours per day, the dosage of Olanzapine is increased, and a further CPA review is to be arranged for the following week. There is discussion between the consultant and patient about street drugs.

The next review is held on 15 May, attended by the Care Coordinator from the Recovery Team, and by the move on worker who reports that there was no suitable supported accommodation available in Bath. Levi does not want to move to Bristol (where there might have been supported accommodation). It is noted in the Rio record of this meeting that "in the MHA (mental health act assessment) there have been concerns about his flat being cuckooed, and Levi not allowing access to staff at times". It was agreed: (i) to increase amount of unescorted leave to 6 hours per day, (ii) to reduce Olanzapine dosage, and (iii) to arrange a discharge CPA for 21st October.

Discharge CPA is held on 21 May, the date of expiry of Levi's section 2 of the MHA. This was attended by Levi Care Coordinator, the (housing) move-on worker, and Levi's mother. The importance of continuing to take Olanzapine, and not using illicit drugs was stressed to Levi. Levi said that "he could tell people in his flat to leave if he does not want them there. He said that he would lock his door from now on". His Care Coordinator was to purse a psychology referral. The Intensive Service would support him initially on discharge and the Options for Living floating support would be restarted with increased hour to 10 hours to be only on weekdays at Levi's request. The CPA does not say what the aims / purpose is of these hours is and how they were to be used. Levi's mother tells the meeting that for the past 2 years, her son has "been up and down". She asks what the plan would be if he relapses. She is told by the Ward consultant that the plan "would likely be readmitted, and consider a depot in lieu of Olanzapine, with a CTO if necessary". At this point the record states that Levi "has insight into his mental health and need for treatment" and he "has capacity to consent to treatment".

What needed to happen during this period? How do we know what 'good' would have looked like?

By this stage suspicions of cuckooing had been recorded three times: by the AMHP, by the assessing team on leaving the flat, and by the ward junior doctor. None of these people discussed it with each other and none of them raised a safeguarding concern. Options for Living had also separately identified this as a risk in their support plan.

Levi's capacity is not formally assessed although it is noted that Levi "lacks insight, doesn't think his is unwell thinking he is fine". Such an assessment would be a key part of a holistic assessment of Levi's capacity to make and see-through decisions (his executive functioning) in terms of his ability to sustain taking his medication might have guided thinking about his prospects and risk triggers.

The question of his accommodation, in common with his previous admission, should have been considered earlier on his admission. Levi was clearly having difficulties in his flat, (and the suspicions of cuckooing) and there is a reference to there not being suitable supported accommodation available in Bath. Ideally such accommodation would have been available, or if not a form of "step down supported accommodation" to which Levi might have been discharged pending securing longer term supported housing rather than a return to his flat.

Risk assessment on discharge would have considered Levi's past compliance with medication and that failure to continue to take his medication would mean that he "would likely be readmitted, and consider a depot in lieu of Olanzapine, with a CTO if necessary". This in effect would have been communicated to the Recovery Team as a plan B in the event that Levi's compliance was to waver for any significant period of time.

Discussion with Levi by the ward consultant about the use of illicit drugs was held, and this would have resulted in at least consultation with the Drug and Alcohol Services about how to engage with Levi on this issue, thereby enabling a referral to be made.

Period 3: Discharge from hospital 21 May 2019 to the date of Levi's death on 19th November 2019

The six-month period up to the date of Levi's death is characterised by fluctuations in Levi's presentation, self-care, and compliance with his medication. Levi's support workers, his Care Coordinator in the Recovery Team, and the Intensive Service all made great efforts to monitor and encourage Levi. For part of the time dossette boxes were used to try to assist Levi in taking his

medication but they were of limited use, and Levi would not take his medication, would forget where he put them, and not be able to show them to those trying to support him. On 4th June Levi is discharged from the Intensive Service caseload back to the Recovery Team with the same Care Coordinator throughout. During this period the family of Levi took photographs showing the level of disorganisation and chaos in Levi's flat.

On 15 June Levi's mother reports to the Services "her son has come to her house that day, demanded money which she declined to give him. He then became aggressive and left. She said that she felt he "should go back Hill view Lodge (i.e. into hospital) as he is unable to look after himself".

Support workers from Options for Living raise with the Mental Health services on many occasions Levi's non-compliance with his medication including:

- On 6 June, the Options for Living support worker visited Levi in his flat – the note records "the flat is looking squalid again" and that Levi could not find his meds which meant it was not possible to verify if he had taken them.
- On 26 June, that Levi had not taken his meds for the preceding 6 days,
- On 1 July, when two dossette boxes were found in which 10 out of 14 days medication was left, and
- On 1 August, the Care Coordinator recorded on Rio that an email was received from the pharmacy that they had 4 weeks of uncollected medication which meant Levi was not taking his medication.

A joint visit is made on 2 August of the support worker from Options for Living with the Care Coordinator. The notes record his personal care as being poor. It is also recorded in the notes that the support worker tells Levi had "left his gas hob on the other day which was a concern". The possibility of a depot being required is mentioned to Levi and he again says that he does not want one and would take his medication [orally].

Alongside the above description, at other times there were improvements in Levi's presentation and in the state of his flat that almost became a proxy for the state of his wellbeing. On the 4 June Options for Living reported to a multi-disciplinary team meeting (MDT) meeting of the Intensive Service that he "had no concerns when he saw Levi yesterday, saying he is the best I have seen [Levi]". But he goes on to say that he "recognises that Levi needs ongoing support for his chronic/longstanding risks (drug use, mental health relapse, self-neglect". On 30 October the support worker reports that Levi "appeared in good spirits" and "I had never seen the flat in as good a state before". Both occasions seem to follow periods of medication compliance.

There are many references in the Options for Living notes during this period to Levi's flat door being open or unlocked and Levi not being in, for example:10 June, door ajar, LS in, 27 Jun, door ajar, LS in, 25 Jul, door ajar, LS out, 19 Aug, door ajar, LS out,30 Sept, door unlocked, no response.

On 20 August Levi's Care Coordinator refers him to the Intensive Service saying that Levi has been exposing himself to other tenants, his disinhibited behaviour, tangential speech, and flight of ideas. The Intensive Service respond same day and carry out a home visit as a result of which his medication dosages are increased and Levi agrees to the Intensive Service monitoring him taking his medication. The notes made by the Intensive Service on Rio at this time describe Levi's declining mental state with fluctuating levels of self-neglect. He is asked several times about whether he is taking drugs and he deflects this by saying he is "using body fluid" or "nanja" and is not able to clarify what this means.

On 2 September, with home treatment seeming to have "limited efficacy", the AMHP involved in Levi's last admission is asked about admission to hospital and he advises that Levi might lack capacity to consent to an informal admission and may require referral for a formal MHA assessment. However, nothing further is progressed in relation to admission. A CPA review is held on 18 September at which is noted that since having his medication supervised by the Intensive Service there has been an improvement in Levi's mental health. The agreed plan is to continue with the medication with daily visits from the Intensive Service to supervise this, and to continue exploring supported accommodation.

The Intensive Service continue to monitor Levi's mental state and risks and medication compliance and slowly his mental state starts to improve as he consistently is taking his medication under the supervision of the Intensive Service. On 26 Sept it is recorded that Levi "had managed to get his flat clean with support from [his support worker] ready for the [flat] inspection. It is recorded that his mother had seen him and "he was clean and well presented" and "he seems better in his mental state". By the end of September, he is receiving his medication in a dossette box, however it is not possible to check if he is taking his medication: for example, on 1 October when asked by the Intensive Service worker to check the dossette box he says that "he has taken all medications from previous dossette box and has now thrown it away". On 29 September it is recorded by the visiting staff from the Intensive Team "[Levi] appeared to be under the influence of illicit substances, red eyes, sweating, cotton mouth".

In anticipation of discharge from the Intensive Service, the Care Coordinator arranges for Options for Living to visit 5 times a week (increased from 4 times a week) - although it is not clear what expectations come with this increase in visits/hours - and to progress with trying to find Levi supported accommodation (see below). The notes record a brief discussion with Levi about some activities he might like to engage in including a book club and a cooking class.

On 4 October a review is carried out by doctor from the Intensive Service (same doctor who had carried out the Medical Review in April) with the Care Coordinator and support worker present. There is "agreement that there had been a significant improvement, although it was apparent as the visit progressed that Levi was displaying thoughts that were delusional and grandiose in nature. This, however, does appear to be chronic for [Levi]".

At the end of the meeting, outside the flat, the support worker informs the doctor and Care Coordinator that [Levi] has been awarded £18,000 in back pay from benefits……. [support worker] will support Levi in purchasing new furniture" and generally in improving his living environment. That is the only comment/ discussion in relation to the back payment that is recorded in Rio or the Options for Living notes.

On 8 October, Levi is discharged from the Intensive Service back to care of the Recovery Team with ongoing support from Options for Living who will continue to try to check that Levi is taking his medication. They are partially successful in this, there being entries in the notes that record medication being missed, or it not being possible to check because the dossette boxes cannot be found. On 21 October the Care Coordinator writes following a visit to Levi at his flat, that she could see from the dossette box that Levi had taken his medication over the weekend. She recorded that she "could see that Levi had made an effort to tidy his kitchen…. he had had a good weekend".

On 30 October the support worker reports that Levi "appeared in good spirits" and "I had never seen the flat in as good a state before". He seemed to be taking his medication. On 5 November Levi told his support worker that "he had annoyed himself because he had spent all of his back dated benefits" but he does not say how, and the notes do not record any discussion about this. The support worker offers help around his finances which Levi accepts. Levi said that he was "looking for a job". "Levi showed a lot of insight today. It demonstrates how far he has come".

On 14 November a joint visit is made by the Care Coordinator and support worker. Levi talks about how "Feeling let down by the fact that he has spent all his back payment…… he says he gave some money to his sister and some to his mother and spent the rest". The notes records Levi as saying that he had an appointment with the Individual Placement Service that day about paid employment, and that he was going to start at cookery classes…"he was keen to start activities and have place to go". The Care Coordinator writes that Levi "was able to make rational conversation and shows more forward planning with no thought disorder or paranoid thinking". It is recorded that Levi has been taking his medication definitely for five days of the week but "a bit hit and miss at the weekend".

Visit on 18 November by the support worker. The notes record that medication not taken over the weekend. Levi has a meeting with a research assistant about enrolling in a research project that day.

On 19 November the support worker attempts to visit but is met outside Levi's flat by a large police presence. The Police had been called by two friends of Levi who had found him unconscious on the sofa in his flat. An Ambulance attends, Levi's presenting condition is cardiac arrest and it is not possible to resuscitate Levi. The cause of death is recorded by the Coroner on 4 December as accidental overdose, likely triggered by a previously unknown underlying health condition.

Accommodation

On 12 June Levi's Care Coordinator first raises with Levi that he might view supported living accommodation at Mulberry House, and he agrees to visit this. On 2 August the Care Coordinator reminds Levi of the plan for him to visit Mulberry House and that she has also arranged for him to visit a second project at 82 Lower Oldfield Place as well. On 19 August Levi with his Care Coordinator visit Mulberry House supported living which is run by St Mungo's. Levi likes this accommodation however a response is sent to Levi a month later on 15 September that they are not able to offer Levi a place. The manager tells the Care Coordinator that "Mulberry place is not able to keep medications or prompt service users to taken them, due to not being CQC registered and also having to many service users to remind them every time". The point about CQC is not challenged and it is not clear even if it had been challenged if a place would have been made available to Levi.

The alternative is a project at 82 Lower Oldfield Park. They are able to offer Levi a room, but he is less enthusiastic as it would have meant moving from his own flat to a relatively small single room. It is not clear if a plan could have been put in place for Levi to take the smaller room on a temporary basis pending the availability of something larger – for example as an alternative to possibly needing a readmission to hospital.

DWP Payments Benefits

The original Options for Living support plan includes: "support workers to investigate LS benefit claim and ensure he is in receipt of all entitlements. To offer support to [Levi] to manage his universal credit claim". During this period with help from this service, rent arrears of Levi were paid, and the ongoing payment of Levi's rent was put onto a direct payment basis. His universal credit claim was updated and resulted in a back payment of arrears. This was all done by the support worker working alongside Levi. At no time did Levi give overall consent to a named individual to deal with his affairs on his behalf, which at the time during 2019 would have been possible. But he did on occasion ask the DWP to speak with his support worker (for example on 6 August 2019 – recorded on the Universal Credit journal messages for 2019) in connection with a specific issue at that time. This meant that no third party was notified when the back payment was made to Levi. It is not clear if Options for Living have a standard operating procedure for supporting clients with their benefits and for managing significant back payments and if they do if this was adhered to in working with Levi. Since the time of Levi's death, the DWP now have put in place policy on the handling of larger payments. It is not clear how widely known this policy is.

On 23 September 2019 the DWP wrote to Levi via the Journal saying: "you are entitled to Universal Credit of £18,653.37 from 25th January 2017 to 24th July 2019. This is because the limited capability for work, and work-related activity element of Universal Credit, has been added to your claim. We've already paid you Universal Credit of £8,755.96 from 25th January 2018 to 24th July 2019. We owe you £9,897.47.41…we'll pay £9,897.47 into your back account. It is assumed that nobody saw this entry on Levi's journal but instead took at face value Levi's misunderstanding that he had been paid arrears of £18,000 as recorded in the clinical and Options for Living records. This is despite the fact that one of the support workers had most certainly sight of the Universal Credit journal before. It is not clear why Options for Living, building on their relationship with Levi, did not at least seek full consent at the outset from Levi to have access to his journal and to communicate on his behalf with the DWP. Of course, Levi would have been within his rights to refuse to give this consent.

Notification of Levi death to his family

Being aware of the distress caused to Levi's family by the way in which they found out informally through social media of Levi's death, the Reviewer asked the Police about this. Their records say that two friends of Levi had been looking for him in town and they turned up at his flat "to find him". They found him unconscious on the sofa and called an ambulance who commenced CPR on arrival but pronounced Levi dead. The ambulance paramedics called the Police. The individuals gave their names to the Police. Under Police procedure: "Sudden, Unexplained and Suspicious Deaths" (Avon & Somerset Constabulary April 2020), Levi's death would have been categorised as a "unexplained death" meaning that an initial investigation would indicate that the death was not suspicious, and that there was no third-party involvement. This initial assessment will often be passed to the Coroner.

This procedure says that "the investigating officer is responsible for informing the next of kin as soon as possible after death. This should always be done in person". From the Options for Living records, it would seem that the Police were already on the scene at 13.00 that day which was the time the support worker arrived at Levi's flat. The Police account is that "the officers were at the home address of the deceased [when] his other SS contacted the Police at 14.45 hours, asking what the police activity was……She was directed to meet an officer at a bus top on Newbridge Road which I believe is nearby. The officer informed her in person of the death and took her back to her home address where he waited for the deceased's sister to arrive before leaving".

What needed to happen during this period? How do we know what 'good' would have looked like?

There needed to be a fresh assessment of Levi's care and support needs across his health and social care needs with a fresh care and support plan that sought to meet Levi's needs. This should have been a Care Act compliant plan (see B&NES Care and Support Assessment & Eligibility Policy and Care and Support Planning Policy 2016).

The plan would reflect the knowledge of Levi's past history, and of risks and vulnerabilities. This plan would have provided a baseline from which to track and monitor progress and a context in which the periodic crises took place which were responded to each time by the Intensive Service. The plan should have been reviewed after six weeks and then again at six months. This would also form the basis for the engagement of support from Options for Living.

The fluctuation in Levi's mental state and self-care would have been linked to his compliance with his medication. When he was being supported to take his medication by the Intensive Service, his wellbeing improved. Based on this fundamental observation of this pattern, an assessment of his ability to sustain compliance without this level of support, would have been made. This would have brought together the knowledge that he was from time to time taking street drugs, the impact of this on his mental capacity, and the risks of cuckooing.

With clear objectives in a care and support plan, Levi's behaviours might have been seen as "self-neglect" and along with the suspicions of cuckooing have led to a referral for a multiagency risk management meeting. This would have considered the ability of Levi to sustain his intentions and what support he would need to remain well, including the need to expedite access to appropriate supported accommodation.

Drug and alcohol services would have been consulted to ask them:

- for guidance about working with someone who would not agree to a referral to their services - this cannot be uncommon
- about local issues in the area that Levi was living
- if they knew what Levi's repeated references to "body fluid" and "nanja" were.

As well as using the MARM, more intensive efforts would have been made to find Levi more appropriate accommodation. This would include working with Commissioning in the Council, given the shortage of supported accommodation in Bath. There is guidance from CQC "Supported living schemes – managing medicines" that sets out that medicines administration is not within the scope of

regulation by CQC. While there may have been other reasons for St Mungo to not offer Levi a place at Mulberry Place, the issue of CQC registration did not apply and would have been challenged – working with Council Commissioners.

Building on the relationship that Options for Living seemed to have with Levi, efforts would have been made by Options for Living support worker to put in place consents to have access to Levi's universal credit journal to track the progress of the back claim that had been put in and to anticipate the likelihood of a back payment and manage these funds.

Appendix I: Drug Taking, Self-Neglect, and Mental Capacity

Assessing mental capacity is one of the most complex areas of work for practitioners. Whilst there is a growing literature about mental capacity and impairment through the excessive use of alcohol there is to date little written about impairment through the misuse of substances. However, this does not mean that the Mental Capacity Act cannot and should not be used to help individuals who misuse substances.

The MCA provides a statutory framework for people who lack capacity to make decisions for themselves. It sets out who can take decisions, in which situations, and how they should go about this. A person who lacks capacity means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. The Act can apply to people who are substance dependent – 'impairment' includes symptoms of alcohol or drug use (MCA Code).

The two-stage test that is applied to decide whether an individual has the capacity to make a particular decision is:

Stage 1 – Is the person unable to make a particular decision (the functional test)? and

Stage 2 – Is the inability to make a decision caused by an impairment of, or disturbance in the functioning of, a person's mind or brain? This could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or **the effects of drugs** or alcohol (the diagnostic test).

The MCA code says that 'Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.' It is acknowledged that it is challenging to assess capacity for this client group as **they often know what to say and do but cannot implement the action/decision when in the real-life situation**. This may mean that the person being assessed is not able to understand, retain and/or **use the relevant information**.

The MCA code gives no specific examples relating to substance misuse but states that 'a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their **compulsion** not to eat might be too strong for them to ignore'. Parallels can be drawn with people who misuse substances. Therefore, it could be argued that the individual being assessed is not able to 'use and weigh' the relevant information due to this **compulsion** which **overrides their ability to take into account risks associated with their behaviour**.

Research in relation to alcohol misuse has shown that, people may be wrongly viewed as having mental capacity, placing them at risk and a national review of SARs has shown that mental capacity was not assessed when there were grounds to do so

In cases of fluctuating capacity, best practice is to take a long-term perspective on someone's capacity rather than simply assessing the capacity at one point in time. This means that if the service user is able to make the decision (e.g. not under the influence of substances) 'you should record the person's decision… and why you consider that the person had capacity to make it'. Depending upon the context, you should also record what the person would want in the event that they lose capacity in future to make similar decisions (Essex Chambers – see below).

'The concept of 'executive capacity' is relevant where the individual has addictive or **compulsive behaviours**. This highlights the importance of considering the **individual's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity)'.** A key question is whether they are aware of their own deficits – whether they able to use and weigh (or understand) the fact that there is a mismatch between their ability to respond to questions in the abstract and to act when faced by concrete decisions.

The recently published guidance by Preston-Shoot and Ward in the section entitled "Challenging myths and the 'choice' concept" the following myths are set out that are relevant to this SAR:

- "If someone says they don't have a problem and doesn't want help, there is nothing we can do."
- "If the person is choosing to live like this, or likes living like this, we can't define them as vulnerable."
- "A person is not vulnerable or self-neglecting if they have mental capacity."
- "Once someone is sober, they no longer lack capacity or have care and support needs."
- "A person has the right to make unwise decisions."

Appendix 2: References

- Mental Capacity Act Code of Practice
- How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales Professor Michael Preston-Shoot and Mike Ward https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf
- Essex Chambers Guide: https://1f2ca7mxjow42e65q49871m1-wpengine.netdna-ssl.com/wp-content/uploads/2021/05/Mental-Capacity-Guidance-Note-Capacity-Assessment-May-2021.pdf
- Decision-making and mental capacity (nice.org.uk) https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917
- https://www.scie.org.uk/mca/practice/assessing-capacity
- National SAR Analysis April 2017-2019 https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

Thanks are due to Dennis Little – Safeguarding Adults Practice Manager - LB Waltham Forest and Jonathan Williams – Clinical Lead CGL for their timely presentation on Drugs, Alcohol & the Mental Capacity Act 2005.

Community Mental Health Framework	https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/
BaNES Recovery Team	http://www.awp.nhs.uk/media/425037/recovery-service-banes-leaflet.pdf
BaNES Intensive Service	https://bathnesshealthandcare.nhs.uk/wp-content/uploads/2017/03/Intensive_Service_BANES.pdf
Carers Charter AWP	http://www.awp.nhs.uk/media/877061/carers-charter-explained-1-.pdf
Triangle of Care	https://www.england.nhs.uk/wp-content/uploads/2017/11/case-study-supporting-well-carers-included.pdf
CQC guidance on Supported Living schemes and managing medication	https://www.cqc.org.uk/guidance-providers/adult-social-care/supported-living-schemes-managing-medicines
Bath Homeless Guide 2011-12	https://www.bathnes.gov.uk/sites/default/files/siteimages/Housing/bath_homeless_guide_2011-12.pdf
Revised Self-Neglect Policy and Best Practice Guidance" (first issued in 2015 and updated in March 2019)	https://www.safeguarding-bathnes.org.uk/sites/default/files/self-neglect_policy_and_guidance_.pdf
Mental Capacity	
Mental Capacity Act Code of Practice	https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales Professor Michael Preston-Shoot and Mike Ward	Safeguarding-guide-final-August-2021.pdf

Essex Chambers' Guide	Mental-Capacity-Guidance-Note-Capacity-Assessment-May-2021.pdf (netdna-ssl.com)
Decision-making and mental capacity	Decision-making and mental capacity (nice.org.uk)
SCIE Guidance	https://www.scie.org.uk/mca/practice/assessing-capacity
National SAR Analysis April 2017-2019	https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
Safeguarding Adults Multi – Agency Policy (June 2019)	https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/20190625-FINAL-Joint-Safeguarding-Adults-Policy-Somerset.pdf

Appendix 3: Abbreviations used in this Report

AMHP	Approved Mental Health Practitioner
AWP	Avon and Wiltshire Partnership NHS Trust
B&NES	Bath & North East Somerset Council
BCSSP	Bath & North East Somerset Community Safety & Safeguarding Partnership
B&B	Bed and Breakfast accommodation
CPA	Care Programme Approach
CQC	Care Quality Commission
CTO	Compulsory Treatment Order
DWP	Department of Work & Pensions
IPS	Individual Placement and Support Service
MARM	Multi-agency Risk Management meeting
MCA	Mental Capacity Act
MDT	Multi-disciplinary team
MHA	Mental Health Act
SAR	Safeguarding Adults Review
SCIE	Social Care Institute for Excellence

Appendix 4: Terms of Reference

Terms of Reference

Safeguarding Adult Review

Mr LS

Introduction

A notification was received by Bath & North East Somerset (B&NES) Safeguarding Adult Review (SAR) subgroup in September 2020 from Avon and Wiltshire Mental Health Partnership NHS Trust regarding a potential SAR.

The notification was discussed at the SAR subgroup meeting on 10th November 2020

Background

The review concerns Mr LS:

- LS died unexpectedly on 19th November 2019 following a cardiac arrest.
- LS was 36 years old at the time of his death and had been known to mental health services since 2007.
- He had care and support needs arising from his mental health challenges.
- It is understood from the coroner's outcome that the cause of death was accidental overdose, likely triggered by a previously unknown underlying health condition.

Legal Framework

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

The case was considered by the PRG on 30th November 2020 and it was concluded that the SAR criteria had been met. The Independent Chair of the BCSSP approved this decision.

Review Scope

The review will include information in relation to:

Name: Levi Swaby **DOB:** 30.11.82

The timeframe the review will consider is from September 2018 until 19th November 2019

There may be significant events or information outside of this time period which influence the decisions made during the period in its scope. If information is identified it will be included within the review terms of impact on the decisions and actions taken.

Review Principles

The review will be underpinned by the following principles, as set out in the Care Act 2014 Statutory Guidance.

- 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

- 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
- 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.

Of key importance will be the engagement with family members and all organisations involved.

Methodology

The review will be conducted using a blended approach, including:

- A review of all relevant agency information undertaken by a person independent of any of the organisations involved
- A SAR panel comprised of relevant and nominated senior persons representative of the agencies involved to provide advice and support to the reviewer in regard to local arrangements and existing policies/procedures
- Early discussions with the family to agree to what extent and how they wish to be involved, and to manage expectations
- Appropriate involvement of professionals and organisations who were working with the adult so they can contribute their perspectives without fear of being blamed for actions taken in good faith
- Individual and integrated chronology reports from agencies who were working with the adult
- Due to the current impact of COVID-19, the methodology will remain flexible in response to information received and how learning can best be facilitated

The methodology will be supported by a Terms of Reference that sets out the focus and scope of the SAR, timeframes within which it will focus, roles, expectations and outcomes required.

Outcome

A final report and recommendations which effectively set out the specific and wider learning indicated by the case.

Agencies expected to contribute to the SAR process

Avon and Wiltshire Mental Health Partnership
B&NES Safeguarding and Quality Assurance Team
Developing Health and Independence
General Practitioner
Guinness Housing
Avon & Somerset Constabulary
Royal United Hospital
South West Ambulance Service Foundation Trust
Virgin Care

Key lines of enquiry

- Was regular supervision available for the people working with LS
- Was there safeguarding supervision provided and if so, how robust Was this element
- There is more than one reference to concerns of LS potentially being cuckooed and an acknowledgement that a safeguarding referral ought to be made. What evidence is there to agencies being alert to cuckooing and their responsibilities to report concerns?
- Were there any barriers to the referral for cuckooing being made?

- Does the information indicate any consideration as to whether LS had capacity to manage the large back payment of benefits he received? Would it have been appropriate to have risk assessed this payment? If it would have been appropriate which agency should have undertaken the assessment.
- Were there points at which the self-neglect policy could have been implemented and concerns managed through a MARM process? If so, what were the barriers to this course of action?
- LS was well known to services – did his history with the service impact on the way that his needs were viewed? Were appropriate risk assessments and reviews undertaken of his needs?