HASCAS

Health and Social Care Advisory Service

Health and Social Care Advisory Service

Independent Investigation

into the

Care and Treatment of

Mr X

Lessons for Learning Report

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Contents

1. Introduction and Background History to the Commissioning of the Report

1.1. The scope of the Investigation is that of a 'desk top review' which precluded the Investigation Team from interviewing the staff and managers of the organisations involved in both the provision and commissioning of care and treatment to Mr X. The following report is anonymised in order to ensure the protection and best interests of the service user.

1.2. The Investigation was commissioned to provide an independent overview of the care and treatment that Mr X received, principally between the point of his transition to adult services and his discharge from the inpatient facility on which he was held. Earlier, and later events, have been taken into account in order to understand Mr X's care and treatment in context.

1.3. The HASCAS Investigation was also commissioned to ensure that the learning from six other investigations and reviews undertaken due to the serious concerns about Mr X's care and treatment would be examined and triangulated. They are:

1. The Trust investigation regarding complaints made by Mr X's parents about the care and treatment their son received from inpatient mental health services.

2. The Care Quality Commission (CQC) review of inpatient services. The review of compliance covered seven key outcome areas routinely examined by CQC and which are essential for the maintenance of quality and safety.

3. The local Safeguarding Adults Unit investigation into the safeguarding issues raised by Mr X's family.

4. The commissioner's Root Cause Analysis report on four selected transition cases.

5. The safeguarding investigation commissioned to investigate the care and treatment Mr X received from inpatient services following the complaint sent to the Chief Executive of the Mental Health Trust by Mr X's parents.

6. The second Care Quality Commission review to examine the implementation of the Mental Health Act in relation to Mr X's care and treatment.

1.4. The HASCAS Investigation had access to the six investigation/review reports and also examined Mr X's clinical records. This ensured the learning could be brought together in one place.

2. Terms of Reference (as set by the Commissioner of the Investigation)

Terms of Reference

2.1. The Investigation will examine:

1. The commissioned care and treatment provided to Mr X from his transition into adult services.

- The suitability of that care and treatment in the light of his history and assessed health and social needs. To include any potential failures to:
  - protect Mr X from harm;
  - respect Mr X's human right to a family life;
  - ensure that Mr X received appropriate care and treatment to enable his optimal recovery from depression;
  - minimise any risk of trauma or loss of capacity or capability given Mr X's life-long condition of atypical autism;
  - ensure Mr X's timely re-access to formal education, as required by his statement of special educational need.

- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies. This with specific reference to safeguarding policy and process and the roles, accountabilities and actions of the senior officers of the public and statutory bodies to include:
  - an examination of whether Mr X was experiencing high quality, effective care appropriately adapted to the requirements of a young person with autism;
  - an examination of whether Mr X's safety, and psychological and mental health were continuously assured;
  - an examination of whether all statutory obligations were met including (amongst others) those covered by the Mental Health Act, Human Rights Act, and the statutory requirements to meet Mr X's educational needs whilst in hospital given he continued to hold a statement of special educational needs;
  - an understanding of why Mr X was not protected immediately the independent adult safeguarding investigation found that he was being ill-treated and abused by the Trust;
  - an examination of local Safeguarding process, policy and procedure.

- The adequacy of any risk assessments and risk management plans:
  - whether the care programme approach was carried out in keeping with Trust policy;
  - the extent to which the services engaged with the family;

- the process by which Mr X transitioned between CAHMS and Adult services;
- the quality of the internal and external reviews conducted and the progress that has been made in implementing the recommendations and associated action plans; to include liaison and consultant processes with the family of Mr X;
- a triangulation of the investigation reports conducted regarding Mr X;
- the commissioning reviews of care and treatment including the processes in place for contract monitoring and quality assurance.

2. To write a report for NHS England that includes:

- a chronology of events from first contact with service to the discharge of Mr X from the Trust's inpatient services;
- an analysis highlighting any missed opportunities and findings based on the evidence revealed;
- a review of the findings of the CQC report regarding the standards of learning disability care and treatment at the inpatient unit in conjunction with an examination of the lessons for learning leading from the Winterbourne View review as part of a structured evidence-base for future service development;
- any notable areas of good practice;
- any new developments in services since engagement and any action taken by services since the incident occurred;
- measureable, achievable recommendations for action to address the learning points to improve systems and services;
- the formulation of actions will feed into the development of a system wide review of learning disability services within the local area.

3. The Investigation Team

Selection of the Investigation Team

3.1. The HASCAS Investigation Team comprised individuals who worked independently of the services under investigation. All clinical team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in investigation and inquiry work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Team Leader

Dr Androulla Johnstone	CEO of the Health and Social Care Advisory Service and Nurse Team Member
Mr Ian Allured	Health and Social Care Advisory Service Associate and Social Work Team Member
Ms Jane Duncan	Health and Social Care Advisory Service Associate (Local Authority Safeguarding Lead Hampshire County Council) and Safeguarding Team Member
Mr Alan Watson	Health and Social Care Advisory Service Associate and Social Work Team Member and Mental Capacity and Mental Health Act Advisor
Dr Rosie Baker	Health and Social Care Advisory Service Associate (Learning Disability Consultant Psychiatrist with a Community Learning Disabilities Team in Hampshire) and Medical Team Member

4. Documents used by the Investigation

4.1. The Investigation Team considered in excess of 8,000 pages of documentation. These comprised:

1. Mr X's clinical records.
2. Mr X's GP records.
3. Independent report files 1-3.
4. Mr X's Local Authority notes.
5. Mr X's LAT review evidence.
6. Mr X's records (non – medical).
7. Local Adult Safeguarding Procedures.
8. Local Complaints Policy and Procedure.
9. Trust - The Management of Challenging Behaviour, Violence and Aggression Policy.
10. Trust - Safeguarding Adults Policy.
11. Trust Seclusion Policy including use of Segregation.
12. Trust Safeguarding Children Policy.
13. Trust Care Programme Approach and non-CPA (Standard Care) Policy.
14. Trust Risk Management Policy Issue 4.
15. Recording, Investigation and Management of Complaints/Concerns Policy.
16. Local Commissioner Complaints Policy and Procedure.
17. Local Commissioner Multi-agency Transition Protocol for Young People 14-25.
18. Local Commissioner Complaints, Comments and Compliments Adult Social Care Services Policy.
19. Department of Health Winterbourne View Report (December 2012).
20. The Internal Review into the complaint from Mr X's parents to the Chief Executive of the Mental Health Trust.
21. The Care Quality Commission (CQC) Review of Compliance at the Inpatient Unit.
22. The Local Safeguarding Adults Unit Investigation.
23. The Commissioner's Root Cause Analysis Report on 4 Selected Cases.
24. The Safeguarding Investigation commissioned to investigate the care and treatment Mr X received at the Inpatient Unit.
25. The Care Quality Commission Mental Health Act investigation.
26. NICE guidance.

5. Methodology

Limitations to Scope

5.1. The HASCAS Investigation conducted a desk top review of documents relating to Mr X's care and treatment. These documents comprised Mr X's clinical records, service review and investigation documentation, and national and local policy best practice guidance.

5.2. The HASCAS Investigation comprised a team of experienced individuals who applied an evidence-based approach to the Investigation. Root Cause Analysis principles as advocated by the National Patient Agency were used. A timeline was developed, an analysis of the evidence made, and findings and conclusions developed. Where the HASCAS Investigation concurred with the findings of the six previous investigation and reviews no further examination was made or additional analysis provided.

5.3. The HASCAS Investigation considered over 8,000 pages of documentation. Mr X's health and social care record comprised notes from several services. Not all of the records were signed or dated, not all of the signatures were legible. This meant that it was not always possible to ascertain when meetings and decisions took place, or who was involved.

Issues with Fulfilling the Terms of Reference

5.4. The scope of the Investigation has been limited in that it has not been possible to interview any health or social care staff (please see Chapter 1). Neither has it been possible to interview any commissioners of the services involved in Mr X's care and treatment.

5.5. Due to the scope of the Investigation it was not possible to:

- ascertain any loss of capacity or capability on the part of Mr X due to his experience on the inpatient unit or the level of any potential trauma sustained; this is because an Independent Investigation Team cannot work as a clinical assessment team;
- ascertain whether Mr X was subject to intentional or institutional abuse beyond the improper use of seclusion;
- ascertain whether Mr X had a timely access to formal education whilst on the inpatient unit as we did not have his education records and could not interview staff;
- understand the process as to how local safeguarding policy was implemented;
- ascertain how services have developed since and how effectively they have implemented the recommendations set by previous investigations and reviews and the findings of the Winterbourne Review;
- ascertain how commissioners contract services in relation to the lessons for learning from an examination of Mr X's case.

5.6. The HASCAS Investigation could only go so far as the documentary evidence would allow. As a consequence there were some issues that could neither be clarified nor established. Consequently an in-depth examination of the detail could not always be pursued or commented upon. However we are of the view that this has not detracted from establishing the key thematic issues relevant to the examination of the case and that the overarching findings and conclusions are sound.

Meeting with Mr X's Family

5.7. Two of the Investigation Team members met with Mr X's parents and sister. We would like to thank them for their time and valuable insights into the case.

6. Narrative Chronology

Background

6.1. Mr X was diagnosed with atypical autism as a young child.

6.2. When Mr X was 14 years of age a referral was made to the Child and Adolescent Service following a serious incident when Mr X attacked his mother necessitating the police being called to the house. The violence and aggression appeared at this stage to have been a well established part of Mr X's presentation.

6.3. Mr X was a pupil at a Specialist School, which provided a specialist environment for children and young people with Autistic Spectrum Disorder and a mix of day and boarding facilities to allow parents some respite from providing care.

History of Mr X's Care and treatment prior to his admission to the Inpatient Unit

6.4. At the age of 18 years Mr X transitioned into adult mental health services; there were some delays and process issues relating to the transfer of care. He had continued to be violent and aggressive on frequent occasions to family members and people at his school. Prior to Mr X's 18th birthday his behaviour had become more challenging and increasingly difficult to manage at home. A Community Learning Disability Nurse and Children's Social Worker visited and recorded that the behaviours were noted to be:

- jumping, bouncing, loud noises/screams;
- destruction of property;
- hitting out/pulling hair;
- punching/scratching;
- biting/wrestling people to the ground;
- continuing to attack even when the other person withdraws.

6.5. Approximately six months after Mr X's 18th birthday his challenging behaviour became so severe that he required an inpatient admission into a mental health facility.

6.6. The Consultant Psychiatrist developed a treatment plan for Mr X. In a letter to the GP the Consultant stated:

1. *"I have advised the family that it is important that we bring him into hospital for a period of assessment to ascertain what could be the cause of this change in behaviour. An admission into [a] Learning Disability Unit is being facilitated and family are happy to take him there informally, and because he has calmed down*

now the Mental Act Assessment that was initially scheduled has been put off, and he will be transferred informally….

2. *On arrival at [the unit] should he be quite disturbed or should his risk to others or himself increase then we will push to section him under Section 2 of the Mental Health Act for assessment.*

3. *We will continue on his current medication and gradually wean him off all medications whilst an inpatient and assess him medication free.*

4. *I have advised family to increase his Diazepam to 4mg up to four times a day for now until the transfer is facilitated, just to help take the edge of his behaviours and aggression".*

Mr X's time on the Inpatient Unit

6.7. Initially Mr X was admitted as an informal patient to the unit but he was regraded to a Section 2 of the Mental Health Act. After four weeks Mr X was discharged home. His return home was to fail after ten days as his challenging behaviour continued and his parents could not cope. Mr X was returned to the inpatient unit and placed under Section 3 of the Act.

6.8. During Mr X's time on the unit concerns were raised by his parents regarding the quality of the care and treatment he received. Their concerns covered a wide range of issues and included:

- medication;
- the use of seclusion;
- the use of management of violence and aggression (MVA) techniques;
- the content of Mr X's care and treatment programme;
- dignity and personal hygiene;
- his safety and psychological wellbeing.

6.9. During Mr X's time on the inpatient unit he continued to be violent and aggressive on frequent occasions. This made nursing him on the ward difficult and he was placed in a quiet zone where he was secluded for significant periods of time. During Mr X's stay on the inpatient unit numerous complaints were made by his family and six investigations were undertaken.

6.10. After Mr X had been an inpatient for eight months a Mental Health Tribunal Hearing Panel ruled that he should be released from detention under Section 3 of the Mental Health Act (1983 & 2007) and discharged with a support package. The date of the discharge was deferred until suitable arrangements could be made. Significant differences of opinion continued (between Mr X's parents and the inpatient unit staff) about how best to manage

Mr X and the arrangements required for his discharge. Mr X continued to be violent and aggressive and difficult to manage on the ward.

Mr X's Discharge from the Inpatient Unit

6.11. A discharge planning meeting was held. Commissioners, members of the treating team, and Mr X's parents were present. The agreed discharge arrangements were:

1. **Option A:** for Mr X to go home with an intensive wrap around community support package and six months funding was available. The commissioner was able to provide the required package of care.

2. **Option B:** a step-down residential placement should be considered should Option A not be ready by discharge.

3. **Option C:** to clarify inpatient options open to Mr X before discharge.

6.12. The service specification consisted of the following main points:

- a service to be provided in a person-centred way by an Autism Specialist provider;
- staffing ratios of 2:1 support to be provided;
- pre-arranged periods of outreach support to be provided in the community and Mr X's home environment (Monday - Sunday 08:00 - 20:00 hours);
- the facility for planned or emergency short breaks to be provided via a respite bed or a 24-hour supported tenancy model.

6.13. However, given the recent escalation in assaultative behaviours the clinical view was that Mr X required 3:1 staffing. There were concerns regarding the risks associated with his being discharged straight back to the family home. It was identified that when discharged from hospital Mr X would require both formal and informal support networks to be available.

6.14. Disagreements continued and consequently Mr X was discharged, ten months after his admission, with a partial crisis plan in place which relied upon the commissioners identifying a residential respite facility where Mr X could go should he prove too difficult to manage at home. Local (health and social care) services had looked at some possible facilities including using part of an existing respite facility. In addition two providers had expressed an interest in setting up the service. The immediate crisis plan involved an independent agency providing additional staff to assist at Mr X's home should more help be necessary to control any emergent situation.

Mr X's Care and Treatment following Discharge

6.15. A letter was sent to the GP informing him that Mr X had been discharged to his home; a full discharge summary was to follow in due course.

6.16. The follow-up plan was:

1. Contact details in an emergency were made available during working hours and out of hours;
2. Seven day follow up by the Care Coordinator on Monday;
3. Follow up by the Consultant Psychiatrist on 25 February 2013;
4. Follow current treatment plan as well as the agreed PRN protocol;
5. Follow the agreed care plan.

6.17. It was recorded that Mr X had returned to live at home with his family and the family stated that this had gone *"remarkably well"* although they had some *"some struggles"*. The family expressed the view that where at all possible Mr X should be supported at home and that any future action to 'send him away' would lead to significant psychological distress.

6.18. Three months after Mr X's discharge the independent agency withdrew its support. The reasons given for this action were:

- the reluctance of the staff team to work with Mr X and his family;
- the levels of challenging behaviour being exhibited;
- the increasing intensity of the behaviour with six incidents which included some serious assaultive behaviour causing staff to seek hospital attention;
- the potential serious nature of future incidents in the home environment.

7. The Themes from the Investigation Process

The Transition Process

7.1. The transition between child and adult services that Mr X and his family experienced was of a poor standard. It was unacceptable for services not to have been coordinated better. From the evidence available it would appear that Mr X was left in limbo between services for a period of several weeks and it is unclear how well the handover process was managed. During this time Mr X presented with significant challenging behaviours which were recognised as potentially placing both him and his family at risk.

7.2. Regardless of the poor transition arrangements the Adult Service Consultant Psychiatrist appears to have made efforts to get to know Mr X and his parents meeting them on a six-weekly basis. It would appear that Mr X's mental health and wellbeing started to improve and were not affected negatively by the transition process *per se*. It would also appear that Consultant Psychiatrist 1 had commenced the process of thinking about Mr X's future transition needs with his parents and this planning would probably have continued had Mr X's mental health remained stable.

- **The HASCAS Investigation concluded that transition processes were of an unacceptable standard which potentially placed Mr X at risk during a period of time when it was known that his behaviour was challenging and his parents were struggling to cope. However it would appear that Mr X's mental health and wellbeing were not directly compromised by this poor level of service and that this in itself did not cause his mental health to deteriorate.**

Diagnosis and Suitability of Treatment Approach and Care Model

7.3. Mr X has been diagnosed with 'atypical' autism in that he appears to be friendly and to value relationships. He has also been diagnosed as having Attention Deficit Hyperactivity Disorder for which he had previously been prescribed medication. It would appear that Mr X has a sensory modification disorder, suffers from depression and has a severe learning disability. Mr X also suffers from sleep disturbance and has hearing and communication difficulties. Co-morbidities are not unusual in autism; however this can create a confusing diagnostic picture. Mr X is a young man who has probably experienced hormonal and maturation issues over the past few years which can be a common complicating factor. Mr X has a significant history of challenging behaviour, but this in itself is not a 'diagnosis' and is usually the expression of anxiety, frustration or unhappiness. Treatment in an inpatient facility for challenging behaviour *per se* is not good practice.

7.4. The HASCAS Investigation found that diagnostic formulation was underdeveloped and no specialist autism advice appears to have been sought in a timely manner. National best

practice guidance advocates that medication should be considered if there is an underlying psychiatric disorder, it should not be provided as a first line of treatment to manage challenging behaviour. The HASCAS Investigation noted that the approach taken to Mr X's care and treatment was usually of a reactive nature which sought to control his behaviour rather than work with his underlying condition.

7.5. Over the ten-month period of time Mr X was on the inpatient unit relatively little focus was placed on developing a complex care package for him which could have placed in him a more appropriate environment. On the face of it there were no apparent reasons why Mr X could not have returned home on a Community Treatment Order with specialist support and outreach services provided, or a placement found within a local supported living facility. It was evident that in the end Mr X returned home with a similar presentation to the one he had initially been admitted with and that materially the situation was no different. It is difficult to understand what exactly was gained from Mr X's protracted stay on the inpatient unit as no long-term complex care package was developed for him and he was discharged with an incomplete discharge and crisis plan that could not ensure his safety.

7.6. Mr X had a complex presentation which appears to been outside of the knowledge and experience of his treating teams over a five-year period. It was remiss for a specialist assessment not to have been sought, or for a more suitable model of care other than that provided by the inpatient unit to have been found, and the failure to do this was detrimental to Mr X's health and continued wellbeing.

- **The HASCAS Investigation concluded that Mr X required a specialist-level of input for his autism and complex set of comorbidities to ensure that the care and treatment he received was evidence-based and part of coherent care and treatment strategy. This was not achieved and best practice NICE guidance not adhered to.**

The Adequacy of Risk Assessments and Risk Management Plans

Risk Management Prior to Admission to the inpatient unit

7.7. Risk management processes were virtually non-existent during the period prior to Mr X's admission to the inpatient unit. Significant risk was identified but it would appear little was done to mitigate against it. This is of particular concern as during most of this time Mr X was a child and his behaviour placed him at significant risk of harm, especially when his physical aggression in the home had to be managed by his family.

7.8. The HASCAS Investigation found it difficult to determine why no appropriate action was taken or why the relevant risk assessment policies were not invoked. It appears that no multiagency approach was taken leaving each agency (health, social services and education) to manage the situation in isolation. Mr X and his family should have been in receipt of a full risk assessment and management process and should also have had a family-centered plan developed for them. The failure to accomplish this left Mr X, his

family and those around him vulnerable and this lack of proactive management made a contribution to his inpatient admission as the situation had been allowed to escalate with only a medication-led approach in place to resolve the problem.

7.9. A multiagency approach should have been invoked and each agency should bear responsibility for not instigating this.

Risk Management on the Inpatient Unit

7.10. The HASCAS Investigation concluded that the planned risk-taking assessments and the work on Mr X's arousal cycle were good practice. The plans provided a clear and detailed set of guidance for Mr X, his family, other patients and the Unit staff.

7.11. However the main focus of the treating team was often on the identification of Mr X's short-term risk, and the management of it, rather than on the understanding of the underlying reasons for his challenging behaviour and its aetiology. Mr X was initially admitted to the Unit because he was in crisis and for a period of assessment. During his admission little timely work was undertaken in developing a diagnostic and behavioural formulation that would have assisted in the understanding of Mr X's risk profile, the underlying reasons for it, and what would be required in order manage it appropriately, both on the unit and following his discharge. The difficulties presented by Mr X's challenging behaviour were significant and posed a high-level of risk to:

- Mr X;
- patients on the Unit;
- staff;
- visitors.

7.12. Whilst it was recognised on many occasions by the inpatient team that Mr X should not be on the unit, as it was not a safe placement for him, moves to transfer Mr X were always blocked by his parents, and no alternative complex care model was developed that would facilitate his discharge home. This meant that what risk management there was tended to be reactive and developed as a result of the difficulties posed by nursing Mr X on the inpatient unit rather than being focused upon the reasons behind his challenging behaviour which was of long-standing and pre-dated his admission. Short-term plans were put into place which did not extend to providing a framework for how Mr X's risk should be managed in the medium and long-term and what kind of care model would be needed for him once he was discharged back into the community.

Risk Management at the point of Discharge and following Discharge

7.13. Despite Mr X's risk of violence and aggression being the defining factor throughout his entire admission to the inpatient unit no clear risk assessment or management plan was put into place to manage this prior to his discharge. Risks were clearly identified, but no action was taken. This left Mr X and his family with an incomplete crisis plan that may not have been robust enough to provide an advance directive as to what would be required for

Mr X if he reached a crisis point in the future. The HASCAS Investigation found this to be an issue of significant concern, especially as the inpatient team had compiled a timeline of Mr X's previous acts of violence in the home.

Summary

7.14. A hallmark of the care and treatment Mr X received was that there was a great deal of activity in the identification of risk, but less by way of mitigation.

7.15. No medium or long-term risk assessment and management planning took place which potentially left Mr X and his family in exactly the same position following his discharge as they were in prior to his admission. If anything the risk was exacerbated as the family had lost faith in mental health services and would be less inclined to seek help and support in the future even if needed.

7.16. The HASCAS Investigation concluded that the family and mental health services failed to come to an agreement about how a future crisis plan for Mr X should be developed. This situation was made worse by the lack of available specialist services suitable for Mr X's needs should he require them in the future. However the Investigation concluded that this situation represented a significant risk in itself and as such should have been examined, assessed and resolved. It would seem that within the timeframe under investigation this risk was not mitigated against and the risks to Mr X may well continue to the present day.

- **The HASCAS Investigation concluded that the standard of risk assessment and management was variable. Whilst there were some examples of good practice these were confined to short-term management solutions. A coherent, long-term risk management strategy and crisis plan were not developed and this potentially continues to leave Mr X and his family vulnerable to this day.**

Mental Health Act (1983 & 2007) and Seclusion Practice

7.17. The Code of Practice for the 1983 Mental Health Act published by the Department of Health in 2008 revised the previous Code of Practice in line with the 2007 revised Mental Health Act.

7.18. The Code of Practice defines 'Seclusion' as *"… the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others"*.[1]

7.19. As a response to the high levels of violence and aggression Mr X displayed during his stay on the inpatient unit, he was often placed in what was termed *"a low stimulus*

1.The Mental Health Act 1983 Code of Practice, DoH 2008, Paragraph 15.43 P122

environment". This was created by placing Mr X into a suite of rooms with its own bedroom, bathroom and sitting room away from the rest of the ward. The suite of rooms could be locked to avoid other patients entering, and also to keep Mr X in a contained area.

7.20. The Code of Practice for the 1983 Mental Health Act also states that:

> *"Alternative terminology such as 'therapeutic isolation,' 'single-person wards' and 'enforced segregation' should not be used to deprive patients of the safeguards established for the use of seclusion. All episodes which meet the definition in the previous paragraph must be treated as seclusion, regardless of the terminology used.*
>
> *Seclusion should be used only as a last resort and for the shortest possible time. Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme. Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety and that any such risk can be properly managed".*

7.21. In addition the Code of Practice states that local policies are required and that they:
"… should include clear written guidelines on the use of seclusion. Guidelines should:

- *ensure the safety and wellbeing of the patient;*
- *ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place;*
- *distinguish between seclusion and psychological behaviour therapy interventions (such as 'time out');*
- *specify a suitable environment that takes account of the patient's dignity and physical wellbeing;*
- *set out the roles and responsibilities of staff; and*
- *set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action".*

7.22. Whilst any patient is in hospital care, including when placed in seclusion, they are entitled to be treated with dignity. In the NHS Dignity Challenge documentation which HASCAS helped to produce the essential elements of dignity were identified as:

> *"… consisting of a number of overlapping aspects of: Respect, Privacy, Autonomy and Self Worth and has been defined as: "a state, quality or manner worthy of esteem or respect; and (by extension) self-respect. Dignity in care,*

therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person's self-respect regardless of any difference".[2]

7.23. The inpatient unit did not provide Mr X with a safe and dignified environment. However the HASCAS Investigation acknowledges the difficulties that Mr X presented to the unit over time. The Investigation concurs with the findings and conclusions of the other reviews but would add that the difficulties Mr X experienced lasted for the entire period of this admission. A care and treatment strategy, and the appropriate clinical environment in which to deliver it, could not be agreed and consequently Mr X ended up in a service that was detrimental to his both his physical and mental health. There were enough flags raised over a six-month period for something more proactive to have been done. Three of the reviews' findings were available four months prior to Mr X being discharged but, whilst changes were made to his care and treatment programme, the larger underlying issues of seclusion, safeguarding and risk went unaltered and Mr X's experience on the unit did not change substantially. It is probable that only a transfer to a different and more appropriate clinical environment could have achieved this.

- **The HASCAS Investigation concludes that Mr X's health and wellbeing suffered as a result of the seclusion practices on the inpatient unit. Despite concerns being raised, and investigations and reviews conducted, little happened to materially alter his experience on the Unit over a ten-month period.**

The Care Programme Approach (CPA)

7.24. The policy that was place in during Mr X's care and treatment with the Trust states: All people on CPA have a right to:

- develop their own care plan in collaboration with a member of their care team;
- a care coordinator;
- the development of a care plan which is regularly reviewed to reflect their current care and recovery requirements and aspirations;
- sign and agree the care plan;
- a copy of their care plan.

7.25. The Policy states that assessment should always take place which supports care planning and the care package. All service users should receive a comprehensive risk assessment and a care planning and care review. An essential part of the process is carer involvement.

2. HASCAS Dignity in Care Standards 2007

7.26. The HASCAS Investigation concluded that a great deal of time and a high level of resource were put into Mr X's CPA whilst on the inpatient unit. A representative sample of Mr X's treating team was always present, Mr X's parents were always invited and involved, and effort was made to maintain contact with the school and the local (health and social care) services. CPA documentation was always completed and shared with the GP and Mr X's parents. Efforts were made to share the information with Mr X but his interest was limited. All of this was good practice.

7.27. However the HASCAS Investigation concluded that CPA is principally a system that ensures a systematic assessment and management of health and social care needs bearing in mind both immediate and long-term requirements. The CPA process is not an end in itself but a mechanism by which service users with severe or enduring conditions can be supported and their needs planned for and met in an appropriate and timely manner. Whilst there was a great deal of activity around Mr X's CPA this did not translate into a coherent medium and long-term care and treatment strategy. A prime example of this is the detailed discussion that appears to have taken place prior to Mr X's initial discharge from the inpatient unit (four weeks after his first admission). However the excellent ideas that were developed did not appear to have translated into tangible actions and consequently Mr X returned again to the unit.

7.28. The HASCAS Investigation could find no evidence to suggest that there was a culture of strong Care Coordination, an essential element of CPA, and that this may be due to a particular ethos within the service with regard to the role of the Care Coordinator. The Investigation can only offer a speculation here as no interviews were possible to ascertain further information. The HASCAS Investigation therefore remains unclear how the Care Coordination process was managed and CPA continuity ensured once Mr X left the inpatient unit. Considering the complexity of the case the HASCAS Investigation would have expected the Care Coordinator and the CPA process to have:

- prepared a strategy to support Mr X's parents;
- provided the offer of family focused therapy;
- arranged for psychological interventions for the reduction of Mr X's challenging behaviour;
- developed specific care plans to address Mr X's ongoing needs e.g. depression, hyperactivity, lack of sleep, nutrition, obsessive behaviour etc.;
- developed a strategy for interagency communication and support with particular reference to the school;
- ensured ongoing review of and support to the independent support service;
- developed an ongoing risk assessment and management strategy;
- ensured regular monitoring and review arrangements.

7.29. It is regrettable that at the point of discharge a personalised care model had not been developed that would have met both Mr X's needs and the approval of his parents. This was compounded by the fact that the CPA process appears to have become less focused at

the point of discharge regarding continued healthcare inputs and multiagency liaison processes. Mr X should not have left the inpatient unit after a period of ten months with such an inadequate level of care planning to address his needs and continued wellbeing. Good practice requires discharge planning to commence on the first day of admission and it was remiss for services to have consistently missed the opportunity for a proactive, responsive and person-centred approach to have been taken. In effect Mr X appears to have left the inpatient unit with an almost total reliance upon social care providers and a relatively minimal level of input from health.

- **The HASCAS Investigation concluded that CPA and care planning processes were in the main weak in that they focused on reactive short-term goals and were not able to address Mr X's medium and long-term needs.**

Carer Assessment and Family Involvement

7.30. The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared-for person's type and level of service provision required.

7.31. Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they cared for. The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. It also facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

7.32. In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- have their own written care plan which is given to them and implemented in discussion with them.

7.33. The HASCAS Investigation concluded that Mr X's parents did not receive an appropriate or timely level of intervention when Mr X's challenging behaviours emerged and they sought help. The HASCAS Investigation also concluded that Mr X's care and

treatment on the inpatient unit was not optimal and that the placement was not equipped to manage his autism. Mr X's parents therefore had every right to challenge the service provider and make their concerns known. However the series of service delivery complaints deflected both service and commissioner attention away from the serious underlying issues in relation to the appropriateness of Mr X's continued inappropriate placement on the inpatient unit, and all the time relationships worsened.

7.34. Health and social care services have a duty to ensure that carers are involved as fully as possible. However services should not defer to carers and allow them to take a care and treatment lead if it is not perceived to be in the service user's best interests. Ultimately the duty of care is to the patient. The HASCAS Investigation concluded that at times services deferred to Mr X's parents whilst often remaining uncomfortable about the decisions made. When a service provider believes a family to be misinformed, or not acting in the best interests of a service user, then it has a duty to be direct and make it clear that its views differ. In intractable cases when the service user is a child or a vulnerable adult then Mental Capacity and Best Interests processes should be considered. In the case of Mr X very little appears to have been resolved over time in a satisfactory manner

7.35. At an early stage an independent, specialist opinion should have been sought to consult as to how an appropriate and personalised care model could be developed for Mr X. This should have been undertaken with Mr X, his advocate, his parents, the service provider and the commissioner. It is evident Mr X was not thriving on the inpatient unit and this should have been the focus of attention. Mr X's parents wanted a care package that would help him to return home and Services understood that the inpatient unit was not the best place for Mr X to be. It is unfortunate that this approach was not pursued.

7.36. It was evident that the relationship between Mr X's parents, the service provider and commissioners deteriorated steadily over time and could not be resolved. The situation had already generated six investigations and reviews, with the HASCAS Investigation being the seventh. In such a situation it is difficult to understand how relationships can be repaired. However it is probable that Mr X will require the ongoing input from a multiagency team for the rest of his life and that the failure to manage the situation may continue to affect him negatively in the future.

- **The HASCAS Investigation concluded that the worsening relationship between the family and services should have been managed more assertively and that an independent consultation sought to identify an appropriate, personalised care model for Mr X.**

Mr X's Involvement in his Care and Treatment, Capacity and Best Interests

The Department of Health Dignity Challenge (2006)

7.37. A core right of all NHS patients is to be treated with dignity and respect and this is set out in the NHS Constitution. On 14 November 2006 the Minister for Care Services

launched the first ever dignity in care campaign. It was established that services that respect people's dignity should:

1. Have a zero tolerance of all forms of abuse.
2. Support people with the same respect you would want for yourself or a member of your family.
3. Treat each person as an individual by offering a personalised service.
4. Enable people to maintain the maximum possible level of independence, choice and control.
5. Listen and support people to express their needs and wants.
6. Respect people's right to privacy.
7. Ensure people feel able to complain without fear of retribution.
8. Engage with family members and carers as care partners.
9. Assist people to maintain confidence and a positive self-esteem.
10. Act to alleviate people's loneliness and isolation.[3]

7.38. During Mr X's stay on the inpatient unit the HASCAS Investigation could find no evidence to suggest Mr X was intentionally abused or his rights denied to him. However the facility was not appropriate to either his presentation or his needs and this created a 'downward' spiral by which Mr X's behaviour continued to worsen and his physical and mental health decline. In an attempt to keep Mr X, the other patients, and the ward staff safe measures were taken which took him away from main part of the ward. The decision to supply Mr X with a suite of rooms was also taken with a view to managing his autism by providing him with a place to withdraw and reduce sensory stimulation. However the use of the suite, no matter how well intentioned for Mr X, was not managed in accordance with a robust clinical management plan.

7.39. Consequently Mr X was subject to a regimen that impinged upon his dignity and, at times, constituted psychological abuse. The HASCAS Investigation concluded that in the latter period of Mr X's stay on the inpatient unit his care and treatment programme was of a good standard; however this took time to develop and was limited in being able to affect a real improvement in his condition.

7.40. That the situation was difficult to manage was evident. Mr X's experience led to six separate investigations and reviews being undertaken. However the focus of these investigations and reviews were primarily based on ensuring a better service response *to* Mr X on the inpatient unit rather than identifying the needs *of* Mr X and the underlying factors that were placing his health and wellbeing at risk; namely that he had a complex condition and was placed within an inappropriate service.

7.41. Disagreements between Mr X's parents and the Service had the effect of displacing the attention from Mr X's medium and long-term needs. The HASCAS Investigation could

3. DH home Policy and guidance Health and social care topics Social care Dignity in care

find no evidence to suggest that Mr X's best interests were established either in relation to his time on the inpatient unit or at the point of his discharge.

- **The HASCAS Investigation concluded that the inpatient unit was not able to respond appropriately to Mr X's needs and best interests. Whilst a great deal of work was undertaken to examine the situation the focus was on the service response and not on the needs of the patient. Since Mr X was 14 years old services have raised concerns about Mr X's challenging behaviour and long-term needs. Several flags were raised over time but no proactive and consistent approach was taken. This has left Mr X in a potentially vulnerable situation especially should his mental health decline again in the future.**

Record Keeping and Professional Communication

Conclusions

7.42. The HASCAS Investigation found that the inpatient unit CPA process appears to have been an exemplar as to how an inpatient service communicates outwardly with a multiagency team. Whilst record keeping may have been of a poor standard at the beginning of his stay on the inpatient unit it was of a good standard towards the end.

7.43. However the HASCAS Investigation concluded from the evidence available to it that communication sharing between agencies and services may not have been robust enough to ensure that Mr X's case was managed in a coherent manner. This meant that concerns were raised but not necessarily shared in a multiagency forum. Mr X's case was complex and merited a multiagency approach. This had been identified as a need on several occasions throughout Mr X's teenage years. It remains unclear why this was not taken forward but was probably as a result of there being no single agency that took the lead in the coordination of Mr X's case management. Had professional communication been managed better then it would have been reasonable to have expected a more proactive approach to Mr X's emerging problems which may have prevented his eventual admission onto the inpatient unit.

- **Professional communication processes between agencies and services was not robust enough to ensure appropriate and timely action was taken to manage Mr X's case effectively.**

Safeguarding Vulnerable Adults

7.44. The HASCAS Investigation concluded that there were considerable safeguarding concerns in relation to Mr X of a long-standing and intransigent nature. It was evident from an examination of the documentary record that several serious incidents had occurred over the years which were known to services and which should have been regarded as significant indicators that Mr X was potentially at risk unless interventions were made. It is

a fact that over a five-year period the following agencies and services were aware of Mr X's challenging behaviour and the worsening situation:

- the police;
- education;
- Social Services;
- Community Learning Disability Services;
- Child and Adolescent Services;
- Acute Accident and Emergency services;
- GP primary care-based services.

7.45. It is also evident that on occasions alerts of some kind were made but did not seem to have been progressed. It would appear that agencies and services either did not communicate well together and that safeguarding alerts and concerns were somehow 'lost' within the system, or that the disparate agencies and services did not understand what constituted a possible safeguarding concern and therefore did not recognise the need to report anything formally. The HASCAS Investigation could not conduct interviews and so we could not establish how embedded child and adult safeguarding is within local services.

7.46. It is possible to establish the following:

1. Mr X had a significant history which comprised a consistent series of serious assaults and challenging behaviours which placed both him and those around him at risk.

2. Significant risks were identified regarding Mr X as a child and as a young adult.

3. Alerts of some kind were raised on a number of occasions and multiple agencies were involved when managing Mr X in crisis;

4. Mr X's parents alerted services on several occasions that they were struggling to cope.
5. Once on the inpatient unit Mr X's behaviour continued. It is evident from examining his history that his condition was not in an acute phase but presented a steadily worsening condition that had been developing for a number of years.

6. Once on the unit two safeguarding reviews looked at the inpatient unit specific issues but did not take the opportunity to look at Mr X's wider safeguarding picture.

7. The significant issues around whether Mr X's best interests were met by remaining on the inpatient unit and the consequent negative effects this would also have on the other patients was not explored.

8. Parental concerns and wishes appear to have been given increasing primacy, even when the treating team disagreed.

9. The disagreements and worsening relationship between Mr X's parents and the treating team meant that towards the end of Mr X's stay on the inpatient unit legal challenges were made by his parents which complicated further the decisions made by the Service. It was evident that the Service thought Mr X's best interests would be served by sending him to another unit and/or in providing a residential placement for him. The Service ultimately bowed to pressures from Mr X's parents. This would have been the opportunity to conduct a capacity assessment and a Best Interests review in order to have made objective decisions.

10. The Service was ultimately unable to put a robust crisis plan in place for Mr X in the light of parental disagreement. This meant that Mr X was discharged home with an insubstantial plan and with no strategy in place to manage him if his condition should worsen again in the future. This was not good practice when managing the care and treatment of a vulnerable adult especially in the light of both current and historic concerns.

7.47. The HASCAS Investigation concluded that a series of significant incidents and concerns were identified over the years in relation to Mr X and his challenging behaviour. It was evident that his health and wellbeing were compromised by the continuance of the situation and that these issues went unexplored and therefore unmanaged.

7.48. The HASCAS Investigation concluded that Mr X was never considered in the light of his entire history. The HASCAS Investigation noted that the Trust Complaint Investigation Report established that the local (health and social care) services had not passed information on to the inpatient team about their full involvement with the family and the concerns and difficulties that they had encountered. This is regrettable.

7.49. To summarise: over time there were several incidents identified and concerns raised that should have triggered safegaurding alerts. Some alerts do appear to have been triggered but it is not clear what happened to them. The fact that two alerts appear to have been made (and over a relatively short period of time in the spring prior to his admission) indicates that action should have been taken to review Mr X's situation. The safeguarding work that has taken place appears to have focused upon service issues (quite rightly), but it would appear that the system has not been sensitive enough to detect and action the more concerning and problematic safeguarding issues about Mr X's continued health, safety and wellbeing over time as a direct consequence of his diagnosis and challenging behaviour.

7.50. Had Services understood Mr X in the light of his full history then it would have been reasonable to have expected a detailed discharge and crisis plan to have been developed prior to his discharge which placed Mr X and his needs in the centre of the process. We conclude that enough information was held by the disparate services for detailed

examination of risk to have been undertaken prior to Mr X's discharge and for an appropriate package of care and treatment to have been put into place. This was not achieved. A capacity assessment took place in relation to care plan interventions and Mr TG's desire to return home. However a more detailed process should have been considered in relation to the identified risks and ongoing safeguarding issues that were evident at this stage.

- **The HASCAS Investigation concluded that significant concerns and several safeguarding alerts were raised in relation to Mr X and his challenging behaviour over a five-year period. The local Safeguarding system examined service-based concerns about the inpatient unit but was not sensitive enough to detect and examine other underlying and more deep-rooted safeguarding issues that had been of historic significance and which continued through to the point of Mr X's return home. This placed Mr X at risk and did not consider his needs as a vulnerable young adult.**

Summary of Findings and Conclusions: Overall Management of Mr X' Case

Findings

7.51. Mr X has a diagnosis of atypical autism; several other co-morbidities have historically been present and he had a complex presentation made more difficult to manage by virtue of his challenging behaviour which was of longstanding.

7.52. Mr X has a supportive family who are his main carers, a role which is supported by care services being brought into the home. The family have always expressed a strong preference over the years to keep Mr X at home and not place him in a residential care context.

7.53. Mr X's increasing violence and aggression ultimately led to his admission onto the inpatient unit. By this time a number of indicators relating to safeguarding had been identified by several agencies and services.

7.54. From the outset the inpatient unit was not thought to be an appropriate clinical environment for Mr X as it was not a specialist autism unit; however it was used initially as a short-term assessment facility for him. Following his initial discharge it was envisaged that he would only return to the inpatient unit as a last resort. Unfortunately no plans were put into place at this stage to ensure a more suitable facility was found and neither was an appropriate care model developed for his long-term needs should he go into crisis again. This was exacerbated by there being no specialist autism facilities in the area.

7.55. Consequently Mr X returned to the inpatient unit (after ten days of being back at home) and a range of clinical management issues emerged in relation to his particular clinical needs and challenging behaviour. Mr X's parents expressed legitimate concerns

about the manner in which Mr X was being managed and these concerns were investigated over the ensuing six months by six separate investigation and review processes.

7.56. Each investigation and review identified shortfalls in the levels of service that the inpatient unit was providing, but none of them focused upon the underlying issue which was that Mr X was being treated in a facility that was not appropriate for him. Consequently changes were made to the unit but the underlying problems continued. It was neither reasonable nor possible to have expected the inpatient unit to have transformed itself into a specialist autism facility. The need for a more appropriate placement was not addressed and Mr X's physical and mental health declined. The ongoing situation also created an unsafe therapeutic environment for the other patients on the unit and an unsafe working environment for the ward staff.

7.57. The relationship between Mr X's parents and the inpatient unit worsened due to disagreements about where he should be placed. Mr X's parents were adamant that he should remain on the inpatient unit prior to returning home and the unit treating team thought that he should be transferred to a more appropriate facility for his safety and that of others. In the event Mr X was to stay on the unit.

7.58. Ultimately these disagreements continued and led to Mr X being discharged, after a ten-month period, with an incomplete and weak discharge and crisis plan as no agreement could be reached in relation to his future needs and how they were to be met. The main issue, that of a personalised care model which was developed around his complex needs, went unaddressed.

Conclusions

7.59. Mr X's case was managed poorly. The general service response from all of the agencies involved was reactive in nature and did not take into account the significance of the information that was held. Consequently no actions were taken and Mr X's situation worsened over time which ultimately led to his admission onto the inpatient unit. The HASCAS Investigation concluded that this was not good practice and placed Mr X at risk. This was probably the result of poor communication, poor interagency working and a collective poor understanding of how to manage safeguarding concerns.

7.60. Once Mr X was admitted to the inpatient unit the focus was placed upon the functioning of the service and immediate short-term care and treatment issues. Whilst these constituted legitimate areas of concern, this displaced the focus from being on the central issue which was the appropriateness of the placement and Mr X and his long-term needs.

7.61. The HASCAS Investigation concluded from the evidence available to it that the inpatient unit provided a good general level of service. This is borne out by the Care Quality Commission reviews which acknowledge that the other patients on the Unit appeared to thrive in the environment. However it would appear that the unique pressures

Mr X placed upon the unit led to complex clinical management issues which pushed the service to breaking point and led to it breaching good practice.

7.62. The inpatient unit is not a specialist autism unit and the HASCAS Investigation concluded that the appropriate NICE guidance was not met. However the central issue is not so much in establishing the limitations of the unit but in the decisions that were made which led Mr X to remain a patient there even when it was evident that his best interests were not being met.

7.63. In short the HASCAS Investigation concluded that the inpatient unit continued to try and adapt to the care and treatment requirements of Mr X beyond the point that it was reasonable to do so. Consequently the unit was found to be in breach of several compliance, statutory and good practice requirements.

7.64. From an examination of the clinical record between it is evident that Mr X required a robust multiagency approach and safeguarding considerations. The service offered appears to have been fragmentary and communication poor. Significant information was known and should have been actioned prior to his transition to Adult Services.

7.65. Services failed to take robust actions in order to maintain Mr X's health, safety and wellbeing over time. It is apparent that the issues that were present, and of longstanding, went unresolved at the point of his discharge from the inpatient unit and may still exist to the present day.

7.66. Parental opposition in the face of what appears to have been in Mr X's best interests over time was not managed well. Parental opposition appears to have been a major factor in services not pursuing what was thought to be an appropriate response to Mr X's ongoing needs. This is regrettable. A key lesson for learning is that the needs of the service user should be central to every decision made, and that the Mental Capacity, Best Interests and Safeguarding processes should be used in order to protect and maintain the health, safety and wellbeing of both children and vulnerable adults, especially when families and health and social care services disagree.

- **The HASCAS Investigation concluded that all of the agencies involved in Mr X's care and treatment, both pre and post admission, did not work in a sufficiently robust manner to ensure Mr X's health, safety and wellbeing was maintained.**

8. Lessons for Learning

8.1. The key lesson for learning based on the examination of this case is that the service user's health, safety and wellbeing should always be placed at the centre of all commissioned services. The needs of, and risks to, children and vulnerable adults are well documented. The Winterbourne View Review examined in detail the circumstances by which poor care and treatment can be delivered to learning disabled individuals. It is a fact that individuals who demonstrate challenging behaviours can present major difficulties to both carers and statutory services, and that once the behaviours are present there may be no straight forward solutions. It is always desirable for forward planning to take place wherever possible and for emerging difficulties to be detected and managed in a timely manner.

8.2. Safeguarding, professional and interagency communication, and commissioning arrangements are themes that run through the findings and conclusions of this report. Whilst there was a great deal of intervention and activity in relation to the care and treatment provided to Mr X and his family it is evident that this was not always coordinated and was largely reactive in nature. This approach served to prevent a coherent care and treatment strategy from being developed. This ensured Mr X's situation was not managed in an outcome focused manner and that his health, safety and wellbeing were, at times, compromised. To-date this is an unfortunate pattern for many learning disabled individuals across the country.

8.3. Learning disabled children should receive a service that provides a life course approach. This should ensure a proactive and person-centred service is delivered which can meet the needs of the individual and their carers. The Department of Health recognises that at present, too many learning disabled individuals are placed for long periods of time either in hospitals or residential homes where their potential is not realised and their quality of life impaired and that services struggle to provide a comprehensive approach to their needs. Consequently as a result of the Winterbourne View Review there is a requirement placed on all commissioners of service to establish person-centered models of care so that individuals with challenging behaviours, such as Mr X, have agreed personalised plans of care, developed with them and their families. The emphasis should be placed on a needs-based approach that maximises potential and quality of life in a proactive manner, and for a service response to be developed that can manage crisis situations with the full agreement of all concerned and the best interests of the service user at heart.

9. Notable Practice

9.1. The HASCAS Investigation found many failings with regard to the care and treatment that Mr X received. However the Investigation found that despite the difficult situation Mr X, his family, provider services and commissioners of services found themselves in there was a concerted effort from everyone involved to try and improve Mr X's care and treatment.

9.2. The HASCAS Investigation found that during the time Mr X spent on the inpatient unit that the Trust continued to try to manage Mr X and the welfare of the other patients on the unit in a robust and sensitive manner. There is evidence to suggest that staff on the inpatient unit tried to engage with both Mr X and his family and that they continued to adapt the service they provided to the best of their ability throughout the time of his admission as a result of the feedback provided by both Mr X's family and the subsequent investigations and inspections that took place.

9.3. During Mr X's time on the inpatient unit commissioners of service steadfastly engaged with both Mr X's family and the providers of service to ensure service improvements were implemented, complaints and concerns were investigated, and that alternative models of care were considered for Mr X.

10. Recommendations

10.1. A Root Cause Analysis workshop was held to facilitate the development of recommendations. The workshop focused upon an abbreviated timeline so understanding could be reached regarding the effectiveness of Mr X's care and treatment.

The key areas under discussion were:

- Safeguarding systems and processes;
- family interventions and relationships;
- service models of care and commissioning;
- professional and inter-agency communication;
- investigation process lessons for learning for the future.

Safeguarding

10.2. The stakeholders discussed the role of the Care Programme Approach and the Care Coordinator role in relation to safeguarding alerts and processes. It was recognised that the Care Coordinator role is difficult and that individuals are often relatively 'junior' in the hierarchy. If this role was to be maximised to the full further training would be needed and cases where safeguarding issues were of concerns would be allocated to more senior and experienced staff.

10.3. Clinical supervision was discussed as being a key method of ensuring that health and social care workers had an opportunity to discuss difficult and challenging cases. It was recognised that clinical supervision was an essential safety net of care when managing challenging cases and families.

10.4. It was also recognised that when dealing with challenging families there was a need for a senior independent liaison person outside of the care and treatment team who could mediate in the best interests of the service user. This would free health and social teams to provide care without having to constantly address conflicting family issues.

10.5. Safeguarding thresholds were discussed. Stakeholders were uncertain how the safegaurding process in relation to Mr X and his family. It was recognised that more work needed to be undertaken in order to understand whether any alerts were actually made, if not why not, and if they were made what actually happened to them.

Recommendations

1. **Training should be offered to Care Coordinators with explicit inputs regarding safeguarding issues.**
2. **Safeguarding should be raised in all clinical supervision meetings.**
3. **Consideration should be given to identifying key senior liaison personnel across the area who could provide independent mediation in difficult cases.**

4. **Clarification of safeguarding protocols and a review of training and inter-agency information sharing.**
5. **Current safegaurding policies should be reviewed in the light of the findings and conclusions of this case with particular regard to professional and interagency communication.**

Family Interventions and Relationships

10.6. The stakeholders were of the view that clarification and guidance were needed in relation to working with families. In this case both parents were very senior professionals and at times the boundary between their role as parents and professionals became blurred. This dynamic, at times made it difficult to make the most effective decisions. The challenge is to create the necessary climate and culture in which appropriate challenge can be managed and facilitated in order to make the best possible decisions.

10.7. The 'breaking of bad news' in the face of difficult learning disability diagnoses should be re-examined. This is something services should consider in general for all families of learning disabled children in general, and with the family of Mr X in particular. It was recognised that families sometimes have unrealistic expectations which can prevail over long periods of time and can be problematic when planning realistic inputs for the service user.

10.8. Learning Disability over a life course was discussed; challenging behaviour in particular. As a result of the investigations into the care and treatment Mr X received the Trust has developed a formulation to understand how families can be worked with better in the future.

Recommendations

1. **A family protocol to be developed to establish boundaries and statutory agency response when differences of opinion develop between families and health and social care agencies when providing care and treatment to both children and vulnerable adults.**
2. **Early work with families when children are diagnosed with a learning disability to be re-visited and a protocol developed (in general).**
3. **Work with Mr X's family to assess their expectations and Mr X's needs for the future (in particular).**

Service Models and Commissioning

10.9. Stakeholders discussed the difficulties in getting new service models in place. It was recognised that the inpatient service could be developed to provide a valuable, specialist autism and challenging behaviour resource for local service users. This is something that could be explored for the future. It would appear that the area does have a significant resource that could be harnessed for the future. There was a recognition that LD over a life

course and challenging behaviour needed to be at the forefront of all thinking and future service planning.

Recommendation

1. **Exploration of current services to be conducted by all stakeholders in partnership in order to ascertain how they could be further developed to provide specialist autism services locally.**

Professional and Inter-Agency Commination

10.10. It was recognised that information often did not flow between disparate agencies and that information about families and concerns was not always shared. It was identified that more work needs to be undertaken to ensure that information comes together in one place. It was also recognised that existing systems were a *"real challenge"*.

Recommendation

1. **Stakeholders to examine current processes and systems using Mr X's case as a worked example in order to understand how processes can be improved for the future. This to be focused upon safeguarding of children and vulnerable adults.**

Investigation process lessons for learning for the future

10.11. The Trust raised the issue that this case had led to a very difficult and traumatising investigation process. Whilst the Trust welcomed the learning it recognised that the multiple investigation processes had not always been positive and had had the result of staff losing confidence. The Trust would like to explore how future investigations can be managed in the future with a sharper focus on lessons for learning.

Recommendation

1. **Stakeholders to examine investigation processes for complex cases to ensure streamlining and maximum lessons for learning.**

HASCAS

Health and Social Care Advisory Service

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Addendum to the Lessons for Learning Report

Into the

Care and Treatment of

Mr. X

Provided by Health and Social Care Services between October 2011 and February 2013

Commissioned by

NHS England North

Report Authored by: Dr Androulla Johnstone and Ian Allured

Date: **March 2014**

Addendum Authored by Mrs Gillian Duncan

Date: **November 2017**

1. Introduction

1.1. This is an addendum to the Lessons for Learning Report into the care and treatment of Mr X.

1.2. The original investigation was commissioned to provide an independent overview of the care and treatment that Mr X received principally between 2011 and February 2013. Earlier and later events were also taken into account in order to understand Mr X's care and treatment in context.

1.3. The HASCAS Investigation was also commissioned to ensure that the learning from six other investigations and reviews undertaken (due to the serious concerns about Mr X's care and treatment) were also examined and triangulated.

The original investigation commissioned was that of a desk top review, as such staff involved in the care of Mr X were not interviewed nor were directly sighted on the report's findings and conclusions. Mr X's family however were given an opportunity to input into the investigation and to provide their views on the final draft.

1.4. The purpose of the addendum is to detail the changes/improvements to service provision that have been put in place since the Independent Investigation was completed in 2014.

1.5. The addendum has been informed by the outcomes of the Investigation Assurance Workshop held on 26 September 2017 attended by those who had been involved in the commissioning and provision of Mr X's care and treatment. The aims and context of the workshop were:

1. To understand and gain assurance of what has changed as a result of the original investigation commissioned by the NHS England Area Team. Conclusions and findings would then to be progressed by the North Regional Team with a focus on Mr X's best interests.

2. To provide the opportunity for sign posting and updates together with a transfer of supporting information/assurance evidence by way of this addendum.

1.6. The addendum highlights the major contextual changes that have occurred since the original report was written and provides detail of the changes/improvements to service provision that have been put in place. These changes are listed under the recommendation themes from the original report.

1.7. The organisations that have contributed to the content of this document are:

- Mental Health Trust 1;
- Local Authority;
- The Clinical Commissioning Group (CCG);

- Mental Health Trust 2;
- NHS England.

2. Background

2.1. In order to refresh the reader a short background narrative chronology has been provided.

2.2. Mr X was diagnosed with atypical autism as a young child. When Mr X was 14 years of age a referral was made to the Child and Adolescence Mental Health Service following a serious incident when Mr X attacked his mother; violence and aggression appeared at this stage to have been a well established part of Mr X's presentation. Mr X was a pupil at a specialist school for children and young people with autistic Spectrum Disorder.

2.3. At the age of 18 years Mr X transitioned into adult services; approximately six months after Mr X's eighteenth birthday, his challenging behaviour became so severe that he required an in-patient admission into a mental health facility. He was admitted to the Inpatient unit during the night of 19/20 April 2012.

2.4. Initially Mr X was admitted as an informal patient to the unit but this was regraded to a Section 2 of the Mental Health Act 1983. After four weeks Mr X was discharged home however this return failed after ten days as his challenging behaviour continued and his parents could not cope. He was returned to the inpatient unit and placed under a Section 3 of the Mental Health Act (1983).

2.5. During Mr X's stay on the inpatient unit numerous complaints were made by his family and six investigations were undertaken.

2.6. Mr X was eventually discharged from the inpatient unit on 7 February 2013 and the discharge arrangements were agreed at a discharge meeting attended by commissioners, members of the treating team and Mr X's parents.

2.7. Mr X returned home to live with his family; the family stated that this had gone *"remarkably well"* although they had "*some struggles"*.

2.8. On 9 May 2013, three months after Mr X's discharge, the independent agency withdrew its support due to the levels of challenging behaviour being exhibited and the reluctance of the staff team to work with Mr X and his family.

3. Changes in the Strategic Context

Transforming Care Agenda - Learning Disability All Age Strategy

3.1. Nationally, the NHS England Transforming Care agenda (2015) has set out a strategic framework for specialist interventions for some of the most vulnerable people with learning disabilities and autism whose behaviours present challenge to services and are often admitted to hospitals and secure provision. The aim is to bring together commissioners from across

health and social care to reshape services, with oversight from local joint Health and Wellbeing Boards.

3.2. In this geographical area, oversight is provided by a Fast Track Board which has developed a Learning Disability Strategy. The relevant CCGs monitor the dynamic risk register. The experience and learning from the case of Mr X has been used to inform the strategy. Locally transforming care is supported by care and treatment reviews.

3.3. The new model has enabled an increase in the capacity of the social care element of the service – a new All Age Complex Needs Service was established in April 2016 in line with Mental Health Trust 2 and The Local Authority. Historically Children's Health and Social Care in this geographical area have been co-located since 2010.

3.4. The Learning Disability All Age Strategy April 2016 states:

> *"This strategy signals the beginning of an approach to deliver whole system change to improve the lives of children, young people and adults with learning disabilities with or without autism".*
>
> *"Our approach to supporting children, young people and adults with learning disabilities and their families will be based upon recognition of their strengths and skills, complementing our needs assessments".*

3.5. There has been collaborative working between the Local Authority, Mental Health Trust 1 and the Clinical Commissioning Group to inform the redesign of learning disability services. A Learning Disability Lead and additional resources have been made available to provide strengthened capacity to lead the reforms and embed all age strategic objectives.

3.6. As part of this strategy, Mental Health Trust 2 provides the strategic lead for the All Age Complex Needs Service. Additional support and advice is obtained from the Principle Social Worker for Adults. There is also a strategic and operational link to Healthy Young Minds (HYM) woven into the approach. There is an established link that connects front line practice to the Multi Agency Transition Board which supports staff from health, education and social care to have early conversations in line with peoples' needs and expressed outcomes. This process had enabled the All Age integrated service to identify young people at the age of 14 years who are likely to require support to transition to adulthood.

The Care Act 2014

3.7. The Care Act (2014) came into effect on the 1 April 2015. It unites a number of different Acts into one single legislative framework for adults with care and support needs and their carers. It also introduced a duty to promote well being when carrying out any care and support functions in respect of a person. Promoting well being means actively seeking improvements, at every stage in relation to the adult with care and support needs and their carers. It is a shift from providing services under a deficit model to an approach that builds on strengths, needs and outcomes.

3.8. The Act also introduced new duties and requirements of local authorities that are referred to in the recommendation themes section of the addendum. The Act does not allow certain functions to be delegated and one of these is safeguarding decision making.

3.9. In relation to adult safeguarding it provided a legislative framework for local authorities and signalled a major shift in safeguarding practice, from April 1 2015 Local authorities have had to:

1. Set up a Safeguarding Adults Board
2. Make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. This includes assuring itself on the outcomes when it has caused others to enquire.
3. Commission Safeguarding Adults Reviews (SARS) as required.
4. Arrange, where appropriate, for an independent advocate to represent and support an adult who is subject of a safeguarding enquiry or safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them.
5. Cooperate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect.

3.10. The Care Act (2014) also states that local authorities and partner organisations should cooperate in order to deliver effective safeguarding, both at a strategic level and in individual cases, where they may need to ask one another to take specific action in that case.

3.11. The Care Act (2014) also provides a Framework for how Social Care Officers should assess the needs and outcomes of individuals and their carers. Where individuals lack capacity the intervention is undertaken in accordance with Mental Capacity Act 2005.

4. Lessons for Learning Report Recommendations: Update

Recommendation: Safeguarding – Training should be offered to Care Co-ordinators with explicit inputs regarding Safeguarding issues

4.1. **Mental Health Trust 1.** The Trust's Essentials Education Programme now includes training in care planning, Care Programme Approach (CPA) and safeguarding for all clinical staff. Care Planning (CPA and Standard Care) was reviewed in June 2016, and was amended in the light of the learning from the Mr X case to ensure that consideration for safeguarding children and vulnerable adults was explicitly included within the policy, training and subsequent application. Also in light of learning from this case, as of May 2017, Autism Awareness Training is part of the Trust's Essential Education Programme, and as such is mandatory for all staff at the Trust, both clinical and non clinical.

4.2. Mr X has a robust Learning Disability Care Plan, which is reviewed at least six monthly, or on a needs led basis. The CPA reviews include family members and all professionals involved in providing care and support to Mr X. The Learning Disability Care Plan and Risk Assessments are in place in line with the Trust policy and are monitored using the team's

dynamic Risk Register. The Trust also has in place a process to enable staff to quickly escalate complex clinical care decisions where necessary and staff are able to seek senior support and input from clinical support teams and medical leaders as required.

4.3. **The Local Authority.** Safeguarding arrangements were in place across agencies however it was recognised that the skills required to work with complex family dynamics was a specialist area and should be sourced across agencies to ensure a unified response. In February 2015 it was agreed that this would be coordinated by NHS England.

4.4. By September 2015 the safeguarding training programme had been revised and a wider pool of trainers was available. The local authority also undertook work with Social Care Institute for Excellence along with the local Clinical Commissioning Group and Mental Health Trust 1 to develop a process for making and escalating complex case decisions to inform how to work with individuals and families who present with complex needs.

4.5. In October 2017 safeguarding training was reported as having been embedded across the whole service and Safeguarding Level 1 training for Children and Adults is mandatory for all staff. Additional role specific training is available for staff who undertake enquiries and managers who oversee the process. This has been updated to reflect changes introduced by the Care Act 2014. Compliance is measured across all Council staff (not just Adult Social Care) and is monitored by the DASS and assurance to the Senior Leadership Team meetings.

4.6. **Mental Health Trust 2.** Clinicians from Healthy Young Minds (HYM) are involved in delivering and accessing safeguarding training aimed at improving a wider understanding of mental health.

4.7. In October 2017, safeguarding children training was confirmed as mandatory for all staff. Level 1training for adults safeguarding is also mandatory. Targets and key performance indicators for training are confirmed as being met.

Recommendation: Safeguarding – Safeguarding should be raised in all clinical supervision meetings

4.8. **Mental Health Trust 1.** There is clear evidence within the organisation, monitored independently by the Care Quality Commission and Ofsted, that safeguarding is an integral part of clinical supervision sessions.

4.9. The Trust Supervision Policy includes safeguarding as a standing agenda item to be discussed at supervision. Compliance visits have been conducted internally with all clinical teams/wards which demonstrated that the supervision standards were being followed in practice. There is a supervision template and handbook which acts as a prompt to all staff and supervisors during supervision sessions as to the importance of safeguarding and enables a record to be kept of the outcomes of discussions and learning.

4.10. Supporting evidence from the Trust included their Supervision Policy and a recent joint targeted area inspection report (JTAI) which identified strong partnership working in relation to safeguarding. Staff were clear on escalation received supervision in relation to their

safeguarding casework as well as further advice and support being available from designated and named safeguarding professionals JTAI report due for publication on 10/11/2017.

4.11. **The Local Authority.** Following a review of the function and form of the Learning Disability Service a decision was made in 2014 to separate line management arrangements Trust/Local Authority to enhance governance and professional assurance. The teams continue to be co-located and clarity has been sought from each organisation regarding clinical supervision and governance infrastructure.

4.12. In 2015 additional management capacity was put in place for the social care Learning Disability team to support the transformation programme and give additional supervision capacity. A new reflective supervision policy has been developed to support this function. In 2017 Service managers meetings have been updated to ensure the Principal Social Worker for adults is aware of individuals who present with significant risk. This in turn ensures a robust governance structure from front- line up to DASS.

4.14. **Mental Health Trust 2.** The Healthy Young Minds (HYM) supervision template has been revised with safeguarding clearly identified as a key issue in all clinical and professional supervision sessions. HYM staff are included in local safeguarding arrangements and safeguarding discussions form part of clinical supervision for all clinical staff.

Recommendation: Safeguarding – Consideration should be given to identify key senior personnel across the area who could provide independent mediation in difficult cases

4.15. **Mental Health Trust 1.** The CPA risk assessment covers the risk from the individual to others including carers/family members, it also articulates any risk to the individual from others including carers/family members if appropriate. The management plan pulls together these risks and the actions to address the issues. This includes details of the individual's vulnerability and safeguarding risks as appropriate.

4.16. Within the Trust, independent senior managers have been appointed to complex cases to undertake the role of mediator; this is part of the learning from Mr X's case. There is also the clinical escalation policy in place to support identification of cases that are complex and to ensure appropriate senior level support.

4.17. **The Local Authority.** A bank of independent complaint investigators has been established and progress has also been made to establish a bank of independent reviewers who will focus on complex case work.

4.18. The Local Authority has also worked in collaboration with the Trust and the Clinical Commissioning Group to inform the redesign of Learning Disability services using the Social Care Institute of Excellence methodology (SCIE). A Learning Disability lead was established as part of the Learning Disability programme redesign in response to identifying that additional leadership capacity was needed for the reforms.

4.19. In 2017 advocacy contracts have been updated to ensure compliance with the relevant legislation and case law findings and are currently part of an update review. In addition, a

dedicated Mental Capacity Act and Deprivation of Liberty Safeguards lead has been appointed to provide independent advice and support for complex situations where the individual lacks mental capacity to make decisions.

4.20. **Mental Health Trust 2.** In Mental Health Trust 2, senior clinicians and managers from HYM meet on a regular basis to increase awareness regarding referral processes and pathways. In line with the Care Act Mental Capacity Act and Deprivation of Liberty Safeguards training is now mandatory.

Safeguarding – Clarification of safeguarding protocols and a review of training and interagency communication

4.21. **Mental Health Trust 2** .The revised safeguarding policy and work plan identified the safeguarding protocols that were needed to ensure adequate provision of interagency information sharing.

4.22. In line with the Care Act (2014), the Local Authority undertook a review of safeguarding policy and practice; in line with the legislation. The Safeguarding Board continues to review the safeguarding policy and practice on an ongoing basis and includes references to protocols for managing complex family dynamics which inter relate with potential safeguarding.

4.23. Cases are being appropriately managed across Clinical Commissioning Group and Local Authority boundaries with effective communication between all interested parties. The Joint Team Area Inspection (JTAI) undertaken in September 2017 gave initial positive feedback.

4.24. All staff, including HYM have access to a range of safeguarding training topics through the annual training provided by the local safeguarding boards.

4.25. In Mental Health Trust 1 the safeguarding team is working closely with the wider safeguarding 'system' and reporting routes through the Trust and the local authority are now clear. The JTAI identified strong partnership working in relation to safeguarding.

Recommendation: Safeguarding – Review of safeguarding policies in the light of the findings and conclusions of this case with particular regards to professional and interagency communication

4.26. The Multi Agency Safeguarding policy was updated in May 2016. The Safeguarding Board is now on a statutory footing and has had an Independent Chair since 2012 and management capacity has been increased to support the work of the Board.

4.27. Within Mental Health Trust 1 the Safeguarding Policy has been reviewed and updated to reflect the findings and conclusions of this case.

Recommendation: Family interventions and relationship – A family protocol to be developed to establish boundaries and statutory agency response when differences of opinion develop between families and health and social care agencies when providing care and treatment to both children and vulnerable adults

4.28. **Mental Health Trust 1.** An independent mediator (such as the carer experience lead) is now made available to offer support and guidance in complex cases. The Trust has also improved support to clinicians regarding senior management support and legal advice when required. This was evidenced in the JTAI report, published in 2017.

4.29. **The Local Authority.** After significant consideration, it was decided not to develop a specific protocol because there were established processes in place that addressed this area of concern. Where the individual is assessed as lacking mental capacity to make a specific decision, staff are required to work in accordance with Mental Capacity Act 2005 and local policy, and decision making follows the Best Interest process. In addition, there is an Escalation and Accountable Decision Making Framework in place. Staff have access to advice from the Principal Social Worker, Legal Services and the Lead Professional for Deprivation of Liberty Safeguards.

4.30. **Mental Health Trust 2.** The Trust decided not to develop a specific protocol because there were "established multiagency processes" in place that addressed this area of concern. The organisation has a Threshold Guidance document which describes the thresholds at which services will get involved and how to manage cases which do not meet these thresholds.

Recommendation: Family interventions and relationships – Early work with families when children are diagnosed with a learning disability to be revisited and a protocol developed (in general)

4.31. **Mental Health Trust 1.** Learning from this case and alongside national initiatives such as Care and Treatment reviews has enabled the definition of a clear pathway from early identification through to multi agency reviews with independent oversight. Furthermore, working with the development of All Age services and understanding individual needs in advance, will allow for strategic planning alongside service user and carer involvement. The use of the Dynamic Risk Register enables proactive monitoring.

4.32. The Transition Practitioner role has been reviewed and will focus on early identification of people with learning disability with complex needs. Partnership working with Local Authorities and other partners and information is a key part of this post to identify people who may be at risk of using in patient services. Care and Treatment and education Reviews compliment this initiative.

4.33. **The Local Authority.** A new Multi agency Transition Policy was launched in 2016 and a new referral document for Adult Social Care was developed and rolled out in 2016. Social care funding processes were updated in 2016 (most recently updated in September 2017) this includes oversight of funding decisions for Children with Complex Needs.

4.34. **Mental Health Trust 2.** The CAMHS has been part of a multi agency work stream including adult mental health services and social care aimed at early identification and improved timelines for children during transition to adult services. The Trust employs the

Strategic Lead for All-Age Complex needs Service and they work alongside the Principal Social worker for adults.

4.35. **Clinical Commissioning Group.** Clearer commissioning management of all families has been put in place to ensure individual patients needs remain as focus even where complaints escalated to NHS England.

Recommendation: Family interventions and relationships – Work with Mr X's family to assess their expectations and Mr X's needs for the future (in particular)

4.36. **Mental Health Trust 1.** Mr X has a robust Learning Disability care plan, which is reviewed at least six monthly, or on a needs led basis. The Trust continues to provide support via the Community Learning Disability Team (CLDT). The family have a positive relationship with the CLDT Psychiatrist who undertakes review of Mr X on a regular basis and proactively works with the family and General Practitioner to support Mr X in both his diagnosis and presentation.

4.37. **The Local Authority.** The Care Act (2014) provides a framework for how social care Officers should assess the needs and outcomes of individuals and their carers. Where individuals lack mental capacity the intervention is undertaken in accordance with local Mental Capacity Act 2005 policy and Best Interests of the client. The Local Authority continues to review the individual's needs and is in the process of ensuring Mr X receives the least restrictive support in his best interests**.**

Recommendation: Service models and commissioning – Exploration of current services to be conducted by all stakeholders in partnership in order to ascertain how they could be further developed to provide specialist autism services locally

4.38. **Clinical Commissioning Group.** The Community Learning Disability Team and the Children's Learning Disability service have undertaken an open competitive tender programme for services, with new contracts to be in place by April 2016. These included the adoption of the new Senate Community Learning Disability Team Service Specification Best Practice Guidance.

4.39. The Clinical Commissioning Group has agreed Service Improvement Plans with Mental Health Trust 1. This related to, better family support and communications, timeliness of reviews and reports.

4.40. **Mental Health Trust 1.** The Autism diagnostic service now operates across the Trust and NHS England are working with the organisation on a pathway for treatment of people who present with Autism, Learning Disability and forensic issues. Autism with or without a learning disability is part of the Transforming Care Partnerships agenda.

Recommendation: Professional and inter-agency communication – Stakeholders to examine current processes and systems using Mr X's case as a worked example in order to understand how processes can be improved for the future. This is to be focused upon safeguarding of children and vulnerable adults

4.41. **Mental Health Trust 1.** The Lessons Learned event held in May 2014 commenced work on this recommendation collectively, in addition the Trust lessons learnt document which focused on a further review of how systems and processes can be improved. As part of the wider action plan, there were a number of actions taken to improve Trust processes in light of learning from this case. The comprehensive Care Quality Commission inspection undertaken in 2015 resulted in wards for people with Learning Disability and/or Autism being judged as 'outstanding'.

4.42. Further work on this recommendation is now being taken forward as part of the Transforming Care Programme.

4.43. **The Local Authority.** Following a joint agency workshop, the Local Authority is leading work to establish a Learning Disability Improvement Programme alongside the Clinical Commissioning Group. The programme is part of a regional Fast Track Programme.

4.44. The All Age Complex Needs service was established in April 2016 with a lead from Mental Health Trust 2 and support from the Principle Social Worker for Adults. The Local Authority employed a Designated Transitions Coordinator but having reviewed the impact of this role, the position was disestablished and the resources were reinvested into the Learning Disability Team. There are now established meetings between Service Managers from Children with Complex Needs and Adult Learning Disability Social Work Team focused on effective monitoring and transition planning.

4.45. **Mental Health Trust 2.** The HYM input has been reviewed by the Clinical Commissioning Group and the Trust. Part of the review focused on improving pathways including young people being transitioned to Adult Mental Health Services. The outcome of the review has been the implementation of the THRIVE Model, joint working on a multi agency transition pathway has also commenced.

4.46. Mental Health Trust 2 now employs Named Nurses for Safeguarding who have responsibility over Children's and Adult Safeguarding. A joint governance and quality assurance process with the Local Authority has also been established.

Recommendation: Investigation process and lessons for learning in the future – Stakeholder to examine investigation processes for complex cases to ensure streamlining and maximum lessons learned

4.47. **The Mental Health Trust 1.** In light of the multi agency and external reviews undertaken relating to Mr X's case, the Trust developed a detailed action plan to ensure lessons were learned and actions correlated to maximum improvements and learning. In addition after the completion of both the internal and external investigations, a Lessons Learnt Review was undertaken and reported to both the Trust Operational Board and Audit Committee. Since the investigation relating to Mr X, the Trust have been involved in other complex investigations and have used a streamlined approach linking with other agencies including the police and safeguarding.

4.48. Most recently, unannounced contact by the Care Quality Commission (Mental Health Act Review June 2017) to the inpatient unit resulted in an extremely positive report, with no actions identified by the inspection team. The Care Quality Commission commented:

> *"In last years report, we described in some detail how we were impressed by the way that the clinical team engaged with patients and their families to ensure they were actively involved in their care programme. This remained an area of good practice".*

4.49. **The Local Authority.** A Safeguarding Adults Review subgroup has been established as part of the Adult Safeguarding Board and this group will take the lead on identifying key lessons learnt from investigations. In addition, a Learning and Improvement Committee has also been established and this reports to the Adult Safeguarding Board.

4.50. There is a multi agency group led by the regional Police force, for monitoring and responding to individuals who present a significant risk to themselves or others. This has been recently updated to ensure that this focuses on individuals where existing single /multi agency polices have not reduced the risk; in line with the expectations of the Care Act 2014 there is a process for identifying individuals at high risk which supports the local dynamic risk register. The group meets every four weeks.

4.51. **Clinical Commissioning Group.** The Clinical Commissioning Group has received regular updates at their Board and related committees on individual cases and wider learning disability service improvement work.

4.52. Direct guidance has been provided to Community Learning Disability Teams regarding the adoption of Mental Capacity Act and Best Interests management requirements (including the specific reviews required in Mr X's case)

4.53. The Learning Disability whole systems review programme agreed with the Local Authority at Chief executive level which involved a review of Learning Disability pooled budget and all wider Local Authority has been undertaken and a CCG led Learning Disability Joint Improvement Programme has been initiated with the focus on individual case reviews and the new Transforming Learning Disability Care Strategy and section 75 pooled budget agreement.

4.54. **Mental Health Trust 2 (Local Division).** A combined Governance and Quality assurance Framework has been established. This includes the review of complaints and investigations at combined meetings to ensure key lessons are identified and disseminated into practice. Process has been updated and uses a seven minute briefing template, to enable managers to present a high level analysis of issues, and support the development of an action plan.

4.55. **NHS England.** There are examples that the learning from the case has informed the approach to taken to subsequent cases including learning disability patients with parents who have attempted to 'by pass' recognised NHS complaints procedures.

5. Conclusion

5.1. The major reorganisation of the Learning Disability Services and the Care Act 2014 changes to Adult Safeguarding have ensured changes have taken place to fill many of the gaps evident when Mr X was going through services.

5.2. In addition the evidence reviewed and summarised demonstrate changes in service delivery and front line practice have improved to ensure safeguarding, risk management and integrated approaches to managing and supporting individuals and their families with complex needs are embedded.

5.3. Based upon the comprehensive evidence presented it is the Independent view of the Health and Social Care Advisory that significant progress has been made against **all** of the recommendations stemming from the 2014 investigation report.