SIGNIFICANT CASE REVIEW

P19

Report by Fiona Rennie and Grace Gilling

ON BEHALF OF ANGUS ADULT SUPPORT AND PROTECTION COMMITTEE

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INDEPENDENT CHAIR OF THE ANGUS ADULT SUPPORT & PROTECTION COMMITTEE FOREWORD

As Independent Chair of the Angus Adult Support & Protection Committee (AAPC), I very much welcome receipt of this Significant Case Review report which has been prepared in respect of Adult P19.

On behalf of the AAPC, I wish to express my sincere condolences to the family for their loss of Adult P19 and also to thank the family for the contribution they have made in the preparation of this Report and its Findings.

I also want to thank and acknowledge the very significant level of work and commitment of the Review Team who have had a very challenging task in reviewing this very complex case and completing this Significant Case Review. They have undertaken their work in a planned, structured, detailed, and professional manner and engaged with many individuals to ensure that their comprehensive Report addresses the agreed Terms of Reference. They have reviewed all key aspects of the Case and the issues that were relevant to Adult P19. The outcome of their diligence and commitment is the delivery of this Report which sets out in detail their findings and recommendations.

The involvement of a wide range of Professionals who work in the arena of Adult Protection in Angus and across Tayside has also been very welcome and their positive contribution to the work of the Review Team has been very much appreciated.

This Report sets out a number of key Findings and subsequent Recommendations, all of which are fully accepted by the AAPC. The AAPC will ensure that all of the Recommendations will be addressed and actioned and that the progress of this work will be closely monitored to ensure that relevant progress is made as quickly as can possibly be achieved. It will also be important to ensure that the good practice identified in the Report is disseminated as widely as possible to all key professionals.

It is absolutely vital that the learning identified in this Report is incorporated into amended policy and practice. This will ensure that vulnerable adults in Angus, as Adult P19 was, are consistently offered high quality levels of support and protection to address their safety and thereby mitigate the risk(s) that exist in their lives.

The outcome of interventions in the lives of vulnerable adults must be that their well-being and quality of life is enhanced, and the implementation of this Report's Recommendations will go a significant way to deliver on this important objective.

Ewen West
Independent Chair
Angus Adult Support & Protection Committee

PART 1 INTRODUCTION

Adult P19 died in December 2018 at the age of 50 as a result of Disseminated Malignancy, which is where the cancer is widespread and, in this case, was within the bowel. There was significant involvement with a number of services in the months leading up to death. P19 was identified as an 'adult at risk' in August 2018.
Following P19's death, the Angus Adult Protection Committee (AAPC) received a request for consideration of a Significant Case Review (SCR) on the grounds that adult P19 was in receipt of services, was subject to an Adult Support and Protection Plan and that P19's experience of services provided an opportunity to learn and improve how we work. Following completion of an Initial Case Review (ICR), AAPC agreed a SCR was deemed necessary to explore in depth the circumstances of P19's death and the time and events leading up to it, given P19s complex medical history and clinical presentation and that a number of agencies were involved in providing care and support.

P19 has touched the lives of many of the professionals involved in their support and this was clear from the recollections of those who provided care and support to P19. P19's family, professionals involved and members of the AAPC share the same goal; that learning is achieved for all services in reviewing the interactions P19 had with services and that best practice is identified and built upon and that ultimately improvements are made to support positive outcomes for vulnerable adults.

Aims of the Significant Case Review

The expected outcomes of the SCR were endorsed by the Angus Adult Protection Committee and agreed by Angus Chief Officers on 02 September 2019. This SCR has been conducted with regard to the Adult Support and Protection (Scotland) Act 2007 and with reference to the Tayside Multi-agency Guidance for Adult Support and Protection (updated 2019) and the Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (2019). The anticipated outcomes are to:

- Identify areas of good practice that should be developed and replicated in adult support and protection work.
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults at risk of significant harm.
- Identify any actions required by the AAPC to promote learning to support and improve systems and practice.
- To determine whether, and if so, what changes in practice are necessary to ensure opportunities are not missed to prevent avoidable tragedies.

Terms of Reference

The terms of reference posed 7 specific research questions and the full Terms of Reference are included within Appendix 1.

Research Question 1:

In respect of P19, to what extent was the information held by Agencies shared appropriately within that Agency and with other partner Agencies?

Research Question 2:

Determine the extent to which decisions and actions were person centred.

Research Question 3:

To what extent did one Professional/Agency have a lead role and hold responsibility for P19 and their Protection Plan; to monitor what was being achieved, any gaps in assessment, planning and decision making and associated risks?

Research Question 4:

How effective are the current processes for requesting a Capacity Assessment within NHS Tayside and how these processes are applied in practice?

Research Question 5:

To what extent is Self-Neglect understood across the multi-agency Adult Protection partnerships and wider Adult Protection providers?

Research Question 6:

To what extent and detail should information be provided to COPFS when someone who was subject to Adult Support and Protection measures dies to ensure that COPFS are able to assess the circumstances surrounding a death in those circumstances and direct further investigation and enquiry?

Research Question 7:

Did all Agencies exercise their full legal Powers to ensure the safety and well-being of adult P19?

Timeframe

The scope of the SCR covers the period from 20th August 2018 (the start of a significant period of escalation in behaviour/risk/illness) until 19th December 2018, when P19 died, a period of 4 months. However, prior to 20th August 2018, a number of agencies did have contact and interaction with P19, which the SCR has given consideration to.

A detailed chronology was developed as part of the ICR and this helped the Reviewers establish a timeline for key events and identify key episodes requiring more in-depth analysis. A more in-depth chronology of events was developed as part of the SCR process and this was used to analyse the approach and response taken by agencies in support of P19. The Reviewers have been careful to consider the responses in the context of work and inter-agency work at the time of the occurrences.

Methodology

The SCR is conducted in accordance with the Terms of Reference (Appendix 1).

The SCR was conducted in a carefully structured way to include exploration of the key issues by way of case file reading and staff engagement. The approach reflected

on how the systems worked together and any barriers to best practice. Individual practice was evaluated but was not the focus of the SCR; where individual practice issues were identified; these were reported to single agency representatives. The focus was on how the culture, systems and processes worked in identifying need, supporting and where necessary, protecting P19 from harm.

A series of 23 individual meetings with key professionals were undertaken. This is reflective of the 17 different service/agencies involved in supporting P19. Questions were raised in a manner that allowed reflection on individual practice within wider systems, process and practice at the time.

A Case Review Group offered professional oversight and challenge to the Lead Reviewers throughout the process and promoted a learning approach. This group also allowed the reviewers to obtain a full understanding of the different agencies perspectives in relation to the management of the particular case so that agencies could feel confident that their specialist issues and themes were understood by multi-agency representation on the review team in order to reflect the particular case. A thematic approach was taken to identifying membership for this group. In addition, the review team also provided:

- A different perspective to add to the depth of enquiry.
- Advice on the relevant specialist processes, systems and pathways and evaluated whether they were followed with due diligence or not and, if not, what the barriers were to this happening.
- Input to establishing the lessons to be learned from the case about the way in which professionals and agencies worked together to support and protect adults at risk of harm and help ensure they get the help they need when they need it.

As part of the continuous improvement process, Network of Support meetings provided an opportunity to share emerging themes and engage with staff to inform recommendations and to ensure that the views and experiences of staff were included in the SCR.

Lead Reviewers

Angus Chief Officers commissioned individuals from the Angus Health and Social Care Partnership and NHS Tayside to lead the Significant Case Review. The individuals were selected based on their experience, skills and knowledge. They have no connection to any operational work involving P19 or operational management of any of the services involved.

Fiona Rennie is a Principal Planning Officer within the Angus HSCP with a 35-year career within Angus Council and the Angus HSCP and broad experience as a social work practitioner and Service Manager in Learning Disability services. Fiona has experience of service review and improvement, investigations, leadership, staff training and development and business coaching.

Grace Gilling is the Strategic Lead for Adult Protection within NHS Tayside with a 32-year career within NHS Tayside with broad experience as a practitioner and Senior

Manager in Mental Health services. Grace has experience of undertaking investigations and reviews with a particular focus on maximising opportunities for learning and improvement.

External Support and Supervision was provided by Mr Fred McBride. Fred is a qualified Social Worker with almost 35 years' experience in the statutory sector. He was Director of Social Work for Aberdeen City Council from approximately 2008 - 2013. During that time, he had responsibility for services to all the care groups, children's services, adult services, criminal justice and older people services. More recently he was CEO of The Child and Family Agency in the Republic of Ireland which is the second largest national state agency in the country, comprising approximately 4000 staff and a budget of 750 million Euro. Since retiring around 2 years ago Fred has provided consultancy work to private, voluntary and state bodies including the government of Abu Dhabi, a private Mergers and Acquisitions company from Qatar operating in the private healthcare sector and a Scottish company developing non-drug therapeutic interventions for dementia.

Views of the Family

The SCR Lead Reviewers sought contributions to the review from appropriate family members and kept them informed of key aspects and progress.

The family wish that they had known that P19 was dying. No one had spoken to them about this and they felt very shocked and unprepared when the police came to their house to inform them of P19's death on the night they died. The family also felt that, if they had known that P19 was dying they could have had conversations with P19 about their wishes and they could have said their goodbyes. They felt they never had the opportunity to do this.

The family felt that P19 should have been in hospital to receive proper care and treatment for their health conditions. P19 did not speak to the family about the pain they were in and the family did not appreciate how much pain P19 was experiencing. They did not attribute any pain P19 was experiencing to advanced cancer as there had been no formal diagnosis.

P19's Story

<u>About P19</u>

P19s family reflected that P19 was 'popular and good looking in their younger days', kind, caring with a 'wicked sense of humour'. P19 was also noted to be a very proud person who took great pride in their personal appearance and was always smartly dressed. P19 was known to have a long-standing interest in Northern Soul music, liked to listen to that music genre, loved dancing and used to travel all over the country attending Northern Soul events.

P19 was a good source of information, had a lot of local knowledge and would talk about past people and friendships and was always having people round socialising and drinking.

P19 was close to their family and was proud of them. They were in regular contact with dad and sister and were very close to mum who had passed away some years earlier, dying in P19's arms. At one point, P19 had told staff it was important to remember mum and always liked to wear a gold chain which was a present from mum. P19 liked to reminisce about family and had a very good memory, remembering lots of details about the family history.

<u>The period from P19 coming to the attention of services in August 2018 until their death 4 months later, in December (scope of the SCR)</u>

P19 died at the age of 50, having had significant involvement with services in the months leading up to their death. The cause of death was recorded as disseminated malignancy (advanced cancer). P19 undertook a bowel screening kit in October 2017, testing positive. At the time of death, P19 was emaciated, weighing only 42 kgs and with a BMI of 14.2. Multiple Sclerosis (M.S.) had been diagnosed in December 2014.

There was significant involvement from services during the 4 months prior to death (the scope of this review). These included:

- Community Alarm
- Community Laundry
- Community Meals
- Care at Home provider
- Physical Disability Service
- Angus Integrated Drug and Alcohol Recovery Service (AIDARS)
- Adult Protection processes
- Scottish Ambulance Service
- GP
- Specialist GP attached to AIDARS
- District Nursing
- M.S. Specialist Service
- Housing
- Police Scotland
- Acute Medicine
- NHS Tayside Inpatient Detox Unit
- Neurology
- Respite Care Service
- Mental Health Officer

In the last week of P19's life P19 was no longer drinking alcohol. The care at home provider's staff continued to provide support visits 2 or 3 times a day assisting with a

range of tasks such as personal care, shopping, eating, drinking, medication prompts, changing bedding, cleaning faeces from carpet/furnishings and general house cleaning and tidying. P19 was eating and drinking very little and staff would offer food and fluids during support visits.

The conditions of the house were described by staff as "horrendous ". P19 was incontinent of both faeces and urine and would be heavily soiled, creating a very unsanitary living environment. There would often be no clean bedding or clean clothes available for P19, who would sometimes be lying on top of a towel in heavily soiled clothes. Carpets and furnishings would also be heavily soiled, and staff would attempt to clean this up. Sometimes there would be nothing available to staff to provide personal care such as toiletries and clean clothes. P19 was in a lot of pain and unable to mobilise. On several occasions P19 was found naked from the waist down during support visits and refused assistance to be dressed. P19's skin was very sore and peeling due to the level of incontinence. 2 days before P19 died, staff had to use a basin to undertake personal care as P19 is unable to mobilise to reach the bathroom. By this point, P19 is constantly soiled with faeces, has poor mobility, sore skin, is in a lot of pain and is eating and drinking very little, not getting enough fluids and often can't sleep.

The care at home provider's health and safety section put in place comprehensive Personal Protective Equipment (PPE) guidance which resulted in staff having to wear white suits, gloves, aprons, shoe covers, oversleeves, protective eye gear and masks, whenever they entered the house. Despite the PPE, staff would find the smell unbearable - some staff would be physically sick, and some were in tears at P19's situation.

Community alarm responded to call outs on a number of occasions in December 2018 due to P19 having fallen.

Community laundry continued to provide a laundry service twice a week and drivers were instructed to wear protective clothing when delivering meals due to the condition of the house and the faeces on the floor.

District nurses visited P19 in the last week of life to assess skin condition and reported concerns to the GP who undertook a home visit but felt that there was nothing that could be done. The GP attempted a hospital admission the following day which was unsuccessful.

Managers at the care at home provider made the decision that they could no longer continue to provide support due to the effects the situation was having on staff and this was discussed at a core group meeting 6 days prior to P19's death. The day P19 died on 19 December 2018 was the last day that the provider was providing support. At this point in time there was no contingency plan in place although a variety of options were being explored. All nursing homes in Angus and Monifieth had been

contacted but there were no vacancies available. A request to community alarm for a planned service had been made but they had no capacity. A hospital admission had been attempted and refused. Care Managers were planning to explore care at home overnight support, care and nursing home vacancies in Dundee and input from the enablement and response team.

P19's previous involvement with services prior to P19 coming to the attention of services in August 2018.

P19 had been known to a variety of services prior to August 2018. Some services had significant involvement with P19 over a number of years whilst others were involved on a more ad-hoc basis for specific interventions. These included:

- Homelessness Support Service
- Multiple Sclerosis Service
- Housing Services
- Occupational Therapy
- Homecare
- AIDARS
- Colonoscopy Services
- Police Scotland
- G.P.

Homelessness Support Service (HSS) had been supporting P19 for approximately 3 years commencing in 2014 with the service ending in March/April 2018. The service was providing support with shopping and attending medical appointments as well as general welfare visits. They also helped P19 with a rehousing application. HSS said the house would appear messy, but this was mainly due to no shelving in the flat and therefore, everything was on the floor. The living room and kitchen were kept to a reasonable standard although P19 would keep rubbish for several weeks resulting in HSS supporting regular visits to the recycling centre.

Between 2014 - 2018, HSS could see that P19 had lost a lot of weight. P19 had periods when they ate well but would also have periods when they drank alcohol and smoked cannabis. P19 had been diagnosed with Multiple Sclerosis (M.S.) in December 2014 and HSS noticed a physical deterioration occurring with P19, particularly in relation to mobility due to M.S. HSS had contacted housing as P19's mobility was becoming more of an issue and they were having difficulty with the stairs to the flat. Occupational Therapy services undertook an assessment and recommended a move to a ground floor property. HSS felt there were no signs of difficulty other than mobility and that P19 was alert and could recall events that had happened many years previously.

Homecare had previously worked with P19 in 2016 providing domestic support. The case was closed to Homecare in March 2017. The decision for this was not recorded in case records. Homecare received a new referral from HSS in February 2018. They had attempted to contact P19 via phone call and letter on several occasions. When

they received no response no service input was progressed and P19 was left without any support until they were found in uninhabitable living conditions in August 2018.

P19 had also previously been open to AIDARS in 2013/2014. P19 engaged well with support from AIDARS. The case was closed as P19 was reporting abstinence from alcohol and seemed to be maintaining this.

P19's Voice

Throughout the scope of this review, P19 repeatedly voiced concerns about the following:

Health – P19 often told staff they felt unwell, regularly complaining of being in a lot of pain, having sore legs, an upset stomach, feeling sick, being unable to eat much and being unable to sleep. On several occasions P19 asked staff for help and asked for the doctor to be called, which they did. In early December 2018, P19 told staff they thought they should be in hospital as they were in great pain. In mid-December P19 stated their mobility was poor. P19 became distressed and very worried about feeling unwell and voiced their concern to staff about "being left in this flat to die". The week before they died, P19 spoke to staff about "being fed up feeling like this".

Support – When P19 was consuming alcohol they often did not want support or to have staff in the house. However, when P19 was not consuming alcohol they appreciated the support provided. P19 voiced a willingness to accept support and an unwillingness to accept support which fluctuated frequently. In October 2018, P19 was agreeable to a respite stay in a different location from their previous respite but, on arrival, they did not want to stay there and returned to their temporary accommodation. In the last few weeks prior to death, P19 would often not want staff in the flat providing support and was angry, often telling staff "leave me in bed".

Housing situation – P19 was unhappy about moving from the previous tenancy, did not like the temporary accommodation and wanted to return to their permanent property. They repeatedly requested to go back to their previous home. They were very worried about belongings that remained in the permanent address when they moved to temporary accommodation. P19 really wanted a ground floor property so they didn't need to struggle with stairs. P19 was angry about the housing situation and said they were unaware of the housing debt they had that meant they could not be allocated a ground floor property. They said they had not been informed of this debt.

Timeline of Significant Events (August 2018-December 2018)

The scope of the SCR covers the period from P19 coming to the attention of services in August 2018 until their death 4 months later, in December 2018.

A chronology was developed as part of the ICR and this helped the Reviewers establish a timeline for key events and identify key episodes requiring more in depth analysis. A more detailed chronology was developed as part of the SCR. The following

is a synopsis of relevant key events from the chronology comprising of information gathered as part of the case record review and meetings with staff.

December 2014: P19 was diagnosed with MS.
October 2017: P19 undertook Bowel screening kit which tested positive.
March/April 2017: Homelessness support services stopped working with P19 as things were stable with the tenancy. P19 was referred to Homecare for ongoing support but, after several unsuccessful attempts to contact P19, they closed the case.
10 November 2017: Letter to GP from colonoscopy services informing P19 of failed attempts to contact for colonoscopy and they will now stop contacting P19 but there will be an opportunity over a 6 month period to arrange this procedure.
5 August 2018: P19 is found by a passer-by lying outside a shop; P19 was under the influence of alcohol and had soiled themselves. Scottish Ambulance Service (SAS) was contacted and attended with no further intervention required. Police Scotland attended and accompanied P19 home at which point home was noted to be uninhabitable. Police raised a Vulnerable Person Report (VPR).
7 August 2018: Angus Council receive VPR from Police Scotland and this is passed to the AIDARs team.
20 August 2018: AIDARs team undertake home visit. GP attempts to admit P19 to acute hospital (1) and Housing Services are made aware of living conditions. Hospital consultant refused admission.
21 August 2018: P19 is admitted to NHS Tayside's Inpatient Detox Service for a 7 Day alcohol detox programme.
28 August 2018: P19 is discharged from the Inpatient Detox Unit and moves to a respite care service for a period of temporary respite.
4 September 2018: Initial Adult Protection Case Conference took place. This should agree whether the adult is an 'adult at risk' and a protection plan is required. P19 was identified as an adult at risk, requiring support and protection and a protection plan was put in place.
12 September 2018: ASP Core Group Meeting (1). Core group meetings should be multi-agency with the purpose of monitoring, implementing and amending as necessary, the protection plan agreed at the case conference. Priority actions were agreed in relation to addressing living conditions, having support in place on discharge from hospital, cognition assessment and support to medical appointments.
18 September 2018: ASP Core Group Meeting (2). Actions from this core group meeting focused on sigmoidoscopy appointment and preparation, relationship with family, house cleaning and assessment and supporting attendance at medical appointments and completion of assessment.
21 September 2018: P19 moves from respite care into temporary housing.
24 September 2018: GP attempts admission to acute hospital (2). Hospital consultant refuses admission.
28 September 2018: Adults with Incapacity Act (AWIA) meeting held. This is a decision making forum where all legal options must be considered to enable welfare and/or financial decisions to be taken. Unanimous agreement that it would be appropriate

for P19 to move to 24-hour care for further assessment under s13ZA of the Social Work Scotland Act 1968.
28 September 2018: P19 is offered further respite in another setting but refused this.
18 October 2018: ASP Core Group Meeting (3). Actions from this meeting include decreasing care at home support to twice a day for 30 minutes due to P19's verbally aggressive presentation. Other actions relate to attending sigmoidoscopy appointment, housing assessment, monitoring of M.S and supporting positive relationship with family.
21 October 2018: admitted to Orthopaedic ward in acute hospital following fall resulting in fracture to shoulder. Care Manager requests that a capacity assessment to inform Welfare Guardianship is undertaken whilst an in-patient.
24 October 2018: Referral made to psychiatry liaison for a capacity assessment but withdrawn the following day.
31 October 2018: Medical staff asked to undertake a capacity assessment.
1 November 2018: Acute hospital ward advises care manager that capacity assessment has been undertaken with outcome that P19 has capacity.
5 November 2018: P19 undergoes surgical procedure for shoulder fracture.
21 November 2018: P19 is discharged from acute hospital.
27 November 2018: ASP Core Group Meeting (4). Agreed actions focused on purchasing and funding toiletries, towels and bedding, obtaining continence aids, having nutrition needs met, arranging a consultation with the M.S. nurse, request input from specialist GP at AIDARS to obtain assistance to get sigmoidoscopy results and speaking to P19 re termination of previous housing tenancy.
14 December 2018: ASP Core Group Meeting (5) This core group meeting acknowledged crisis point had been reached, P19's health was deteriorating, and health needs were not being met. The action plan included trying to access health service support, expertise and advice. Actions from this core group meeting included approaching GP re hospital admission, contacting District Nurses for additional support/advice, liaising with health and safety re infection concerns, discuss unmet needs with AIDARS Senior management, consult with GP/nurses re food intake, explore care options, speak with specialist nurse advisor, arrange telephone consultation with M.S. nurse.
14 December 2018: GP attempts to admit P19 to acute hospital. Admission refused by hospital consultant (3).
19 December 2018: P19 passed away.

A Root Cause Analysis approach was utilised using fishbone diagrams in relation to 3 key themes: death of adult at risk, bowel testing and diagnosis and capacity assessment and these can be viewed within Appendix 4. These tools aimed to assist the SCR by identifying the contributory factors and possible causes of problems and events thereby identifying the root cause of these and helping to identify solutions to inform the SCR recommendations. Within each diagram, issues with the biggest impact have been highlighted in red.

PART 2 FINDINGS

Research Questions

Research Question 1 – In respect of P19, to what extent was the information held by Agencies shared appropriately within that Agency and with other partner Agencies?

- Explore good practice in Information sharing which impacted on assessment and decision making.
- Explore what, if any, barriers existed to the sharing of information which would have impacted on assessment and decision making.
- Explore the extent of actions taken by Professionals and how these impacted on the final outcome in respect of P19's life.

There will be specific follow-up on some of the issues identified in the ICR in respect of:

- Information sharing within and across Health Services to other Services involved with P19.
- Information sharing within and across all NHS Services to include Primary Care, Acute services and the Scottish Ambulance Service.
- Information known to single Agencies across the Angus Health & Social Care Partnership and Angus Council.

Information Sharing and Recording Systems

Generally, information sharing was found to be disjointed, often insufficient and sometimes not accessible to other key professionals. This resulted in some professionals being unsighted on key information which impacted on decision making. Information sharing appeared particularly poor at times of transition such as hospital discharge, entry to respite care and transferring from homelessness support services to homecare. There were occasions when information was shared and no action or follow up occurred.

Within and across health services to other services involved with P19, information sharing was generally poor with little or no contact and communication taking place between health service areas. This resulted in a fragmented and often task focussed approach to meeting P19's health care needs which was not person centred, with little co-ordination of P19's overall healthcare needs resulting in health needs being unmet. This also impacted on decision making and required treatment not being delivered.

Information sharing within and across all NHS Services including Primary Care, Acute Services and the Scottish Ambulance Service was also often disjointed and insufficient. Communication did take place between Primary Care and Acute Services but the detail of this is not available due to lack of record keeping. It is therefore unclear what detail of information was shared between these services although any communication that did take place effected little progress in having P19's health needs met. There is no evidence of information sharing between the Scottish Ambulance Service and any of the social work services.

Information known to single Agencies across the Angus Health & Social Care Partnership was generally effectively shared with good information sharing evidenced between the two care management teams, from the care provider to the care management teams and from the care provider and care management teams to the GP. There was insufficient information sharing from the care management teams to other services supporting P19 such as the respite service, community alarm, the care provider and some primary care services. There was a lack of health information available to many of the community-based services.

Efficient information sharing is critical to effective and timely integrated health and social care, particularly for those who are most vulnerable. For this reason, section 49 of the Public Bodies (Joint Working) (Scotland) Act 2014 provided NHS Boards, Local Authorities, and Integration Joint Boards the statutory powers to share information in relation to the carrying out of integration functions, including adult support and protection. In relation to adult support and protection, cooperation between the police, health boards, local authorities and other designated public bodies is mandatory under section 5 of the Adult Support and Protection (Scotland) Act 2007 and is in accordance with the Caldicott principles.

In Angus, data sharing is underpinned by an overarching information sharing memorandum of understanding between NHS Tayside, Angus Council, and the Angus Integration Joint Board which sets out how the three bodies will share and process data lawfully. There is no legal barrier to these bodies sharing information about service users / patients where it is necessary to the provision of health and social care services and related functions.

There are, however, significant challenges to efficient data sharing arising from the use of multiple data systems within the key organisations, particularly NHS Tayside and Angus Council. This was one of the main barriers that prevented staff from sharing information about P19 effectively.

The recording systems used by case holders employed by Angus Council and those employed by NHS Tayside working in the Angus Health and Social Care Partnership are different and not always accessible to those staff who need to access them. Furthermore, housing use a separate system from either of the 2 above that is only accessible to housing staff.

Health services have a variety of different recording systems not accessible to other relevant health professionals or to social work staff. This relates to recording systems within primary care and within acute care and impacts not only on information sharing within both these areas but information sharing between them.
Although a shared recording system to promote information sharing between all agencies would be the ideal solution this would be unrealistic and unobtainable.

Organisations have made significant investments in existing data systems and a variety of methods are available to enable interoperability and access.
There was no consistency found in the quality of record keeping which varied from some excellent practice to some very poor practice.

Good Practice

The two care management teams and the care provider regularly communicated and shared detailed information and good team working was evidenced, with a 'one team' approach adopted. The care provider sent very regular updates, detailed records and information to both Care Managers.

Good practice in relation to record keeping was identified across several different service areas such as the AHSCP respite service, the care at home provider, and NHS Tayside Inpatient Detox Unit.

Findings

There are a variety of different recording systems across various sectors of the health service, between social work and health and within housing services resulting in not all relevant information being accessible to those that need them, when they need it. This is a barrier to effective information sharing which contributed to inadequate information sharing between some agencies and resulted in some key professionals being unsighted on key information which impacted on decision making and robust risk management. If recording systems had the ability to operate in conjunction with each other to exchange and make use of information then this would have enabled professionals to have access to the information they required, when they needed it. This may have influenced assessment and decision making resulting in P19 having access to the correct treatment, support and interventions required at an earlier stage.

Record keeping within the District Nursing service was of poor quality with no reference of self-neglect or poor living accommodation mentioned in any case records. When P19 changed address there was a failure to record this information accurately in ehealth systems which resulted in some professionals visiting an address that P19 no longer lived at and P19 missing appointments and being identified as 'disengaging'.

The quality of record keeping in homecare is poor. There are no records to confirm why the case was closed in 2017 and again in early 2018. If referrals are received and later classified as 'for no further action' there is no record of these or the decision-making process. The service referral process does not provide the information required. Since the SCR process highlighted this issue, the service has now commenced a process of updating processes and guidance in relation to case recording and referral information.

Recommendation 1.1

Angus Council and NHS Tayside should agree and implement methods that will enable interoperability and access of recording systems, with a focus on improving information sharing between acute, primary care and the Scottish Ambulance services and effective information sharing at points of transition of care between primary care services, adult care services, housing and care providers.

Recommendation 1.2
Although good record keeping was found across several service areas not all records were completed to the required agency/organisation/professional standards. To provide assurance of this, all agencies should have robust governance processes in place to ensure record keeping is of the required standard and supports effective communication and decision making.

Recommendation 1.3
The District nursing service should undertake an audit of records across the service and develop an action plan to address the poor record keeping, in line with the NHS Tayside Record Keeping Policy and NMC Standards for Record Keeping. This should have a particular focus on ensuring that records reflect the current circumstances of the individual.

Recommendation 1.4
Homecare should complete the programme of updating processes and guidance across the service that has commenced in relation to case recording and referral information. The service should implement an audit of records across the service and develop an action plan to address the poor record keeping.

Health Service Involvement
Co-ordinated discharge planning did not happen, and key professionals such as district nurses, were not included as part of any discharge procedures/discussions neither was their input requested. There was no health professional co-ordinating any health input or monitoring health needs. Community services received limited health information following discharge from hospital.

There was a lack of knowledge and awareness from social work professionals about what health services could/should have been involved in supporting P19 and how they could be accessed. The involvement of an Advanced Nurse Practitioner (ANP)did not appear to be considered. This may be because in Angus, the ANP's in some areas mainly work with people over the age of 65. Had the core group meeting identified that an ANP was beneficial, this may have resulted in P19 having access to required care and treatment. Advanced Nurse Practitioner's (ANP's) undertake extra training in clinical assessment so they can safely manage patients presenting with undifferentiated and undiagnosed conditions. They can see people with undiagnosed medical conditions, make treatment decisions and refer to secondary care.

Multi-disciplinary meetings (MDT's)are often only on offer for people over 65 (in accordance with national policy) and those under 65 are not included. People under 65 therefore often fall through gaps in services.

The process for contact between Primary Care and Secondary Care remains variable.

Findings

Had effective discharge procedures taken place and a referral to district nurses been made at the point of discharge, P19 may have been placed on the caseload for the district nurses and input may have resulted in access to a range of interventions and support such as palliative care. In Angus, the ANP's in some areas mainly work with people over the age of 65. If this role had been available to people under 65, then P19 may have had access to treatment and interventions required. There is no evidence to confirm that P19 was discussed at an MDT. If this had happened, then unmet health needs may have been identified. A co-ordinated approach to supporting unmet health needs in the community could also have been progressed.

There were no records available from Acute Services although a system is now in place where written electronic referrals are received by Acute Services from GP's. This referral system states when further telephone discussion is required between GP's and Acute services and should address some of the identified gaps in recorded information.

Recommendation 1.5

NHS Tayside should review hospital discharge procedures to ensure processes for sharing information on hospital discharge are robust and this happens timeously to inform community services. District Nurses should be included in these procedures. They should consider the appointment of a health professional to co-ordinate health input/ monitor health needs ensuring links to primary healthcare are made for community settings.

Recommendation 1.6

The AHSCP should consider the development of an enhanced care service for people under 65 to include expanding the current MDT system to enable it to be more flexible, responsive, and inclusive to need, rather than be focussed on age. This should include considering a review of the provision of ANP roles across Angus to ensure equity of access and support to treatments and consideration of an ANP within the AIDARS service.

Recommendation 1.7

NHS Tayside should progress the finalisation of work currently underway to introduce an electronic referral process from Primary Care to the Acute Medical Unit (AMU), assess whether any similar referral processes are required between Primary Care and other acute services and, develop clear referrals processes where they are required.

Transfer of Cases

Some service areas within the AHSCP have no system in place that provides assurance that a case referral made from one service to another has been received or to inform them that the required support has commenced, prior to current service support ending and the case being closed.

Findings

P19's service input ended, and the case was closed by service 1 after they had made a referral for ongoing support to service 2. This support was not provided by service 2 and service 1 were not aware of this. This resulted in P19 receiving no support for approximately 4 months. Service input only recommenced following receipt of a VPR by Police Scotland in August 2018. Had there been a system in place, P19 may have received the support required. This, in turn, may have resulted in action being taken to address health and social care needs more quickly as well as addressing the deterioration of living conditions thus preventing P19 living in the unsanitary and uninhabitable conditions found in August 2018.

Recommendation 1.8

The AHSCP should ensure all services have a system in place to provide assurance that a case referral made from one service to another has been received and that the required support has commenced, prior to current service support ending and the case being closed. This will ensure that no one is left without any ongoing support when they have been assessed as requiring it.

Research Question 2 - Determine the extent to which decisions and actions were person centred.

Specific consideration should be given as to whether appropriate weight was given to the diagnosis and extent and complexity of P19's mental health conditions in regard to assessment, intervention and decision making and how this affected professional support

Bowel Testing and Diagnosis

Changes in P19s bowel habit were first noted in January 2017 but a formal diagnosis was still outstanding at the time of P19s death in December 2018. Throughout this time, a number of appointments were offered which P19 did either not attend or was unable to attend (on one occasion no transport was arranged for P19). The GP attempted to secure an in-patient bed the night prior to a planned investigation to try and ensure that this was undertaken but this request was not supported by in-patient services. It should also be noted that throughout much of this time period, concerns were being raised in relation to P19s capacity.

Alternative options to the colonoscopy do not appear to have been considered despite the challenges associated with undertaking this. The use of qFIT (faecal immunological test) may have been one such option which could have been progressed by the District Nurses and can reduce the need for colonoscopies in some patient groups.

Professionals appeared to have 'diagnosis paralysis' where they were pre-occupied with the need for a diagnosis of cancer to initiate access to palliative care rather than using all the clinical information available to them, including what they were seeing, to ensure a person centred approach focused on a person's needs. The District Nurse who visited P19 in the days prior to death was escalating concerns regarding pain management but was unaware of the results of P19s colonoscopy and this was not discussed when raising concerns.

On reviewing the records, the reviewers noted that the Colorectal Nurse Specialist had entered information to the Clinical Portal on 26 November 2018 relating to the results of P19s CT scan of abdomen which was undertaken during an in-patient stay a few weeks earlier. This entry identifies the presence of a locally advanced (T4) tumour with no obvious spread and that P19 requires a further attempt at a flexible sigmoidoscopy by surgical team. This would suggest that when the GP was seeking admission in December 2018 to the AMU, admission to surgical services would have been more appropriate, based on the information within the clinical portal. This information provides a diagnosis for the primary care team to use to inform care and treatment.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO, 2020). The WHO recognises palliative care as a human right for everyone and can be started as soon as someone is known to have a life-limiting or shortening condition and alongside medical treatments and investigations.

P19 was not identified for a palliative care approach and the impact of this was significant in the latter stage of P19s life which included significant pain and an inability to mobilise. This was described by care staff who, on one occasion, found P19 'crawling on [their] hands and knees on the kitchen floor attempting to reach the fridge to get a drink of juice'.

Changes in P19s bowel habit resulted in an inability to control bowel movements, and the amount of faecal incontinence experienced by P19 as a result of bowel cancer was highly unusual and, as such, required further assessment and management. This did not take place and led to reduced dignity for P19 including enduring uninhabitable living conditions, as well as limiting the available options for 24 hour care.

Gastroenterology had recommended the use of Creon to improve diarrhoea and assist with symptom management and this information was passed to the GP in late August 2018. It appears that this was never prescribed due to a misunderstanding that P19 was not taking this medication when in fact it had not been commenced.

Compliance with medication was identified as an issue for P19 who often forgot to take prescribed medication and could get mixed up with the days and time to take medications. To support this, a venalink had been arranged but was unsuccessful. No other methods of supporting medication compliance were explored to ensure P19 received the necessary medication to manage symptoms, including pain management.

P19 was noted to experience significant pain but was being managed with Paracetamol and Codeine. Consideration of non-parenteral medications such as a low dose Fentanyl patch which can be changed every 72 hours by District Nurses may have been a suitable option. Alternative options may have included consideration of modified release medications to accommodate a once or twice daily regime, with prompting to take medications overseen by District Nurses.

During the review process, the reviewers asked staff why they did not summon the input of the Scottish Ambulance Service when they found P19 in such distress, pain and were concerned for their health and wellbeing. Many staff had reflected that on hindsight they wish they had however it was of concern that one practitioner shared that undertaking this would have been seen as 'going over the GPs head and there would be repercussions'.

Health care professionals involved in P19's care appear to have failed to recognise that they were dying and information sharing difficulties possibly contributed to this. This was despite:

- a positive bowel screening test in 2017
- a CT scan in August 2018 with the result that indicated an abnormal bowel mass tumour in the sigmoid colon
- severe weight loss of approximately six stone over an eighteen-month period and significantly 2 stone from June – October 2018
- loss of appetite
- weakness
- behaviours that may have indicate they were frightened.

Finding

P19 had a right to treatment to meet needs regardless of whether a formal diagnosis was available, and practitioners need to consider how they identify when a person would benefit from a palliative approach. The District Nursing service should have progressed with a holistic assessment and plan for P19s physical,

emotional, social and spiritual care needs, along with an anticipatory care plan to incorporate Just in Case Medications for symptom management.

The health care team failed to recognise and reach an agreement that P19's death was expected and imminent. This resulted in P19 dying with uncontrolled physical, emotional, social and spiritual symptoms. No timely or sensitive communication was undertaken to explore P19's wishes, preferences and preferred goals of care, preferred place of death and any fears about dying. P19 died with no dignity and none of their needs anticipated or managed. The control of symptoms for any individual should be parallel to any ongoing investigations rather than waiting until a diagnosis has been made.

It is recognised that the last days and hours of a person's life may be a distressing time for family and others who are close to the person. There are no documented accounts of any support being offered to family or others close to P19.

Recommendation 2.1
Primary Care services consider the use of the Palliative prognostic score which might prompt clinicians to realise that someone is dying, even in the absence of a diagnosis.

Recommendation 2.2
Health care professionals should be committed to the provision of consistently high-quality end of life care for all that reflects the 4 principles set out in The Scottish Government's guidance for caring for people in the last days and hours of life (2014).

Primary Care
The service involvement to P19 was significant with many agencies involved in the months prior to death. However, not all key professionals were involved in decision making, planning and support or involved at the right time. P19 was not discussed at the Enhanced Community Support (ECS) meetings, not all services were aware of the involvement of other services or agencies and some key services were not involved at all or not until later e.g. Angus Specialist Palliative Care Services.

Whilst there was no diagnosis of mental disorder in P19's case, there was evidence in reports which indicated that there were occasions when P19 was sober that they displayed difficulties in concentration, anxiety, depression, memory and confusion. No reference or mention of this being formally considered for referral to the Community Mental Health teams for further assessment for P19 was found throughout the course of this review. This is further discussed within Research question 4 in relation to capacity.

District Nurses were involved with P19 in September 2018 to administer bowel preparation in advance of a colonoscopy and in December 2018 for the purpose of continence assessment but P19 was never referred to the District Nursing service or

placed on their caseload. The GP confirmed that the normal process for District Nurse involvement would be to allocate specific tasks to District Nurse's to carry out and that this is task focussed and not at all person centred.

Finding

There was a lack of a holistic person centred approach to care and an absence of anticipatory care planning (or thinking ahead) which would have provided planning to ensure P19 had the right person to do the right thing, at the right time, facilitating shared decision-making and person-centred care in the appropriate setting. Staff from support agencies did not feel that their knowledge was sufficiently valued and were not included in key discussions.

There is a need for a health professional role to be identified, if not the GP, who should adopt an overarching health caretaker role to ensure individuals are supported, the right health services are involved at the right time and unmet health needs are escalated promptly.

Recommendation 2.3

Services within Angus HSCP should ensure they support integrated working and the involvement of the correct professionals/agencies at the correct time. Consideration should be given to inviting Social Care Officers (SCOs) to practice MDTs or ECS meetings. There is a need for clear information and guidance to be made available for staff about what health services are available and how these can be accessed.

Recommendation 2.4

The Angus HSCP should review the process for referring to District Nurses to adopt a person centred rather than a task focussed approach. This review should include a system where, when required, individuals are admitted to the District Nursing caseload rather than just receiving input for specific tasks to ensure a holistic and person-centred approach to meet the health needs of individuals. Written criteria relating to the role of the District Nursing service and the referral process should be made widely available to aid understanding of the District Nursing role and how it can be accessed.

Recommendation 2.5

Angus HSCP should review the current reach of anticipatory care planning to ensure that patient's receive care earlier rather than later and that information is available to all professionals involved in unscheduled and secondary care.

Secondary Care

P19 was considered to be 'hard to engage' in the sense that some appointments were missed, follow up investigations not progressed and services at times declined and this was seen as an indication of informed choice being exercised rather than possibly evidence that something was wrong which required intervention.

The reviewers heard that there was a lack of clarity across the agencies as to what protocols and procedures exist when a person gets lost to follow up treatment within the NHS as a result of non-engagement or the ability to attend outpatient appointments. This lack of clarity extended to clinical pathways with many practitioners noting they were unaware of many of the care pathways, the criteria to access these and where the responsibility sat for progressing these.

The escalation process used by GPs when they are seeking hospital admission is viewed at times as person dependent and built on relationships and influence rather than process driven and requests are often refused. Staff noted that the criteria is either 'it is medical, or it is social care' rather than a more flexible approach.
NHS Tayside developed robust criteria for admission to the acute medical unit and it appears that around 25% of individuals referred to the service do not require same day admission. The criteria identify that issues such as pain management and dehydration can often be managed within the community and progressed by the GP.

Medical staff within primary and secondary care acknowledged that there is a current gap in clinical pathways for urgent out-patient appointments where there is possibility of cancer and other conditions that requires further investigation in a shorter time period rather than the usual referral process. These types of investigations do not fit within the role and function of the AMU but in the absence of a more appropriate pathway, the GP has no other route, and this would suggest there is a need for an urgent cancer referral pathway. GPs have the ability to access CT scans in a reasonable time period but identify that this process would benefit from being formalised.

Finding
Whilst P19 often refused interventions and support to meet health and personal care needs, interventions failed to take a person-centred approach with a failure to see the person which resulted in missed opportunities to work with P19.

Recommendation 2.6
NHS Tayside should consider a pathway for admission to an acute medical hospital setting for people with chronic long-term issues where wider acute medical problems cannot be managed within primary care settings.

Recommendation 2.7
NHS Tayside should consider the need to develop a "suspected cancer" fast-track service that GPs can access.

Falls Management

Having a diagnosis of MS increases an individual's risk of falls due to the changes in muscle strength, muscle tone, co-ordination and gait. In addition to MS, P19 had a number of other risk factors including history of binge drinking, was not eating regular meals, was experiencing pain, significant weight loss and altered bowel habit.

The Falls service received a referral from the Scottish Ambulance Service in June 2018 following fall outside of P19s flat however P19 did not engage despite numerous attempts by the service and P19 was therefore discharged from the service, with no input.

Despite P19 experiencing a number of falls both within and out with the home setting between August 2018 and December 2018, the Falls service received no further referrals or notifications regarding P19 despite a number of falls recorded by the Community Alarm service and carers as well as a fall resulting in admission to hospital and a surgical procedure.

A limitation of the current falls pathway is that it fails to provide the referrer with confirmation that the referral has been received, information on follow up action to be taken or when these will be taken.

Finding

Despite a number of agencies being aware of a number of falls, no referral was progressed to the locality Falls service in line with the falls pathway to ensure a person-centred approach to falls and fall prevention.

Recommendation 2.8

Angus HSCP should review the falls pathway to include confirmation to referrers that the referral has been received, what follow up action will be taken and when and alerting referrers to issues of non-engagement and case closure.

Recommendation 2.9

The Angus Falls Service should consider liaising with Occupational Therapists and Physiotherapists who attend practice Multidisciplinary Team meetings (MDTs) and ECS meetings.

Recommendation 2.10

Angus HSCP should review the need for staff education and training in relation to the Falls Pathway.

Research Question 3 - To what extent did one Professional/Agency have a lead role and hold responsibility for P19 and their Protection Plan; to monitor what was being achieved, any gaps in assessment, planning and decision making and associated risks?

There will be specific reference to the implementation and understanding of Adult Support and Protection processes and opportunities for intervention with P19.
There will also be specific reference to the use of Chronologies and Risk Management plans and opportunities to have a fuller understanding of P19's risks and experiences.

Adult Support and Protection (ASP)

P19 came to the attention of services in early August 2018 when Police accompanied home and identified that living conditions were uninhabitable. Whilst Police progressed a timely VPR and this was actioned, it took 6 days for the referral to be allocated to the AIDARS service and a further 7 days for AIDARS to undertake the first home visit – a total of 15 days between Police identifying home conditions and the first home visit happening.

Following the progression of the VPR by Police Scotland in August 2018, a case conference was held in early September 2018 and identified P19 as an adult at risk of harm. Whilst there was good representation of the main agencies at this meeting, along with sharing of information and identification of risks, this was an emerging situation. Following this case conference, five core group meetings were held.

Not all the right people were involved in the ASP process at the right time and this would have benefitted from a wider group and co-ordination of a more comprehensive multiagency risk management plan. It is unclear how all the documents containing various risk plans and actions interrelated to deliver coordinated and cohesive risk management planning.

The reviewers noted there is a lack of understanding across the wider partnership about the difference between the purpose and membership of ASP core group meetings and case conferences. Membership of the core group meetings did not involve all the key professionals required to take action in relation to the presenting issues and concerns and this contributed to the lack of progress and accurate information and included:

- District Nursing Service were not involved in core group meetings until the final meeting in December 2018.
- No health professionals (with the exception of the GP who was invited to meetings but did not attend) were involved following the initial case conference.
- The police were involved in the initial ASP case conference but had no further involvement after this but felt they should have been. There is no reason recorded in relation to why police were not invited to attend further meetings.

The invitations are a decision for the Council Officer and Team Manager conducting the investigation. The local operating procedures in place at the time were specific about police involvement in relation to criminal investigations, but not more generally.

- Due to the systems in place within Police Scotland at the time, they were aware that P19 was known to be an adult at risk, however, were unaware that P19 was under formal Adult Support and protection measures. This meant the Procurator Fiscal was not informed of this in the Sudden Death report.
- No homecare services were involved in core group meetings despite their significant role in supporting P19.
- The care at home provider was not involved in core group meetings until November 2018.
- Neurology services were not involved in ASP processes and were not aware of concerns in relation to self-neglect and inhabitable home conditions.
- Advocacy services were not involved in the ASP process as P19 had originally refused this support but there was no evidence this was discussed beyond this.

Whilst a number of benefits were noted from the ASP process, for example, progressing access to temporary accommodation with housing, some members of the core group felt the meetings were ineffective in the latter stages as the same issues were being discussed, with no resolutions being found. The core group meetings did not effect all the changes that were required to mitigate the identified risks and latterly, staff involved did not know what to do or who to go to next. Staff reported a lack of clarity in relation to where the authority and decision making at case conference and core groups lies and it was the view of the majority of professionals involved in this case that adult protection processes did not make a difference to P19's quality of life prior to death.

Since this case it has been agreed that reports will be forwarded to Police Scotland on a monthly basis of all people who have become subject to Adult Support & Protection in Angus and this will also include when a person who has been subject to those procedures is no longer deemed an adult at risk. This will allow Police Scotland to maintain accurate records within their own internal processes. In terms of inviting Police Officers to Case Conferences and Reviews, this remains at the discretion of the Chair and the Council Officer/Team Manager depending on the need for Police to be part of this discussion. However, this decision should also take into account the views of the Subject of the Case Conference who may have a preference that the Police do not attend, and local Operational Instructions have been amended to reflect these Proposals.

Good Practice
There is now an identified Police representative for Adult Protection within Angus which provides consistency and continuity from Police Scotland.

Minutes of AIDARS core group meetings are prepared by Team Leaders/Council Officers and as part of the review process, staff highlighted the additional demands this places on the team when they often have multiple adult protection cases on top of full caseloads. Whilst chronologies and risk assessments were in place, these were not reflective of all the relevant information from all agencies and were not up to date.

The reviewers identified that it was difficult to determine with any accuracy if all relevant staff across both health and social care had undertaken adult protection training and at what level.

Records for Council Officer training attended by Council employees are retained on an electronic system, but this does not log those who have completed Council Officer training with another Local Authority, and it does not track health staff who also undertake this same training. Health staff training is logged on a different electronic system but does not record if Council Officer training has been undertaken.

Finding

There was uncertainty in relation to roles, authority and decision making at the ASP case conference and core group meetings which meant that not all required actions were identified and followed through to support and protect P19. Core group meeting documentation needs to be able to facilitate analysis of risk and effective review planning, risk and decision making.

Difficulties remain in securing attendance and information at ASP meetings from various services and organisations. There were missed opportunities to engage health professionals in the ASP process and this included the 4-week in-patient stay and there would have been merit in holding a multiagency discharge planning meeting for P19 that also acted as an ASP Core Group meeting.

Recommendation 3.1

Angus APC review the learning and development and quality assurance opportunities in place to support staff, managers and Review Officers to develop consistent practice in producing adult protection plans that are linked to a clear assessment of need and risk, which are reviewed to ensure they are dynamic in nature, clear for the adult at risk and offer direction to agencies involved.

Recommendation 3.2

Angus APC should develop clear guidance in relation to decision-making and accountability of the various stages of the ASP process e.g. referral, investigation, case conference and that any guidance is supported by a governance and quality assurance process that monitors the effectiveness of the process. Staff training should be provided to ensure this is clearly understood and local operational procedures should be reviewed within this context.

Recommendation 3.3
The AHSCP should ensure that membership of core group meetings include health professionals and the introduction of Adult Protection Advisor posts within NHS Tayside should be considered to support ASP meetings to ensure there is always adequate representation, good decision making and escalation.

Recommendation 3.4
For those subject to ASP measures and in hospital for two weeks or more, consideration should be given to developing a joint process with the locality HSCPs and NHS Tayside that allows, at the point of discharge, a joint ASP core group and pre-discharge planning meeting to take place.

Recommendation 3.5
All statutory partners should explore how advocacy services can become more involved in the ASP/AWIA process to ensure adults are supported throughout these processes. This should include reviewing current practice and identifying barriers to the involvement of advocacy.

Recommendation 3.6
Angus HSCP should review the documentation process for core group meetings to ensure they are able to evidence the discussion and decision making process. This should include considering the role and provision of admin to support operational staff preparing minutes for AP meetings. It would also be helpful to add a section to the current documentation that allows for 'barriers to information sharing and agreed actions to mitigate against the risk of information not being shared" being captured.

Recommendation 3.7
All statutory partners should ensure that the Tayside ASP Minimum Learning Standards that have been identified for ASP training are shared and that training is available within each partner organisation to meet these requirements and that training data is shared routinely with the Angus APC.

Escalation, Professional Accountability and Decision Making
Lines of professional accountability and decision making were a confusing picture. Within the Angus Health and Social Care Partnership, understanding of this differed between different services. Within acute services and primary care, it was difficult to establish where professional accountability lay as there was wide variation in how this was viewed in different teams and services.

The care provider was clear on their accountability but not clear on where to report concerns or how to escalate these further when their route to escalation was proving ineffective, despite repeatedly and consistently raising their concerns.

Understanding of personal accountability varied greatly across services. Some services understood the accountability they had yet were unable to find a way to meet this. Other services felt that accountability lay elsewhere. This ranged from funding required goods and equipment, to accessing support, treatment and interventions. Staff were unclear of lines of accountability, roles and authority to commit resources and assign personal responsibility between people in authority, ASP case conferences and the role and authority of the Angus Adult Protection Committee.

The following is not exhaustive but provides an overview of the extent of escalation failure:

- The Community Alarm service did not escalate their concerns to any managers.
- The Physical Disability service did not escalate their concerns above Team Manager level.
- The AIDARS service escalated concerns to the Service Leader. These concerns were not escalated any further and did not affect any further interventions.
- Community meals and community laundry did not escalate concerns.
- The GP did not escalate concerns apart from to acute services in attempting hospital admissions.
- The District Nurses, once involved, escalated concerns to the GP that did not effect any further interventions regarding unmet health needs.
- Housing services did not escalate concerns.
- The Multiple Sclerosis service did not escalate concerns.
- The care provider was robust in escalating concerns to care managers and within their own organisation but did not escalate these anywhere else when this was proving ineffective.

Despite continual escalation to Team Managers and one Service Leader, many concerns remained unaddressed. Avenues for escalation such as multi-disciplinary meetings or ASP case conferences were not utilised to escalate concerns and aid decision making. Had even one of these services escalated concerns appropriately this may have resulted in P19 accessing the current care and treatment they required.

The AIDARS Team Manager regularly brought the case to the Service Leader's attention due to the complexities of it. She used supervision to discuss it, informed him that it was going to ASP case conference and thereafter, regularly raised the case with him due to her concerns. He advised her to continue to have regular core group meetings. The AIDARS Service Leader made his Head of Service aware of the case when P19 died. He explained he did not escalate this prior to death because he felt this responsibility sits more with him at Service Leader level and he has the expertise in relation to ASP processes.

The Physical Disability Service Leader has a process in place where Team Managers bring up ASP cases in supervision if there are any aspects of a case they are worried

or have specific concerns about. The Team Manager did utilise this process for P19 in terms of requesting funding for respite provision or authorisation for a respite placement, but never utilised it to escalate concerns in relation to P19's living conditions and health and wellbeing. This resulted in the Service Leader being unaware of the serious concerns and critical situation P19 was in. It is unclear why the Team Manager did not escalate this to the Service Leader. As she is no longer an employee of Angus Council it has not been possible to obtain clarity regarding this.

It was particularly concerning that Community Alarm staff, who were called out to P19 regularly in the weeks prior to death to assist with manual handling after a fall, did not escalate any concerns to their immediate manager. Records note they had no concerns which is reflective of a task focussed rather than a person-centred approach to support and care.

Good Practice
The care provider escalated concerns regularly and repeatedly, comprehensively specifying what these concerns were and providing evidence for them, based on their daily engagement with and observations of P19.

Findings
Lines of professional accountability are unclear within different services. There is no clarity of how professional accountability works across different organisations. Where escalation did happen, it did not make a difference. Although good team working was evident between staff and case workers, having 2 case holders responsible from 2 different service areas (rather than one case holder from one service area having lead responsibility), relies on that level of collaborative working happening at all levels of management within and across services in a consistent way. It also relies on a shared understanding of escalation, professional accountability and decision making.

This did not happen in relation to P19 as the 2 services involved had differing understandings and expectations of escalation and accountability at various levels within each service. The issues and concerns regarding P19 were never escalated to Head of Service level or Service Leader level in the Physical Disability service and were never escalated to the Head of Service level in the AIDARS service. This meant that the casework, concerns, risks and related decisions did not attract the attention or oversight of Senior/Middle Managers, even when a high risk of death had been identified. Had this happened, managers could have assisted more widely to influence, put pressure on others, escalate to a higher level or try to address system blockages. This may have resulted in P19 having access to the correct treatment, support and interventions required at an earlier stage.

Given the nature of the presenting problems, P19's case may have benefited from periodic reflection on whether the responses continued to be appropriate.

Oversight by someone not directly involved might well have prompted a considered review of the case.

As part of their duties within Section 42 of the Adult Support and Protection (Scotland) Act (2007), APCs and their member organisations have a responsibility "to make, or assist in or encourage the making of, arrangements for improving the skills and knowledge of officers or employees of the public bodies and office-holders to which this section applies who have responsibilities relating to the safeguarding of adults at risk present in the council's area," (Guidance for APCs. Appendix 2)

Recommendation 3.8
The Angus Adult Protection Committee should review the Tayside Escalation Good Practice Guide to ensure escalation and professional accountability in adult support and protection cases includes clear information on escalation expectations particularly where serious concerns exist and effecting the desired change is not being achieved. This guidance should be shared and promoted widely to ensure staff are aware of it and a consistent approach is implemented.

Recommendation 3.9
The Angus Adult Protection Committee should develop criteria for the role of the case holder with lead responsibility for ASP cases. This could be included within the above guidance, with a clear focus on empowering them to make decisions.

Recommendation 3.10
All agencies should update their local operating procedures to reflect the above guidance which should include having one clear case holder with responsibility for the case. Although it is recognised that it is often necessary to have more than one service co-working a case and collaborating to achieve best outcomes for the individual, there should be one clear case holder leading the co-ordination of complex cases, to ensure clear lines of accountability.

Recommendation 3.11
The AHSCP should consider the role of a lead professional within adult support and protection processes and what the role, function and decision making requirements would be.

Recommendation 3.12
The AHSCP should ensure Service Leaders have a robust system in place for monitoring ASP cases and raising these with Team Managers in supervision.
The AHSCP should consider the extent to which there is a culture of support in managing complex adult support and protection cases, including time for cases to be explored, risks to be escalated and decisions to be given some further oversight and governance. Staff need to understand how Senior Managers can influence. Clear information should be provided to Team Managers about the role and

responsibilities of Service Leaders which is consistent across all services within the AHSCP.

Recommendation 3.13
The Angus Adult Protection Committee should provide training to care at home staff about thresholds, escalation and person-centred care and accountability in the context of adult protection. This could be informed by the Tayside Practitioners good Practice Guide.

Recommendation 3.14
Angus Council should ensure that contracts with providers make explicit escalation responsibilities. This should include clear information to the provider on how to escalate concerns and who to escalate these to.

Research Question 4 - How effective are the current processes for requesting a Capacity Assessment within NHS Tayside and how these processes are applied in practice:

There will be specific reference to:

- the understanding of Capacity Assessments and their application in practice.
- respectful challenge of decisions made around Capacity Assessments and the process for so doing.
- consider opportunities to review capacity in light of the deterioration of a person's health and well-being (such as self-neglect) and how does this inform a dynamic Risk Assessment and Care Management Plan.
- how any Capacity Assessment(s) undertaken took full account of P19's personal situation and conditions.

Capacity Assessments
Adults with Incapacity legislation states that professionals should always assume that people have capacity unless they are able to establish otherwise. Incapacity is defined within the Adults with Incapacity (Scotland) Act 2000 as being incapable of

- acting; or
- making decisions; or
- communicating decisions; or
- understanding decisions; or
- retaining memory of decisions

by reason of mental disorder or an inability to communicate because of physical disability.

When the Local Authority is considering if legal frameworks need to be used to support an individual who they believe to lack capacity with their decision making, an Adults With Incapacity Act (AWIA) Case Conference needs to be convened to determine the most appropriate, and least restrictive legal framework to be applied. For this meeting to progress, an initial statement on an individual's capacity needs to be sought. A suitably qualified medical practitioner (i.e. GP, Psychiatrist or Psychologist) can pass comment on if the person has capacity. Once it has been agreed, following an AWIA Case Conference taking place, that a Local Authority Welfare Guardianship should be progressed, then two formal assessments of capacity need to be completed for the guardianship application to be progressed.
One of these reports needs to be completed by a Consultant Psychiatrist who requires to be S22 approved and a second report is normally completed by a GP, but the second report can be completed by any suitably qualified medical practitioner. In P19s case, there was confusion on whether the GP could complete his report before the Consultant Psychiatrist. A GP can provide an initial comment on someone's capacity before a Psychiatrist undertakes their formal assessment.
There are large variances across Tayside in relation to accessing a capacity assessment. There is varying understanding between professionals regarding the process of obtaining a formal capacity assessment. Professionals described 'going around in circles' in terms of trying to access an assessment of capacity for P19 and in obtaining clarification on the formal assessment process and requirements for this. There are difficulties for people accessing a capacity assessment generally but specifically for people with a physical disability who do not access a psychiatry service. People with a physical disability do not have a pathway in place for accessing capacity assessments; however, there is no pathway in place for any service.

There is a lack of knowledge within acute services in understanding capacity and their responsibilities in caring for patients who require capacity assessments as opposed to consent to treatment. An assessment of capacity was requested whilst P19 was an inpatient in hospital and abstinent from alcohol. The hospital informed professionals that an assessment of capacity had been undertaken and that P19 did have capacity. Hospital records note that it was not an assessment of capacity but Informed Consent for medical treatment that was assessed and documented. There are misunderstandings within acute care of what a capacity assessment is, and health professionals often see AWIA as specifically relating to S47 consent to treatment.

An AWIA decision making meeting was held for P19, where it was unanimously agreed that a move to a care home would be in P19's best interests and they could move to a 24-hour facility under Section 13ZA, on the understanding that an application for Welfare Guardianship was made to safeguard and protect P19. At this point, two medical reports should have been requested for the application of guardianship to begin. S13ZA places duties on the local authority to provide care services when there is no one with the legal authority to make decisions on the adults' behalf and this should take into account the past and present wishes of the person and the nearest

relative. However, despite P19 initially agreeing to the move, they later changed their mind therefore 13ZA could no longer be used as all parties, including the person, need to agree to the proposed care. Due to the fact that 13ZA could no longer be utilised, a further AWIA meeting was arranged. However, this meeting was cancelled after the ward advised that the Consultant Psychiatrist had assessed P19 as having capacity. As a result of this, the AWIA could not progress. The consultant had, in fact, not undertaken an assessment of capacity but a S47 consent to treatment, as highlighted above.

Despite the level of concerns from professionals in relation to P19's capacity, no one challenged the capacity assessment decision from the hospital. No one requested a copy of the capacity assessment or any detail of the assessment that would assure them that it had taken full account of P19's personal situation. Practitioners did not seem to be aware that when there is a disagreement between clinicians regarding an adult's capacity, that a 3rd medical opinion can be sought. The AHSCP are currently amending Operational Instructions for AWIA to reflect the option to have a 3rd medical assessment where there is a difference of opinion. This will ensure practitioners are clear on this option which should minimise delays in progressing assessments.

The worker who had requested the capacity assessment had been clear in their request that they were requiring an AWIA assessment of capacity and they had specified the areas of capacity that required to be assessed. Had the Consultant shared his written assessment, it would have been apparent that it was a section 47 certificate that had been completed and not a formal assessment of capacity. There is no process in place to confirm in writing what areas of capacity were assessed that would assist professionals in satisfying themselves that this has taken account of P19's ability to safeguard themself, which in turn could have informed risk assessments. What was described as a capacity assessment was not shared in a formal written manner. Professionals did not consider requesting this in writing and accepted the verbal account as accurate.

It must be understood that capacity involves not only the ability to understand the consequences of a decision, but also the ability to execute the decision and retain the memory of this decision. Capacity is not an all or nothing concept and it can fluctuate. While individuals can make small everyday decisions, they may not be able to make more complex, significant decisions.

Findings

No one person took responsibility for obtaining a capacity assessment.

There were numerous attempts to identify someone to undertake a capacity assessment for P19 and varying understandings of who should/could do this. This

resulted in no assessment of capacity being undertaken. Having one person with clear responsibility for obtaining a capacity assessment would have resulted in a co-ordinated approach and a holistic overview of the challenges and issues surrounding this, which may have resulted in a clearer course of action and a capacity assessment being obtained. This could have had a significant impact on the care and treatment P19 received.

There is no clear pathway for people to access an assessment of capacity, including people with alcohol issues. This currently appears to be dealt with on a case by case basis. This is further confused by the fact that the AIDARS Consultant is not S22 approved, therefore unable to undertake formal capacity assessments, despite the regular requirement for service users to have an assessment of capacity. Having a clear pathway that includes access to the required S22 approved consultant would have significantly increased the likelihood of P19 having an assessment of capacity undertaken, and that this would have been done timeously. Taking into account the complexities of undertaking an assessment of capacity when P19 was often under the influence of alcohol, nonetheless, there were opportunities when P19 was alcohol free and a capacity assessment was not undertaken. The reasons for these missed opportunities were various and included administrative errors and ineffective communication and information sharing. Had an assessment of capacity been undertaken at any one of these missed opportunities this would have resulted in professionals being clear about the role of any protective legislation in protecting P19 and ensuring they received the care and treatment required. This could have had a significant impact on P19's health and wellbeing.

No one requested a copy of the "capacity assessment" completed by the Consultant or any information that would provide assurance that it had taken full account of P19's ability to safeguard themself. Had this happened, then it would have become apparent that a capacity assessment was not undertaken and only consent for medical treatment was given. An assessment of capacity could then have been progressed as required.

Recommendation 4.1
NHS Tayside should develop a clear pathway for accessing an assessment of capacity. This should include individuals with alcohol issues, those who have substance use dependencies and people with a physical disability who are not accessing a psychiatry service and should be irrespective of age.

Recommendation 4.2
NHS Tayside, the AHSCP and Angus Council should develop a protocol for sharing the outcome of a capacity assessment with the care team, particularly if an adult is deemed to retain capacity. This should include guidance in relation to where there are challenges in terms of determining if someone has capacity. If they are

under ASP measures, there should be a specific plan identified in terms of identifying how the capacity assessment will be progressed, with clear actions and timescales identified.

Recommendation 4.3
NHS Tayside should ensure appropriate AWIA education and training is provided to relevant acute and primary care services on the difference between an assessment of capacity and S47 consent to treatment. This should include GPs, so they are clear on their role in terms of undertaking assessments such as S47 and capacity assessments. Local operating procedures should be updated to make this explicit.

Recommendation 4.4
The AHSCP, Angus Council and NHS Tayside should ensure that ASP/AWIA training, including regular refresher training, is made mandatory for all relevant professionals. Clear governance should be put in place to ensure mandatory and refresher training is undertaken by all staff.

Capacity and Alcohol
Professionals were unclear about P19's capacity. Several agencies did question whether P19 had capacity and concerns had been raised in relation to P19's short-term memory and use of alcohol, which could have impaired long-term capacity and decision making. When P19 was sober they were seen by some professionals as being capable of making informed decisions; however, some professionals did not agree with this. When intoxicated P19 would be incoherent, have a poor recollection of events and their capacity to make decisions was severely impaired. Whilst there was no diagnosis of mental disorder in P19's case, there was evidence in reports which indicated that there were occasions when P19 was sober that they displayed difficulties in concentration, anxiety, depression, memory and confusion. This could be indicative of Alcohol Related Brain Damage (ARBD)although no reference or mention of this being formally considered for P19 was found throughout the course of this review. ARBD is a recognised mental impairment. It is significant that P19 may have had a mental disorder that would have afforded the protection of the Adults with Incapacity Act.

The MWC report on Mr H states that it is acknowledged that services for people with ARBD are deficient throughout Scotland, staff awareness of ARBD needs to be improved and services need to be able to respond to this very vulnerable group of individuals much earlier than is often the case at present. This is essential if NHS Boards and local authorities are to be in a position to meet their general statutory duties, as well as their specific statutory responsibilities under both the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act.

P19's decision making and ability to effectively care for themself was potentially influenced by their anxiety, depression and alcohol use. It appears that P19's capacity would regularly fluctuate. Issues regarding fluctuating capacity, mental

health and alcohol use, and its impact on conducting accurate assessments is complex and there are often differing opinions in relation to the nature of addiction and its impact on capacity which means that professionals have to rely on their own professional judgement when considering when and how the legislation should be applied. This makes cases like P19 complex in terms of the decisions that professionals have to make. However, there was no record of ARBD having been considered.

Professionals were advised from medical staff that they had to wait for P19 to be free from the influence of alcohol to have a capacity assessment undertaken. Locally there were varying opinions of how long a period of time P19 had to be abstinent from alcohol before a capacity assessment could be undertaken.

As a consequence, staff often felt disempowered and assumed that there was little that they could do to intervene, particularly when P19 was still consuming alcohol. This presents a challenge for agencies to deliver effective intervention as, on occasions, they are unable to wait for the opportunity to assess the person when sober.

Findings

Professionals who assessed P19 did not appear to have an understanding of the link between prolonged alcohol use and impaired mental capacity. ARBD was not assessed and thiamine treatment was not considered. Professionals appeared to take poor co-operation and non-engagement with treatment as indicative of a conscious, informed choice, and therefore made little effort to pursue assertive treatment or consider the use of relevant legislation. The assessment and potential diagnosis of ARBD may have resulted in maximising early intervention for P19 and progressing the potential role of protective legislation in implementing care plans to protect P19.

Recommendation 4.5

NHS Tayside should develop procedures for identifying and investigating impaired cognitive function, including alcohol-related cognitive impairment. Such protocol and procedures should identify appropriate referral and treatment options.

Recommendation 4.6

NHS Tayside, Angus Council and the AHSCP should provide guidance and training for staff around the relationship between alcohol, care, capacity and ARBD. All appropriate staff should be trained in the identification, assessment and management of ARBD. This should include responsibility to assess the impact of persistent alcohol abuse on an individual's capacity to respond to proposed care and treatment plans, the potential role of protective legislation in implementing care plans to protect individuals and clarity on how long an individual requires to be abstinent from alcohol before a capacity assessment can be undertaken. The resulting agreed process should be shared across Tayside. The Angus Alcohol and

Drugs Partnership intend to explore commissioning some bespoke training for staff on this issue.

Research Question 5 – To what extent is Self-Neglect understood across the multi-agency Adult Protection partnerships and wider Adult Protection providers?

There will be specific reference to:

- exploring potential barriers to P19 receiving appropriate levels of care and treatment to ensure their personal dignity and well-being was maintained and enhanced.
- considering how Services balanced P19's protection from self-neglect and P19's right to self-determination.
- considering the wider social and health implications in terms of staff and the wider public as a result of the level of P19's self –neglect, illnesses and associated environmental conditions.

Understanding Self-Neglect

Self-neglect commonly poses complex challenges to practitioners involved in supporting individuals such as P19 and these are enormously challenging and fraught with ethical and legal dilemmas, particularly when adults are judged to have mental capacity but refuse support.

The term 'self-neglect' covers a wide range of behaviour and P19 displayed a number of characteristics often associated with self-neglect and these included:

- availability of adequate clothing which was evidenced on admission to the detox service whereby staff noted P19's clothes were too big due to weight loss
- living in unclean conditions which staff described as 'squalid' and included faeces in a number of rooms
- failing to care for self which resulted in a decline in health and wellbeing
- poor diet and nutrition
- non-compliance with prescribed medication
- refusing community supports
- non-attendance at appointments leading to untreated medical conditions

Home conditions in April 2018 were noted by Angus Housing Service as acceptable and yet by August 2018, Police Scotland noted P19s living environment to be uninhabitable.

Staff noted that P19 did not appear to have insight into how unsanitary conditions within the home were and cited an example whereby P19 was noted to be eating a sandwich while soiled and in a room where faeces was present. There was further evidence to support the extent of self-neglect which included when P19 arrived at NHS Tayside's Inpatient Detox Unit in August 2018 having travelled there covered in faeces and with no spare clothing, and that the clothing being worn was ill fitting due to obvious weight loss.

It is noted that during P19's inpatient stay in hospital in October/November 2018 that deep cleaning was undertaken within the accommodation and new bedding was provided but conditions quickly deteriorated and were compounded by the severity of the faecal incontinence.

Managing the balance between protecting adults from self-neglect against their right to self-determination is a serious challenge for statutory services and partners along with other people involved in the person's life. Balancing choice, control, independence, and wellbeing calls for sensitive and carefully considered decision-making. Dismissing self-neglect as a "lifestyle" choice is not always an acceptable solution in a caring society. On top of this, there was the question of whether P19 had the mental capacity to make an informed choice about how they were living and behaving and the amount of risk this created. The reviewers note that the Tayside Practitioner's Guidance: Self- Neglect and Hoarding Protocol and Toolkit has since been developed on a Tayside Adult Protection basis.

Good Practice
Angus APC arranged for the National Adult Protection Co-ordinator (NAPC) to deliver a learning session to a wide range of practitioners on self-neglect in Nov 2019

Finding
Staff did not fully understand P19s circumstances and what led to the extent of the self-neglect. This was at times viewed by some as a lifestyle choice which prevented a deeper analysis of the underlying cause and the likelihood that alcohol related brain injury played a part. As such, there was a failure to fully recognise and understand the relationship between alcohol misuse and self-neglect. Additionally, staff did not know what to do and where to turn for advice and guidance and at that time, there was no available guidance to assist staff.

Recommendation 5.1
Angus APC should consider additional learning opportunities on understanding and dealing with self-neglect on a multiagency basis and should include information on the legal framework surrounding this issue. Such training should include a specific focus on alcohol-dependent adults and recognise the complicated role that alcohol plays in adult protection and that 'lifestyle choice' is often an unhelpful paradigm, and to avoid stigmatising those who misuse alcohol.

Recommendation 5.2
Angus APC should continue to promote the Practitioner's Guidance and review this in light of learning from this case. Additionally, there would be merit in seeking

feedback on this toolkit from practitioners on its relevance in order to further refine and enhance the guidance over time.

Recommendation 5.3
NHS Tayside should build on the process adopted for MAPPA alerts to include alerts for vulnerable adults within ehealth systems such as EMIS/Trak and that such alerts can also be used to highlight risks such as non-engagement that can then be acted upon. NHST should develop a Standard Operating Procedure to better manage and track vulnerable patients who fail to attend clinic appointments.

Recommendation 5.4
Partners within Angus HSCP should develop and implement a process which allows staff to purchase basic items quickly when required to ensure essential care can be provided in cases of extreme self-neglect.

Staff Impact
The physical, emotional, and psychological impact of seeing someone die in front of their eyes with no palliative care in place, no pain management, no dignity and feeling that nothing was being done despite their repeated escalation was clearly a traumatic experience for the staff of the care at home provider. Staff shared they felt helpless and some have required ongoing counselling and support. As a result of this there may have been a failure towards the moral, legal and ethical responsibilities for the wellbeing of these staff.

Due to the severity of P19s living conditions which staff were exposed to, staff were advised of the need to wear full PPE protection on entering the house due to the health and safety risks this posed for them.

The decision by the care at home provider to withdraw support was a very difficult one to make and is not a situation that is common. The reviewers noted that the service did not want to be in the position whereby they felt the need to withdraw support but made that decision based on the impact the situation was having on their staff. There was also the assumption on the part of the care at home provider that if they withdrew the service, they were providing to P19, then Angus HSCP would have to intervene and this would improve P19's situation.

Values and Behaviour
Throughout the review, the reviewers heard that some services felt that their 'voice' was not being heard because of their position or job role and this was possibly because they are perceived to be of a lower grade within the wider hierarchy and as such they felt their expertise and experience was not recognised and that their views not sought or valued by other professionals involved.

Finding
The reviewers recognise the efforts that the care at home provider's staff went to in their efforts to support P19 and that included their persistence to escalate concerns to health professionals and managers. Staff were determined and resourceful and they continued as long as they could despite the impact the situation was having on them.

Recommendation 5.5
The Angus APC should ensure that learning and recommendations from this SCR are shared within Angus and across Tayside and provide assurance to staff that a range of improvements will be implemented to decrease the chances of such a situation happening again.

Recommendation 5.6
A multi-disciplinary approach should be taken across Angus HSCP to ensure all individuals, irrespective of grade or employing organisation who are supporting individuals should have the opportunity to be involved in team discussions and have their contributions valued.

Stigma Relating to Alcohol Issues
The prominent position that alcohol has within our society means that professionals involved in planning and delivering services may well be influenced by some of the prevailing attitudes and perspectives towards the use and abuse of alcohol. There may be feelings of pessimism about the possibility of rehabilitation or recovery; or that the individual is undeserving of help having brought the problem on him or herself; whilst others may feel reluctant to make value judgements about someone else's drinking. It is likely that individual as well as institutional attitudes play a role here and the importance of staff being aware of their own values, beliefs and prejudices is paramount.

The MWC report on ARBD states that disorders relating to alcohol are often subject to stigma, in part, due to the belief that they are self-inflicted. Individuals often become estranged from families and friends and are socially isolated. In the case of those still drinking, anti-social behaviour may be a feature.

It is apparent that the assessment, planning and delivery of care by some professionals involved with P19 was adversely affected by prevailing critical attitudes towards people who abuse alcohol.

Findings
Assumptions were made by services about alcohol misuse being the cause of P19's physical ill health and non-engagement. Staff from agencies such as the care provider and care management encountered attitudes and stigma relating to people with alcohol issues from other professionals including the Scottish

Ambulance and primary care services. It is important that all agencies involved (not just substance misuse specialists) are sensitive to alcohol problems, to approach it in a non-stigmatising way, and to recognise the complex role alcohol plays in relation to other issues. It is difficult to ascertain whether attitude and stigma around alcohol use influenced the care P19 received and whether that impacted on treatment received and pathways experienced. However, a more sensitive and non-stigmatising approach from some professionals to supporting P19 may well have resulted in a more person-centred and pro-active approach being taken to the care and treatment received.

Recommendation 5.7
The AHSCP, Angus Council, NHS Tayside and the ADP should ensure all relevant staff receive training and awareness in relation to alcohol use, substance misuse and co-morbidities to address the attitudes and stigma surrounding these and so that staff know where they can go for support, and where to refer people when they need help. This should include GP's and commissioned service providers.

Recommendation 5.8
NHS Tayside and the AHSCP should consider the need for alcohol enhanced outreach services for individuals who are heavily reliant on acute services and build on any existing work that is already being undertaken in this area.

Non-Engagement and Duty of Care
Services failed to recognise the range of complex factors affecting non-engagement in the context of vulnerability, which had an impact on P19 accessing the support required when it was needed. There is no evidence that these services considered whether P19 had the capacity to understand their welfare needs, make decisions about accepting interventions or had the ability to engage in the way services demanded e.g. travel to and attend clinic appointments.
A variety of services offered P19 services but failed to pursue P19's refusal to engage. There is no evidence that they considered whether P19 had the capacity to understand their welfare needs or make decisions about accepting interventions.

Findings
P19 was offered services, but many services failed to pursue non-engagement. For example, district nursing, bowel testing and orthopaedic follow up. When P19 did not respond to a phone call message or a card left through the door advising P19 to make contact the case was closed, no follow up took place or they were discharged. No assessment of any depth was made before the decision was taken to place the responsibility on P19 to initiate contact for help in the future.

Had P19 been more actively supported to engage with services and had those methods of engagement been more person centred and taken into account an

assessment of P19's abilities to engage in the way that services required, then this may have resulted in maximising intervention at an earlier stage for P19, it would have increased the likelihood of P19 receiving the care, support and treatment required and this, in turn, would have had a significant impact on P19's health and wellbeing.

Recommendation 5.9
NHS Tayside and the HSCP's should develop guidance to assist practitioners in providing safe and appropriate care for individuals who are difficult to engage or who do not attend an appointment. Such guidance should recognise there may be valid barriers to engagement which an individual may need help to overcome and takes account of the severity of concerns and levels of risk and includes support for multiagency systems to co-ordinate positive and assertive engagement.

Recommendation 5.10
The AHSCP should review their assessment and care management procedures to include guidance for staff when an individual who is dependent upon alcohol repeatedly comes to the attention of health and/or social work services. Procedures should ensure an assessment of the individual's capacity to consent to and co-operate with proposed care and treatment necessary to protect his/her health, safety and/or welfare.

Housing
Housing are experiencing an increase in the level of self-neglect of the tenants they are supporting. Regular inspection of houses doesn't ordinarily take place to pick up issues of self-neglect at an early stage. Housing were therefore unaware of the uninhabitable living conditions P19 was found to be living in. A recent restructuring of the housing service has led to smaller patch sizes for Housing Officers which should enable more regular inspections of those tenancies, where housing is aware a vulnerable person resides. Sufficient flexibility now exists within the current system to support this approach.

Housing were unaware that P19's gas had been capped leaving them without heating or hot water for a considerable length of time. A review has now taken place resulting in housing receiving a notification from gas safety section if tenants have had their gas capped.

Housing had no temporary accommodation available for P19 when found by police, in a crisis situation in August 2018 and no other options were offered. The Physical Disability Service Leader identified a potential option and liaised with housing to secure this, resulting in temporary accommodation being sourced. This was the temporary accommodation that P19 remained in, until their death in December 2018.

If a local authority has reason to believe an applicant is homeless it has a duty to secure temporary accommodation until the authority has discharged its homeless

duties. (S29, Part II, Housing (Scotland) Act 1987 as amended). In practice, housing provides temporary accommodation for homeless people from its own stock, Bed & Breakfast accommodation or the units provider by Hillcrest Housing Association. Temporary accommodation is usually full or close to it, particularly in the town P19 resided (although temporary accommodation for homeless people can be provided anywhere in Angus).

P19 had been awaiting allocation of a ground floor property due to a physical deterioration caused by Multiple Sclerosis resulting in difficulty accessing the outside stairs to the property. This process commenced in April 2017 and at date of death on 19 December 2018, P19 was still living in temporary accommodation with outside stairs and awaiting allocation to a ground floor property. This had been delayed for some time due to historical housing debt.

The fact that P19 had historical housing debt meant that the application process for allocation of a ground floor property was suspended. Although this suspension was eventually lifted at the request of a care manager, it took over a year for this to be identified and actioned. The housing allocation policy includes a discretionary allocation procedure for special cases, for example people who are terminally ill and unlikely to be rehoused within existing priority processes. Applications can be made by an applicant or the agency supporting them to the Service Leader, and if approved, these cases will receive a higher priority to ensure they are rehoused quickly. Furthermore, if an applicant is deemed to be homeless (which includes people who have accommodation, but it is not reasonable to occupy it), current housing debt is disregarded. Housing are entitled to take arrears over 1/12 of annual rent into account when deciding to suspend an application for non-homeless applicants.

Housing have now introduced the Housing Adaptations Joint Working Policy. The policy is supported by Housing Options & Occupational Therapy Operational Guidance which sets out joint working arrangements to ensure that all options to meet a person's needs are explored from the earliest opportunity, including the suitability of the property to meet the medium to long term needs of an individual and the opportunities for rehousing. The guidance was reviewed and approved by the Housing Management Team earlier in 2020 and now includes a section covering the role of joint case review meetings to ensure cases are being monitored and reviewed consistently across the 3 housing teams, in partnership with the Occupational Therapy service.

The purpose of the Case Review meetings are to consider any changes in circumstances, determine the complexity and urgency of the household's circumstances and to judge whether the recommended solution can be realised, taking account of any risks and the consequences of the recommended solution not being available at that time. Where it is determined that a housing solution will not be available within either existing stock, new developments or from other initiatives or

options, the case will be referred to the Joint Complex Housing Panel and a Housing Options appraisal will provide evidence of the options considered.

P19's circumstances highlight the importance of these case review meetings in monitoring applications where there is an unmet medical / adaptation need and provides the opportunity to identify any changes in circumstances or barriers to rehousing (e.g. rent arrears) so these can be addressed more proactively.

Good Practice
The Physical Disabilities Service Leader displayed good practice in identifying an opportunity for temporary accommodation for P19 at the point when housing said they had nothing available. Housing then progressed this accommodation quickly.

Housing provided a new bed and bedding for P19 in preparation for P19 returning from an inpatient stay following operation on dislocated shoulder.

Findings
No regular inspecting programme is in place in relation to the inspection of properties. Had this been in place for P19, self-neglect and uninhabitable living conditions would have been identified at a much earlier stage and P19 would not have had to live in the squalid conditions they were found in, for the length of time that they did.

There is a reluctance to expand supply of temporary accommodation due to the move to Housing First and Rapid Rehousing outlined in the Homelessness and Rough Sleeping Action Group's (HARSAG) recommendations in their 2018 report. Clarification is required on roles and responsibilities for vulnerable people requiring temporary housing including who has responsibility to secure accommodation when housing have no accommodation available. In P19's situation the actions of the Physical Disability Service Leader in identifying a potential solution, which housing then progressed, enabled P19 to move from an uninhabitable living environment to temporary accommodation. It is unclear what, if any, accommodation would have been secured for P19 if the Service Leader did not identify this solution, or who had responsibility for ensuring P19 had a suitable living environment to move to.

There is sufficient flexibility already in the housing allocation policy to deal with vulnerable tenants and to have addressed P19's situation, although this flexibility appears to not have been appropriately used in this case. Had the flexibility in the policy been utilised in P19's situation this may have resulted in P19 securing a ground floor property and no longer having to endure difficulties accessing their property due to the outside stairs. This allows individuals or their support workers to apply for discretion if they feel their case merits it. This includes a mechanism for interested

parties to challenge Housing if they feel a service user's needs are not being appropriately addressed.

Recommendation 5.11
Angus Council Communities (housing) should develop clear guidance that provides the flexibility and governance required to ensure regular inspection of those properties where concerns have been raised on a regular basis.

Recommendation 5.12
Angus Council Communities (housing) should develop a protocol in relation to vulnerable people at risk requiring urgent housing that provides clarification on roles and responsibilities for vulnerable people requiring temporary housing. This should make clear who has responsibility to secure accommodation when housing have no accommodation available and this should be made widely available to partners.

Respite Provision
The majority of respite provision in Angus is registered with the Care Inspectorate to provide care to people over 65 only. Although the process of changing the registration to include people under 65 is not particularly long or onerous it does involve being able to evidence to the Care Inspectorate that the provision can suitably meet the needs of people under 65.

Some providers do not feel they can adequately meet the needs of those under 65 within their current provision and are reluctant to progress a change of registration resulting in a lack of beds/availability of care home and respite places for people under 65 in Angus.

P19 was provided with respite care in a provision that was for older people. In order to accommodate P19, this provision firstly had to progress a change of registration with the Care Inspectorate in order to be able to support someone under the age of 65. This was progressed efficiently and quickly, however staff at the provision felt it was an unsuitable environment for P19 and they could not adequately meet their needs due to age, complex needs and the presenting needs of the other service users.

Good Practice
Good practice was identified in displaying flexibility in changing the Care Inspectorate registration category quickly to enable P19 to access the service.

Staff at the respite service evidenced commitment and effort to provide good quality care to P19 albeit they felt they were not adequately trained to do so.

Finding

It is difficult to meet the respite needs of younger people within an older people's respite environment due to the different lifestyles that people lead at different chronological ages. Staff felt they were not adequately trained to meet P19's needs and were only able to meet basic needs. P19 had no understanding or tolerance of the older residents living within the respite environment and staff found this difficult to manage. For these reasons, when a future respite need was identified for P19, this respite provision was unwilling to accept P19 a second time.

Alternative respite options were very limited and P19 refused to stay in the only other available one that was sourced. Had a respite service for people under the age of 65 been available for P19, which provided tailored support within an appropriate environment, with suitably qualified and experienced staff, then this may have resulted in P19 having future respite needs met. It may have influenced how P19 experienced respite provision and their willingness to consider future respite placements. Having a dedicated respite provision for people under 65 may also have meant that P19's specific needs relating to their disabilities would have been met within the respite environment.

Recommendation 5.13

The AHSCP should consider how they will meet the needs of people under the age of 65 who have a need for respite care and progress plans to develop adequate provision. This could include a local, dedicated respite service for people under 65 in Angus who have complex lifestyles and that includes the right type of support and environment for this younger age group along with a suitable environment and suitably qualified and trained staff.

Recommendation 5.14

The AHSCP should provide training to staff in respite services and/or bespoke input or support when they are required to support younger people with complex needs within an older people's respite environment.

Research Question 6 - To what extent and detail should information be provided to COPFS when someone who was subject to Adult Support and Protection measures dies to ensure that COPFS are able to assess the circumstances surrounding a death in those circumstances and direct further investigation and enquiry.

There will be specific reference to:

- who has clear responsibility to notify the Police/COPFS that a person subject to Adult Support & Protection measures has died?
- who the specific Single Point of Contact within the Partnership Agencies should be for engagement with and subsequent provision of information to the Police/COPFS in such circumstances?

Notification and Information Sharing

The Sudden Death Report received by COPFS from Police Scotland did not specify that P19 was an Adult at Risk and was subject to Adult Support and Protection (ASP) procedures at the time of death. The Report did not include any detail of the risks that had been identified for P19 nor the issues relating to mental capacity. As previously highlighted, one reason for this was because Police were unaware that P19 was under formal Adult Support and Protection procedures and had received no notification of this.

In line with the reporting process, the GP provided information to the sudden death report and although P19's GP was aware that P19 was subject to ASP procedures, the GP did not highlight this to the Investigating Officers or directly to the PF.

The reviewers met with a member of the COPFS in respect of this specific death who advised that had information been shared with them, that P19 was subject to ASP procedures and they were made aware of the concerns/risks that were in place at time of death, then it is likely that a more detailed Post Mortem would have been requested than that which was actually undertaken. This may have subsequently led to further enquiries.

The COPFS has noted that in respect of the current electronic form that the Crown receives from Police Scotland to report Sudden Deaths, this form does not have a specific section to indicate that a deceased person was subject to ASP procedures prior to death and this is not replicated in any area in Scotland, where such a notification is provided to the Crown. The same situation applies when the Crown are advised of deaths occurring in a hospital setting by the NHS and inclusion of ASP status on ehealth systems as previously suggested would ensure any NHS clinician completing such notifications would be aware of this information.

During the SCR process, issues were highlighted in respect of the Police being aware of who is actually subject to Adult Support & Protection procedures and Police Officers attending Adult Protection Case Conferences and Reviews. This has resulted in an agreement that reports will be forwarded to Police Scotland on a monthly basis containing the details of all adults who have become subject to Adult Support & Protection and this will also include when a person who has been subject to those procedures is no longer deemed an adult at risk. Police Scotland will ensure its records are kept updated using their own internal processes.

In terms of inviting Police Officers to Case Conferences and Reviews, it has been agreed that this will be at the discretion of the Chair and the Council Officer/Team Manager depending on the need for Police to be part of the discussion. However, this decision should also take into account the views of the adult who may have a preference that the Police do not attend.

Following this, actions have been agreed to be progressed across primary care services to include coding vulnerable adults on practice lists as an adult at risk which will ensure all those supporting an adult are able to view and note that they are dealing with a vulnerable adult and this would extend to other practitioners such as Scottish Ambulance staff.

Findings

The sudden death report failed to include key information that was later identified and shared with the COPFS. Had this information been available to the COPFS at the time of P19s death, a more detailed post-mortem may have been warranted.

The current documentation in use across Scotland (both within hospitals and primary care) does not specifically ask whether the person who has died suddenly was or may have been subject to formal adult support and protection procedures and there is a lack of best practice in reporting sudden deaths when adult protection may be relevant.

Recommendation 6.1

Angus HSCP should review local ASP Operational Instructions to reflect the agreement described within this section in relation to Police Scotland.

Recommendation 6.2

Police Scotland and Primary Care should work together to develop clear guidance for GP's and police detailing the information that sudden death reports should contain including good practice principles on how these reports should be written.

Recommendation 6.3

NHS Tayside should identify a single point of contact within each practice/hospital service with responsibility for providing information to the Procurator Fiscal. This will ensure a process where it is clear where the responsibility lies for notifying the Procurator Fiscal when an adult subject to formal adult support and protection procedures has died and ensuring the correct information is provided.

Recommendation 6.4

Prior to completion of the SCR, a recommendation was submitted to Police Scotland as detailed below:

'Police Scotland and NHS Primary Care Services to ensure that when reporting Sudden Deaths to the Procurator Fiscal, that they should include in their reporting procedures when relevant, that the Deceased was subject to Adult Support and Protection procedures at the time of death'.

Research Question 7: Did all Agencies exercise their full legal Powers to ensure the safety and wellbeing of adult P19?

Use of Legislative Powers

The 3 main legal routes available to keep people safe are via the Adults with Incapacity (Scotland) Act 2000 (AWIA), the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and the Adult Support and Protection (Scotland) Act 2007 (ASPA). No additional legal powers are available to the police apart from these 3 legal routes. Appendix 2 provides a legislative overview of the AWIA 2000 and the ASPA 2007.

There was evidence that the use of The Adults with Incapacity (Scotland) Act 2000 was considered for P19. The detail of this is explained in Research Question 4 of this report in terms of the AWIA decision making meeting that was held, the decision to use section 13ZA to facilitate P19 moving to a care home and the decision to progress welfare guardianship. Due to P19 changing their mind about agreeing to a move to a care home, 13ZA could no longer be utilised. The AWIA process was also stopped after the hospital ward advised that the Consultant Psychiatrist had assessed P19 as having capacity. As a result of this, the AWIA could not progress. The consultant had, in fact, not undertaken an assessment of capacity but a S47 consent to treatment, as highlighted above. There was no evidence that the use of other legal powers had been considered for P19.

The use of the Mental Health Act was not considered. This may not have been appropriate for P19 as the 5 criteria required would not have been met to satisfy this. Guardianship under the Adults with Incapacity Act may have been the best route to pursue rather than a detention, but clarity on capacity is needed to pursue this legal option.

A short-term detention order (if satisfied there is a mental disorder) would not have been appropriate to use as it is only applicable to treat the individual rather than to keep them out of harm's way.

Professionals displayed differing understanding/interpretation of the Mental Health legislation, particularly in relation to assessment of capacity.

There is no evidence that powers under the Adult Support and Protection (Scotland) Act 2007 were considered in relation to P19. There are three Orders that can be applied for by a local authority to protect adults at risk. These are: -

1. Assessment Orders – the purpose of an Assessment Order is to decide whether the person is an adult at risk and, if so, whether action needs to be taken to protect the person from harm. The order is only valid for 7 days. In terms of P19, the ASP case conference had already decided that P19 was an adult at risk and that action was required to protect from harm, as detailed in the risk management

plan. However, it may have been worth exploring if an assessment order would have facilitated the required capacity assessment for P19 and the progression of welfare guardianship, as well as allowing for a formal diagnosis to inform treatment/support as P19 was an adult at risk and was asking for help. It should be noted that whilst a person can be taken to an assessment under an Assessment Order, the person does not need to participate or co-operate with the assessment. Whether this is how this legislation could or should be used would also be relevant to consider in terms of whether legislation should be required to provide an assessment of capacity. Professionals also appeared to lack knowledge and confidence around the use of Assessment Orders as they are not frequently used.

2. Removal Orders – a Removal Order authorises the Council to move the person to a specified place and take reasonable steps to protect the person from harm. In terms of a Removal Order, the Sherriff authorises the location based on the fact that this will protect the adult. Respite facilities have been used within this process in previous cases and a hospital environment may also have been suitable. It could be argued that a Removal Order could have been applied to P19 to remove from the harmful living environment to a place where the care and treatment required could be received in a safe and sanitary environment. The difficulty in utilising this order would have been identifying and securing a suitable place to remove P19 to. The Sherriff has to be satisfied to the availability and suitability of the place to which the adult at risk is to be moved. The order only lasts for 7 days which would not have been enough time to use it to carry out an assessment of capacity and apply for welfare guardianship, following the required period of abstinence from alcohol.

3. Banning Orders. A banning order would not have been applicable in this case as this order is used to prevent someone coming into contact with P19.

It should be noted that a Sheriff cannot make an Assessment Order or a Removal Order if the Sheriff knows that the adult at risk has refused to consent to the order being granted. The Sherriff can only ignore a refusal to consent if he believes the adult has been unduly pressurised to refuse consent or there are no steps which could reasonably be taken with the adult's consent which would protect the adult from the harm which the order or action is intended to prevent.

P19 had been asking for help and willing to co-operate with support/interventions on many occasions. P19 had also refused support/interventions on several occasions such as a second opportunity for respite care. Exploring the likelihood of consent in relation to these orders should have been undertaken.

Under Environmental Health regulations (EPA 1990) legislative powers available focus on statutory nuisance's out with rather than within a person's house and therefore would not have been applicable.

The only legal power available to housing would have been to pursue a Breach of Tenancy leading to eviction. In this case, that would not have been helpful or supportive to P19 and the preferred route was to identify support to improve living conditions.

Consideration was given as to whether there had been a breach of Human Rights legislation in relation to P19's care and treatment. The European Convention on Human Rights (ECHR) is an international convention to protect human rights and political freedoms in Europe. The Human Rights Act 1998 (HRA) incorporates the rights set out in the (ECHR) into domestic British law. This was introduced into UK law in 2000 and means that if human rights have been breached, a case can be taken to a British court rather than having to seek justice from the European Court of Human Rights in Strasbourg, France. By signing up to the ECHR and passing the Human Rights Act 1988, Britain has made a legal commitment to abide by certain standards of behaviour and to protect the basic rights and freedoms of citizens.

In relation to P19, consideration has been given to whether their human rights were breached in relation to Article 3 of the Human Rights Act 1988 which states:

'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'.

Inhuman treatment or punishment is defined in the HRA as treatment which causes intense physical or mental suffering. It includes:
- serious physical assault
- psychological interrogation
- cruel or barbaric detention conditions or restraints
- serious physical or psychological abuse in a health or care setting, and
- threatening to torture someone if the threat is real and immediate.

The ECHR was developed following the second world war to ensure that governments would never again be allowed to dehumanise and abuse people's rights. In this context, the definitions of inhuman treatment covered by the HRA do not appear applicable to the lack of dignity and the degrading living conditions P19 died in.

However, it is also recognised that respect for the fundamental dignity of each and every person lies at the heart of human rights. People accessing health and social care support should not only have their rights recognised, but these rights should be realised. Human rights should be at the very heart of health and social care and embedded in practice. Not providing P19 with access to the right care and the right pathways, may have been a failure of practitioners and/or their managers to take positive action to protect P19's Human Rights.

Findings
Not all legal powers available were considered and not all legal options had been fully explored within the ASP case conference and core group meetings.

Demonstrating that all legal powers available had been considered, fully explored and utilised within the ASP case conference and core group meetings and that these discussions were recorded may have resulted in further actions/interventions being progressed to ensure the safety and wellbeing of P19. The only way that a safe, long term future could have been secured for P19 was through a welfare guardianship. This requires an assessment of capacity. Had P19 accessed an assessment of capacity, at the right time, then this could have been achieved.

There was no evidence that the powers contained within the Adult Support and Protection (Scotland) Act 2007 had been considered and fully explored. If this had been done, it may have established whether an Assessment Order or a Removal Order would have been an appropriate intervention to protect P19 from further harm.

Recommendation 7.1
The AHSCP should amend local operating processes to ensure that a prompt is built into the core group meetings where the core group should consider the need for any of the legal powers available. The chairperson of these meetings should explicitly record why Legal and/or Mental Health Officer representation are not included within the core group membership, if this is the case.

Recommendation 7.2
The Angus Adult Protection Committee should review adult protection training to ensure, within the training, that there is a clear focus on the use of emergency powers covered in the training, as well as clarity of communication; ability to challenge another professional's decisions and that the views of others are considered. This should also consider how to address the issue of workers becoming unfamiliar with and less skilled in the use of legal interventions due to them being infrequently used.

Recommendation 7.3
The Angus Adult Protection Committee should consider the introduction of training for relevant staff that provides an overview of the 3 Acts available to keep people safe: the Adults with Incapacity (Scotland) Act 2000 (AWIA), the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and the Adult Support and Protection (Scotland) Act 2007 (ASPA). From a learning perspective consideration should be given to requesting input and guidance from the Sherriff's Office in terms of criteria around the use of relevant orders including how these are used effectively in other areas of the country.

PART 3 SUMMARY AND CONCLUSION

P19 was recognised as an adult at risk and there seems to have been a genuine effort on the part of professionals involved to engage and support P19, albeit unsuccessfully to the point of being able to prevent death as a result of advanced bowel cancer. Clearly, there are lessons to be learned from the events that led to such a sad outcome and these have been reflected in the learning and recommendations within this report.

This has been both a challenging case and a challenging process for some of the staff involved in supporting P19 and the emotional impact of the work and of the case outcome is understandably still being felt. The involvement by those staff who worked closely with P19 was essential to the learning available from this Review and, without exception, their engagement has been open, positive, constructive and reflective.

The interconnection of diagnosis of bowel cancer, management of associated symptoms, capacity assessment, understanding the impact of alcohol use in identifying risk, delivering multiagency risk management plans together with P19 and information sharing all played a part on the overall experience and outcomes for P19. Whilst there are practice improvements that can be made in some single agency process and procedures, P19 had an advanced bowel cancer and no actions would have prevented P19 from dying. However, P19's life may have been extended and they should have been allowed to die well and die with dignity but were failed this in the last few months of life.

This case highlights a number of challenges that exist for professionals when the needs of an individual do not neatly meet the criteria for existing services and leads to unmet needs (for example, the ability to provide a timely capacity assessment for someone under 65 years of age). In this case, the assessment of mental capacity was not straightforward and highlights challenges in this complex area.

As stated in the introduction, this SCR was commissioned by the AAPC to be delivered by Internal Reviewers in order that the best local learning could be achieved. The review has highlighted findings and broad recommendations that will enable the AAPC to reflect on their partnership and collaborative leadership and develop an action plan and associated performance outcomes to ensure long term sustainable system change is achieved.

AAPC are committed to supporting partners to ensure the organisational culture both within and between agencies involved in adult protection creates the conditions for real learning and change to occur. The Reviewers would encourage AAPC to involve and consult staff in ideas for change, as there were ideas and innovations borne from individual experience within our systems that should be capitalised upon.

Summary of Recommendations

Recommendations are set out in this summary by research question and we have added letters in the right hand column to indicate which agencies the recommendation relates.

Key to table letter codes

A	Angus Adult Protection Committee (APC)
B	Angus Council
C	Angus Council and NHS Tayside
D	Angus Health and Social Care Partnership (AHSCP)
E	All Statutory Partners/All Agencies (NHS Tayside, AHSCP, Angus Council, Police Scotland)
F	NHS Tayside
G	NHS Tayside and AHSCP
H	NHS Tayside, AHSCP, Angus Council
I	NHS Tayside, AHSCP, Angus Council, Angus Alcohol and Drugs Partnership (ADP)
J	NHS Tayside and HSCP's/ All Health professionals
K	Police Scotland and NHS Primary Care

Research Question 1 **In respect of P19, to what extent was the information held by Agencies shared appropriately within that Agency and with other partner Agencies?**	
Recommendation 1.1 Angus Council and NHS Tayside should agree and implement methods that will enable interoperability and access of recording systems, with a focus on improving information sharing between acute, primary care and the Scottish Ambulance services and effective information sharing at points of transition of care between primary care services, adult care services, housing and care providers.	**C**
Recommendation 1.2 Although good record keeping was found across several service areas not all records were completed to the required agency/organisation/professional standards. To provide assurance of this, all agencies should have robust governance processes in place to ensure record keeping is of the required standard and supports effective communication and decision making.	**E**
Recommendation 1.3 The District nursing service should undertake an audit of records across the service and develop an action plan to address the poor record keeping, in	**D**

line with the NHS Tayside Record Keeping Policy and NMC Standards for Record Keeping. This should have a particular focus on ensuring that records reflect the current circumstances of the individual.	
Recommendation 1.4 Homecare should complete the programme of updating processes and guidance across the service that has commenced in relation to case recording and referral information. The service should implement an audit of records across the service and develop an action plan to address the poor record keeping.	**D**
Recommendation 1.5 NHS Tayside should review hospital discharge procedures to ensure processes for sharing information on hospital discharge are robust and this happens timeously to inform community services. District Nurses should be included in these procedures. They should consider the appointment of a health professional to co-ordinate health input/ monitor health needs ensuring links to primary healthcare are made for community settings.	**F**
Recommendation 1.6 The AHSCP should consider the development of an enhanced care service for people under 65 to include expanding the current MDT system to enable it to be more flexible, responsive, and inclusive to need, rather than be focussed on age. This should include considering a review of the provision of ANP roles across Angus to ensure equity of access and support to treatments and consideration of an ANP within the AIDARS service.	**D**
Recommendation 1.7 NHS Tayside should progress the finalisation of work currently underway to introduce an electronic referral process from Primary Care to the Acute Medical Unit (AMU), assess whether any similar referral processes are required between Primary Care and other acute services and, develop clear referrals processes where they are required.	**F**
Recommendation 1.8 The AHSCP should ensure all services have a system in place to provide assurance that a case referral made from one service to another has been received and that the required support has commenced, prior to current service support ending and the case being closed. This will ensure that no one is left without any ongoing support when they have been assessed as requiring it.	**D**

Research Question 2 **Determine the extent to which decisions and actions were person centred.**	
Recommendation 2.1 Primary Care services consider the use of the Palliative prognostic score which might prompt clinicians to realise that someone is dying, even in the absence of a diagnosis.	**G**

Recommendation 2.2 Health care professionals should be committed to the provision of consistently high-quality end of life care for all that reflects the 4 principles set out in The Scottish Government's guidance for caring for people in the last days and hours of life (2014).	**J**
Recommendation 2.3 Services within AHSCP should ensure they support integrated working and the involvement of the correct professionals/agencies at the correct time. Consideration should be given to inviting Social Care Officers (SCOs) to practice MDTs or ECS meetings. There is a need for clear information and guidance to be made available for staff about what health services are available and how these can be accessed.	**D**
Recommendation 2.4 The AHSCP should review the process for referring to District Nurses to adopt a person centred rather than a task focussed approach. This review should include a system where, when required, individuals are admitted to the District Nursing caseload rather than just receiving input for specific tasks to ensure a holistic and person-centred approach to meet the health needs of individuals. Written criteria relating to the role of the District Nursing service and the referral process should be made widely available to aid understanding of the district nursing role and how it can be accessed.	**D**
Recommendation 2.5 AHSCP should review the current reach of anticipatory care planning to ensure that patient's receive care earlier rather than later and that information is available to all professionals involved in unscheduled and secondary care.	**D**
Recommendation 2.6 NHS Tayside should consider a pathway for admission to an acute medical hospital setting for people with chronic long-term issues where wider acute medical problems cannot be managed within primary care settings.	**F**
Recommendation 2.7 NHS Tayside should consider the need to develop a "suspected cancer" fast-track service that GPs can access.	**F**
Recommendation 2.8 Angus HSCP should review the falls pathway to include confirmation to referrers that the referral has been received, what follow up action will be taken and when and alerting referrers to issues of non-engagement and case closure.	**D**
Recommendation 2.9 The Angus Falls service should consider liaising with Occupational Therapists and Physiotherapists who attend practice Multidisciplinary Team meetings (MDTs) and ECS meetings.	**D**

Recommendation 2.10 Angus HSCP should review the need for staff education and training in relation to the Falls Pathway.	**D**

Research Question 3 **To what extent did one Professional/Agency have a lead role and hold responsibility for P19 and their Protection Plan; to monitor what was being achieved, any gaps in assessment, planning and decision making and associated risks?**	
Recommendation 3.1 Angus APC review the learning and development and quality assurance opportunities in place to support staff, Managers and Review Officers to develop consistent practice in producing adult protection plans that are linked to a clear assessment of need and risk, which are reviewed to ensure they are dynamic in nature, clear for the adult at risk and offer direction to agencies involved.	**A**
Recommendation 3.2 Angus APC should develop clear guidance in relation to decision-making and accountability of the various stages of the ASP process e.g. referral, investigation, case conference and that any guidance is supported by a governance and quality assurance process that monitors the effectiveness of the process. Staff training should be provided to ensure this is clearly understood and local operational procedures should be reviewed within this context.	**A**
Recommendation 3.3 The AHSCP should ensure that membership of core group meetings should include health professionals and the introduction of Adult Protection Advisor posts within NHS Tayside should be considered to support ASP meetings to ensure there is always adequate representation, good decision making and escalation.	**D**
Recommendation 3.4 For those subject to ASP measures and in hospital for two weeks or more, consideration should be given to developing a joint process with the locality HSCPs and NHS Tayside that allows, at the point of discharge, a joint ASP core group and pre-discharge planning meeting to take place.	**J**
Recommendation 3.5 All statutory partners should explore how advocacy services can become more involved in the ASP/AWIA process to ensure adults are supported throughout these processes. This should include reviewing current practice and identifying barriers to the involvement of advocacy.	**E**
Recommendation 3.6 Angus HSCP should review the documentation process for core group meetings to ensure they are able to evidence the discussion and decision making. This should include considering the role and provision of admin to	**D**

support operational staff preparing minutes for AP meetings. It would also be helpful to add a section to the current documentation that allows for 'barriers to information sharing and agreed actions to mitigate against the risk of information not being shared" being captured.	
Recommendation 3.7 All statutory partners should ensure that the Tayside ASP Minimum Learning Standards that have been identified for ASP training are shared and that training is available within each partner organisation to meet these requirements and that training data is shared routinely with the Angus APC.	**E**
Recommendation 3.8 The Angus Adult Protection Committee should review the Tayside Escalation Good Practice Guide to ensure escalation and professional accountability in adult support and protection cases includes clear information on escalation expectations particularly where serious concerns exist and effecting the desired change is not being achieved. This guidance should be shared and promoted widely to ensure staff are aware of it and a consistent approach is implemented.	**A**
Recommendation 3.9 The Angus Adult Protection Committee should develop criteria for the role of the case holder with lead responsibility for ASP cases. This could be included within the above guidance, with a clear focus on empowering them to make decisions.	**A**
Recommendation 3.10 All agencies should update their local operating procedures to reflect the above guidance which should include having one clear case holder with responsibility for the case. Although it is recognised that it is often necessary to have more than one service co-working a case and collaborating to achieve best outcomes for the individual, there should be one clear case holder leading the co-ordination of complex cases, to ensure clear lines of accountability.	**E**
Recommendation 3.11 The AHSCP should consider the role of a lead professional within adult support and protection processes and what the role, function and decision making requirements would be.	**D**
Recommendation 3.12 The AHSCP should ensure Service Leaders have a robust system in place for monitoring ASP cases and raising these with Team Managers in supervision. The AHSCP should consider the extent to which there is a culture of support in managing complex adult support and protection cases, including time for cases to be explored, risks to be escalated and decisions to be given some further oversight and governance. Staff need to understand how Senior Managers can influence. Clear information should be provided to Team Managers about the role and responsibilities of Service Leaders which is consistent across all services within the AHSCP.	**D**

Recommendation 3.13 The Angus Adult Protection Committee should provide training to care at home staff about thresholds, escalation and person-centred care and accountability in the context of adult protection. This could be informed by the Tayside Practitioners good Practice Guide.	**A**
Recommendation 3.14 Angus Council should ensure that contracts with providers make explicit escalation responsibilities. This should include clear information to the provider on how to escalate concerns and who to escalate these to.	**B**

Research Question 4 **How effective are the current processes for requesting a Capacity Assessment within NHS Tayside and how these processes are applied in practice?**	
Recommendation 4.1 NHS Tayside should develop a clear pathway for accessing an assessment of capacity. This should include individuals with alcohol issues, those who have substance use dependencies and people with a physical disability who are not accessing a psychiatry service and should be irrespective of age.	**F**
Recommendation 4.2 NHS Tayside, the AHSCP and Angus Council should develop a protocol for sharing the outcome of a capacity assessment with the care team, particularly if an adult is deemed to retain capacity. This should include guidance in relation to where there are challenges in terms of determining if someone has capacity. If they are under ASP measures, there should be a specific plan identified in terms of identifying how the capacity assessment will be progressed, with clear actions and timescales identified.	**H**
Recommendation 4.3 NHS Tayside should ensure appropriate AWIA education and training is provided to relevant acute and primary care services on the difference between an assessment of capacity and S47 consent to treatment. This should include GPs, so they are clear on their role in terms of undertaking assessments such as S47 and capacity assessments. Local operating procedures should be updated to make this explicit.	**F**
Recommendation 4.4 The AHSCP, Angus Council and NHS Tayside should ensure that ASP/AWIA training, including regular refresher training, is made mandatory for all relevant professionals. Clear governance should put in place to ensure mandatory and refresher training is undertaken by all staff.	**H**
Recommendation 4.5 NHS Tayside should develop procedures for identifying and investigating impaired cognitive function, including alcohol-related cognitive impairment. Such protocol and procedures should identify appropriate referral and treatment options.	**F**

Recommendation 4.6 NHS Tayside, Angus Council and the AHSCP should provide guidance and training for staff around the relationship between alcohol, care, capacity and ARBD. All appropriate staff should be trained in the identification, assessment, and management of ARBD. This should include responsibility to assess the impact of persistent alcohol abuse on an individual's capacity to respond to proposed care and treatment plans, the potential role of protective legislation in implementing care plans to protect individuals and clarity on how long an individual requires to be abstinent from alcohol before a capacity assessment can be undertaken. The resulting agreed process should be shared across Tayside. The Angus Alcohol and Drugs Partnership intend to explore commissioning some bespoke training for staff on this issue.	**H**

Research Question 5 **To what extent is Self-Neglect understood across the multi-agency Adult Protection partnerships and wider Adult Protection providers?**	
Recommendation 5.1 Angus APC should consider additional learning opportunities on understanding and dealing with self-neglect on a multiagency basis and should include information on the legal framework surrounding this issue. Such training should include a specific focus on alcohol-dependent adults and recognise the complicated role that alcohol plays in adult protection and that 'lifestyle choice' is often an unhelpful paradigm, and to avoid stigmatising those who misuse alcohol.	**A**
Recommendation 5.2 Angus APC should continue to promote the Practitioner's Guidance and review this in light of learning from this case. Additionally, there would be merit in seeking feedback on this toolkit from practitioners on its relevance in order to further refine and enhance the guidance over time.	**A**
Recommendation 5.3 NHS Tayside should build on the process adopted for MAPPA alerts to include alerts for vulnerable adults within ehealth systems such as EMIS/Trak and that such alerts can also be used to highlight risks such as non-engagement that can then be acted upon. NHST should develop a Standard Operating Procedure to better manage and track vulnerable patients who fail to attend clinic appointments.	**F**
Recommendation 5.4 Partners within Angus HSCP should develop and implement a process which allows staff to purchase basic items quickly when required to ensure essential care can be provided in cases of extreme self-neglect.	**D**

Recommendation 5.5 The Angus APC should ensure that learning and recommendations from this SCR are shared within Angus and across Tayside and provide assurance to staff that a range of improvements will be implemented to decrease the chances of such a situation happening again.	**A**
Recommendation 5.6 A multi-disciplinary approach should be taken across Angus HSCP to ensure all individuals, irrespective of grade or employing organisation who are supporting individuals should have the opportunity to be involved in team discussions and have their contributions valued.	**D**
Recommendation 5.7 The AHSCP, Angus Council, NHS Tayside and the ADP should ensure all relevant staff receive training and awareness in relation to alcohol use, substance misuse and co-morbidities to address the attitudes and stigma surrounding these and so that staff know where they can go for support, and where to refer people when they need help. This should include GP's and commissioned service providers.	**I**
Recommendation 5.8 NHS Tayside and the AHSCP should consider the need for alcohol enhanced outreach services for individuals who are heavily reliant on acute services and build on any existing work that is already being undertaken in this area.	**G**
Recommendation 5.9 NHS Tayside and the HSCP's should develop guidance to assist practitioners in providing safe and appropriate care for individuals who are difficult to engage or who do not attend an appointment. Such guidance should recognise there may be valid barriers to engagement which an individual may need help to overcome and takes account of the severity of concerns and levels of risk and includes support for multiagency systems to co-ordinate positive and assertive engagement.	**J**
Recommendation 5.10 The AHSCP should review their assessment and care management procedures to include guidance for staff when an individual who is dependent upon alcohol repeatedly comes to the attention of health and/or social work services. Procedures should ensure an assessment of the individual's capacity to consent to and co-operate with proposed care and treatment necessary to protect his/her health, safety and/or welfare.	**D**
Recommendation 5.11 Angus Council Communities (housing) should develop clear guidance that provides the flexibility and governance required to ensure regular inspection of those properties where concerns have been raised on a regular basis.	**B**
Recommendation 5.12 Angus Council Communities (housing) should develop a protocol in relation to vulnerable people at risk requiring urgent housing that provides clarification on roles and responsibilities for vulnerable people requiring temporary housing. This should make clear who has responsibility to secure	**B**

accommodation when housing have no accommodation available and this should be made widely available to partners.	
Recommendation 5.13 The AHSCP should consider how they will meet the needs of people under the age of 65 who have a need for respite care and progress plans to develop adequate provision. This could include a local, dedicated respite service for people under 65 in Angus who have complex lifestyles and that includes the right type of support and environment for this younger age group along with a suitable environment and suitably qualified and trained staff.	**D**
Recommendation 5.14 The AHSCP should provide training to staff in respite services and/or bespoke input or support when they are required to support younger people with complex needs within an older people's respite environment.	**D**

Research Question 6 **To what extent and detail should information be provided to COPFS when someone who was subject to Adult Support and Protection measures dies to ensure that COPFS are able to assess the circumstances surrounding a death in those circumstances and direct further investigation and enquiry?**	
Recommendation 6.1 The AHSCP should review local ASP Operational Instructions to reflect the agreement described in this section in relation to Police Scotland.	**D**
Recommendation 6.2 Police Scotland and Primary Care should work together to develop clear guidance for GP's and police detailing the information that sudden death reports should contain including good practice principles on how these reports should be written.	**K**
Recommendation 6.3 NHS Tayside should identify a single point of contact within each practice/hospital service responsible for the provision of information to the Procurator Fiscal. This will ensure a process where it is clear where the responsibility lies for notifying the Procurator Fiscal when an adult subject to formal adult support and protection procedures has died and ensuring the correct information is provided.	**F**
Recommendation 6.4 Prior to completion of the SCR, a recommendation was submitted to Police Scotland as detailed below: 'Police Scotland and NHS Primary Care Services to ensure that when reporting Sudden Deaths to the Procurator Fiscal, that they should include in their reporting procedures when relevant, that the Deceased was subject to Adult Support and Protection procedures at the time of death'.	**K**

Research Question 7 **Did all Agencies exercise their full legal Powers to ensure the safety and well-being of adult P19?**	
Recommendation 7.1 The AHSCP should amend local operating processes to ensure that a prompt is built into the core group meetings where the core group should consider the need for any of the legal powers available. The chairperson of these meetings should explicitly record why Legal and/or Mental Health Officer representation are not included within the core group membership, if this is the case.	**D**
Recommendation 7.2 The Angus Adult Protection Committee should review adult protection training to ensure, within the training, that there is a clear focus on the use of emergency powers covered in the training, as well as clarity of communication; ability to challenge another professional's decisions and that the views of others are considered. This should also consider how to address the issue of workers becoming unfamiliar with and less skilled in the use of legal interventions due to them being infrequently used.	**A**
Recommendation 7.3 The Angus Adult Protection Committee should consider the introduction of training for relevant staff that provides an overview of the 3 Acts available to keep people safe: the Adults with Incapacity (Scotland) Act 2000 (AWIA), the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and the Adult Support and Protection (Scotland) Act 2007 (ASPA). From a learning perspective consideration should be given to requesting input and guidance from the Sherriff's Office in terms of criteria around the use of relevant orders including how these are used effectively in other areas of the country.	**A**

References and Key Documents

Alcohol Change UK (2019) - Learning from Tragedies, An analysis of alcohol-related Safeguarding Adult Reviews

Angus Adult Protection Committee (2018)- Initial and Significant Case Review Guidance

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Scotland, Scottish Fire and Rescue Service (2019) – Protecting and Supporting Adults at Risk in Tayside, Multi Agency Adult Support and Protection Protocol
Angus Council (2015) - Adults with Incapacity Act Operational Instructions
Angus Council (2017 -updated 2020) - Housing Adaptations – Housing Options & Occupational Therapy Operational Guidance
Angus Council (2017) - Housing Adaptations Joint Working Policy
Angus Council (2013) - Mental Health Officer Operational Instructions
Angus Health and Social Care Partnership (2017 updated 2019) - Adult Support and Protection Operational Instructions
Angus Social Work and Health (no date) - Angus HSCP SW to Falls Service Pathway
Crown Office & Procurator Fiscal Service, Scotland's Prosecution Service (2015) - Reporting Deaths to the Procurator Fiscal - Information for Medical Practitioners
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Dr Anne Campbell, Dr Trisha Forbes, Dr Aisling McLaughlin, Professor Gavin Davidson, Dr Michelle Butler, Dr Trisha Forbes, Dr Carolyn Blair, Norma Menabney, Dr Clare McKeaveney (2019) - Queens University Belfast Rapid Evidence Review: The Relationship between Alcohol and Mental Health Problems
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NHS Tayside (2019) Policy for Records and Record Keeping for Registered Nurses, Midwives and Specialist Community Public Health Nurses
Nursing and Midwifery Council (NMC) (2015) The Code: Professional Standards of Practice and behaviour for Nurses and Midwives
Scottish Government (2000) – Adults with Incapacity (Scotland) Act
Scottish Government (2007) - Adult Support and Protection (Scotland) Act 2007
Scottish Government (2017) - Health and Social Care Standards – My support, my life
Scottish Government (2018) - Homelessness and Rough Sleeping Action Group: Final Recommendations Report 2018
Scottish Government (1987 and 2006) - Housing (Scotland) Act 1987 and 2006
Scottish Government (2019) - Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review
Scottish Government (2003) – Mental Health Care and Treatment Act (Scotland) 2003
Scottish Government (2014) - The Public Bodies (Joint Working) (Scotland) Act 2014
Social Care Institute for Excellence (2020) - New resources for safeguarding, social work and care providers

South Gloucester Council (2020) - Safeguarding Review in respect of Adult A
Stirling University commissioned by the Scottish Executive (2004) - A Fuller Life: Report of the Expert Group on Alcohol Related Brain Damage'
UK Government (2018) - Data Protection Act 2018.
UK Government (2018) - Guide to the General Data Protection Regulation
UK Government (1988) – Human Rights Act
UK Government (2018) - Network and Information Systems Regulations 2018

Appendix 1

SIGNIFICANT CASE REVIEW – P19
TERMS OF REFERENCE

1. **Initial Case Review**

   As a result of an Adult Protection referral submitted by Angus Integrated Drug and Alcohol Recovery Service (AIDARS), an Initial case Review was undertaken and completed into the circumstances surrounding Adult P19.

   P19 was subject to Adult Protection measures and a Protection Plan was in place at the time of death.

   The conclusion of the Initial Case Review identified a number of issues that a Significant Case Review (SCR) should focus on and explore further, in respect of the Terms of Reference which are set out below, with a view to identifying lessons learned and opportunities for practice learning and improvement, as well as recognising good practice.

   It should be noted that there has been a delay from the end of the ICR process to the point where the SCR process has commenced as the Crown Office & Procurator Fiscal Service (COPFS) requested they be given a period of time to further consider the circumstances of this case from a legal/criminal perspective. Having completed further enquiry, COPFS have now intimated they are content for the SCR process to commence.

2. **Timeframe**

   The SCR will explore the involvement and interaction with and between the Agencies involved with P19 from 20th August 2018 (start of a significant period of escalation in behaviour/risk/illness) until 19th December 2018 when P19 died. However, prior to 20th August, a number of Agencies did have contact and interaction with P19 which the SCR should also consider, given that information available to those Agencies had an impact on the Care and Risk management of P19 prior to 20th August 2018.

   Specifically, the SCR should focus on the following questions;

Research Question 1:

In respect of P19, to what extent was the information held by Agencies shared appropriately within that Agency and with other partner Agencies?

- Explore good practice in Information sharing which impacted on assessment and decision making.
- Explore what, if any, barriers existed to the sharing of information which would have impacted on assessment and decision making.

- Explore the extent of actions taken by Professionals and how these impacted on the final outcome in respect of P19's life.

There will be specific follow-up on some of the issues identified in the ICR in respect of:

- Information sharing within and across Health Services to other Services involved with P19.
- Information sharing within and across all NHS Services to include Primary Care, Acute services and the Scottish Ambulance Service.
- Information known to single Agencies across the Angus Health & Social Care Partnership and Angus Council.

Research Question 2:

Determine the extent to which decisions and actions were person centred.

Specific consideration should be given as to whether appropriate weight was given to the diagnosis and extent and complexity of P19's mental health conditions in regard to assessment, intervention and decision making and how this affected professional support

Research Question 3:

To what extent did one Professional/Agency have a lead role and hold responsibility for P19 and their Protection Plan; to monitor what was being achieved, any gaps in assessment, planning and decision making and associated risks?

There will be specific reference to the implementation and understanding of Adult Support and Protection processes and opportunities for intervention with P19.

There will also be specific reference to the use of Chronologies and Risk Management plans and opportunities to have a fuller understanding of P19's risks and experiences.

Research Question 4:

How effective are the current processes for requesting a Capacity Assessment within NHS Tayside and how these processes are applied in practice?

There will be specific reference to:

- the understanding of Capacity Assessments and their application in practice.
- respectful challenge of decisions made around Capacity Assessments and the process for so doing.
- consider opportunities to review capacity in light of the deterioration of a person's health and well-being (such as self-neglect) and how does this inform a dynamic Risk Assessment and Care Management Plan.
- how any Capacity Assessment(s) undertaken took full account of P19's personal situation and conditions.

Research Question 5:
To what extent is Self-Neglect understood across the multi-agency Adult Protection partnerships and wider Adult Protection providers?
There will be specific reference to:

- exploring potential barriers to P19 receiving appropriate levels of care and treatment to ensure their personal dignity and well-being was maintained and enhanced.
- considering how Services balanced P19's protection from self-neglect and P19's right to self-determination.
- considering the wider social and health implications in terms of staff and the wider public as a result of the level of P19's self –neglect, illnesses and associated environmental conditions.

Research Question 6:
To what extent and detail should information be provided to COPFS when someone who was subject to Adult Support and Protection measures dies to ensure that COPFS are able to assess the circumstances surrounding a death in those circumstances and direct further investigation and enquiry.
There will be specific reference to:

- who has clear responsibility to notify the Police/COPFS that a person subject to Adult Support & Protection measures has died?
- who the specific Single Point of Contact within the Partnership Agencies should be for engagement with and subsequent provision of information to the Police/COPFS in such circumstances?

Research Question 7:
Did all Agencies exercise their full legal Powers to ensure the safety and well-being of adult P19?

Involvement of the Family:
The SCR Lead Reviewer will seek contributions to the review from appropriate family members and keep them informed of key aspects and progress should they intimate they wish to be involved. The SCR Terms of Reference should be shared with the family.

Outcomes of the SCR:
With reference to the above Research questions, the SCR will:

- Identify areas of good practice that should be developed and replicated in Adult Support and Protection work.

- Establish any learning from this Case as to how local Professionals and Agencies should work jointly to safeguard Adults at risk of significant harm.

- Identify any actions to be implemented by the Angus Adult Support and Protection Committee to promote learning and develop training in order to support and improve processes and practice.

- To determine whether, and if so, what changes in practice are necessary to prevent future missed opportunities in Adult Support and Protection cases.

Approach:
A Lead Reviewer will be appointed to lead the SCR work and to prepare a Report based upon the findings from the afore-mentioned research questions and any other relevant information gathered during the course of the review.
A Case Review Team will be established to take a learning approach to this Case and focus on a 'Network of Support' type analysis of the work relating to P19 to ensure that the views and experiences of the staff involved with P19 re fully included in the SCR.
The Lead Reviewer will provide regular updates on the progress of the SCR to the Independent Chair of the Angus Adult Support and Protection Committee to whom the final SCR Report should be submitted.

Appendix 2

SCR – P19

Legislative Overview

The Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act")

The Adult Support and Protection (Scotland) Act 2007 ("the 2007 Act")

The purpose of this document is to provide an overview of the legislative provision/measures contained in the above two Acts and to set out how these Acts can be used in a way to protect persons and the benefits and limitations of the measures that can be taken.

It has been written having regard to the information available in respect of P19 and should not be considered a comprehensive statement of the law in relation to these two Acts.

The 2000 Act

Section 57(1) provides that an application may be made under this section by any person (including the adult himself) claiming an interest in the property, financial affairs or personal welfare of an adult to the sheriff for an order appointing an individual or office holder as guardian in relation to the adult's property, financial affairs or personal welfare.

Where the sheriff is satisfied in considering an application under section 57 that–

(a) the adult is incapable in relation to decisions about, or of acting to safeguard or promote his interests in, his property, financial affairs or personal welfare, and is likely to continue to be so incapable; and

(b) no other means provided by or under this Act would be sufficient to enable the adult's interests in his property, financial affairs or personal welfare to be safeguarded or promoted,

he may grant the application.

Where it appears to the local authority that–

(a) the conditions mentioned in(a) and (b) apply to the adult; and
(b) no application has been made or is likely to be made for an order under this section; and
(c) a guardianship order is necessary for the protection of the property, financial affairs or personal welfare of the adult,

they must apply under this section for an order.

An application for a welfare guardianship must be accompanied by three reports. These are two reports of an examination and assessment of the adult carried out not more than 30 days before the lodging of the application by at least two medical

practitioners, one of whom, in the case where the incapacity is by reason of mental disorder must be a medical practitioner having special experience in the diagnosis and treatment of mental disorder. The other must be from Mental Health officer containing his opinion on the general appropriateness of the Order sought (based on an interview and assessment of the adult carried out not more than 30 days before the lodging of the application) and the suitability of the individual nominated in the application to be appointed guardian.

The Chief Social Work Officer of a local authority may only be appointed as a welfare guardian.

Once an application for a guardianship has been lodged in court, it is open to the applicant to seek interim orders and must satisfy the Sheriff that these are necessary pending the disposal of the application. This allows steps to be taken immediately to protect or promote the adult.

A guardianship application must set out the powers that the applicant wishes to have in relation to the adult and can be detailed and comprehensive. The Sheriff will carefully consider the terms of each powers sought and will consider whether these are necessary having regard to the extent and nature of the adult's incapacity and their individual circumstances. Guardianship Orders can, for example, contain the following powers: -

1/ Permitting the Guardian to consent to medical treatment.
2/ Permitting the Guardian to determine where the adult should reside and what care they should receive,
3/ Permitting the Guardian to determine who the adult can consort with; and
4/ Permitting the Guardian to determine the adult's presentation, diet and personal care.

When a guardianship is granted the Sheriff determines how long the Guardianship should last. A Guardianship normally last for a period of 3 years or such other period (including an indefinite period) as, on cause shown, the Sheriff may determine.

Section 47 of the 2000 act permits a number of professionals (including medical practitioners the medical practitioner primarily responsible for the medical treatment of the adult, registered nurses, dentists and ophthalmic opticians) to certify that he is of the opinion that an adult is incapable in relation to a decision about the medical treatment in question. If such a certificate is signed, then medical treatment can be carried out in relation to this adult. The certificate relates solely to medical treatment and in no way relates to the capacity of the adult to determine any other matter. An adult can have the capacity to consent or otherwise to medical treatment but lack the capacity to make many other decisions.

The 2000 Act contains other powers available to others in relation to an adult. These include applying for Intervention Orders (when a longer term Guardianship is not considered appropriate) and Access to Funds in relation to an adult's finances. However, these are not considered directly relevant in these circumstances.

The 2007 Act

The 2007 Act contains provisions/measures that can be used to protect "Adults at risk". Adults at risk are adults who—

(a) are unable to safeguard their own well-being, property, rights or other interests,
(b) are at risk of harm, and
(c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

An adult is at risk of harm if—

(a) another person's conduct is causing (or is likely to cause) the adult to be harmed, or
(b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

There are three Orders in terms of the 2007 Act that can be applied for by a local authority to protect adults at risk. These are: -

1/ Assessment Orders (Section 11)
2/ Removal Orders (Section 14); and
3/ Banning Orders (Section 19).

It is not considered that Banning Orders are relevant in this instance given that a Banning Order prevents someone from coming into contact with the Adult.

Section 11 of the 2000 Act provides that a council may apply to the sheriff for an Assessment Order which authorises a council officer to take a specified person from a place in order to allow—

(a) a council officer, or any council nominee, to interview the specified person in private, and
(b) a health professional nominated by the council to conduct a private medical examination

of the specified person

The purposes of the assessment order are to assist the Council to decide

(a) whether the person is an adult at risk, and
(b) if it decides that the person is an adult at risk, whether it needs to do anything (by performing functions under the 2007 Act or otherwise) in order to protect the person from harm.

An Assessment Order is valid from the date specified in the Order and expires 7 days after that date.

The criteria for granting the Assessment Order is that the Sheriff may grant an assessment order only if satisfied: -

(a) that the council has reasonable cause to suspect that the person in respect of whom the order is sought is an adult at risk who is being, or is likely to be, seriously harmed,
(b) that the assessment order is required in order to establish whether the person is an adult at risk who is being, or is likely to be, seriously harmed, and
(c) as to the availability and suitability of the place at which the person is to be interviewed and examined.

A person may be taken from a place in pursuance of an assessment order only if it is not practicable (due to a lack of privacy or otherwise) to—

(a) interview the person under section 8, or
(b) conduct a medical examination of the person,

during a visit.

It should be noted that whilst a person can be taken to an assessment under an Assessment Order, there is no power to compel the person to participate or co-operate with the assessment.

Section 14 of the 2000 Act provides that a council may apply to the sheriff for a removal order which authorises—

(a) a council officer, or any council nominee, to move a specified person to a specified place within 72 hours of the order being made, and
(b) the council to take such reasonable steps as it thinks fit for the purpose of protecting the moved person from harm.

A removal order expires 7 days (or such shorter period as may be specified in the order) after the day on which the specified person is moved in pursuance of the order.

The sheriff may grant a Removal Order only if satisfied—

(a) that the person in respect of whom the order is sought is an adult at risk who is likely to be seriously harmed if not moved to another place, and
(b) as to the availability and suitability of the place to which the adult at risk is to be moved.

There are provisions in relation to contact with other persons, but they are not considered relevant in this instance. There also provisions in relation to the variation or recall of a Removal Order and in respect of the protection of a person's property but they are not considered relevant in this instance.

Section 35 of the 2000 Act provides that a Sheriff must not make an Assessment or Removal Order if the sheriff knows that the affected adult at risk has refused to consent to the granting of the order. Notwithstanding this a refusal to consent may be ignored by the Sheriff if he reasonably believes-

(a) that the affected adult at risk has been unduly pressurised to refuse consent, and

(b) that there are no steps which could reasonably be taken with the adult's consent which would protect the adult from the harm which the order or action is intended to prevent.

It should be noted that, in proceedings under the 2007 Act, the capacity of an adult is a relevant factor in determining whether under that Act should be pursued. The reason for this is that there are procedures available under the 2000 Act to protect and promote adults who lack capacity in the longer term.

In addition, it is also submitted that: -

1/ Both Assessment and Removal Orders last for short periods of time; and
2/ Can only be obtained for the purposes specified in the 2007 Act.

Manager – Legal Team 1
November 2020

Appendix 3

Emerging themes with links to previous investigations and reviews

Investigation into the care and treatment of Mr H. Mental Welfare Commission. June 2006

Some of the themes and recommendations within this SCR resonate with the findings within the MWC investigation as noted above and include:

- Any activity seeking to safeguard Mr H appeared unstructured, lacked focus and sense of urgency.
- The report highlights the serious failure of practitioners to understand the complex circumstances that influence capacity, and how this failure directly contributed to delays in implementing appropriate and proportionate care and treatment.
- Indecision across health and social work about who took the lead on safeguarding the welfare of Mr H (links to Research Q3).
- A lack of a strategic approach between health and social care in the planning and provision of services. In Mr Hs' case, this relates more to Alcohol Related Brain Damage (ARBD) but resonates with a lack of strategic approach to how services support those where there is evidence of self-neglect.
- As above, the MWC report highlighted the apparent lack of knowledge and awareness of ARBD across health and social care. The report concluded that this lack of awareness is likely to have compromised Mr H's health and social welfare over a number of years.
- The report gave reference to the view that assessment, planning and delivery of services across health and social care over a number of years was adversely affected by the professional attitudes towards those who experience alcohol misuse.
- The investigation was critical in what it considered to be a managerial oversight of social works front line /intake system and in the context of the SCR, had a similar theme whereby there was a 15 day period between receipt of the VPR to the first contact being made with P19.

The National Adult Protection Coordinator paper on "Self-Neglect and Hoarding", A Practitioner and Strategic Briefing, by Paul Comley 2018.

This briefing paper provides both a strategic and operational steer on care, support and treatment to those who experience self-neglect and there are a number salient points that relate to P19:

- Highlights the need for a multi-agency/intra agency response to supporting those where self-neglect is a feature.

- The paper acknowledges the role of capacity to determine the legal right to intervene and how this can leave someone at risk where this is misunderstood. However, the paper also recognises the complex areas in assessing capacity and draws on evidence to suggest capacity can be separated into decisional capacity and executional capacity.
- In respect of this SCR, there was evidence that P19 was able to make what was considered informed decisions about care, support and treatment, but evidence suggests P19 did not follow this through, which again was considered by some professionals as P19's choice, given it was considered that P19 had the informed capacity to take this. However, this briefing paper throws some doubt by separating capacity into being able to decide what was in P19s best interest, but not having the capacity to follow this through.

Learning from Tragedies, An Analysis of Alcohol-related Safeguarding Adult Reviews published in 2017, Alcohol Change UK (2019)

This report identifies some common characteristics among the adults whose deaths resulted in the Safeguarding Adult Reviews and considers how alcohol use was perceived by the practitioners who were working with these adults. It reveals the extent to which alcohol is a contributory factor in a number of tragic incidents and highlights some key themes that can inform improved future practice. There are a number of points that relate to P19:

- People with ARBD can be exposed to significant risks to their health, safety and wellbeing. They are at risk of poor self-care and nutrition, poor mobility, neglect of medical conditions and falls. The report highlights the multiple complex needs of the individual in addition to alcohol misuse, such as chronic physical health conditions, neurological conditions caused by alcohol, self-neglect and unfit living conditions, and services struggling to cope with that complexity. All of these factors relate to P19 and were often the focus of discussion at core group meetings.
- The report includes a number of recommendations such as better multiagency working, stronger risk assessments, and improved understanding and training for practitioners to help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm. Similar recommendations have arisen from this SCR in relation to P19.

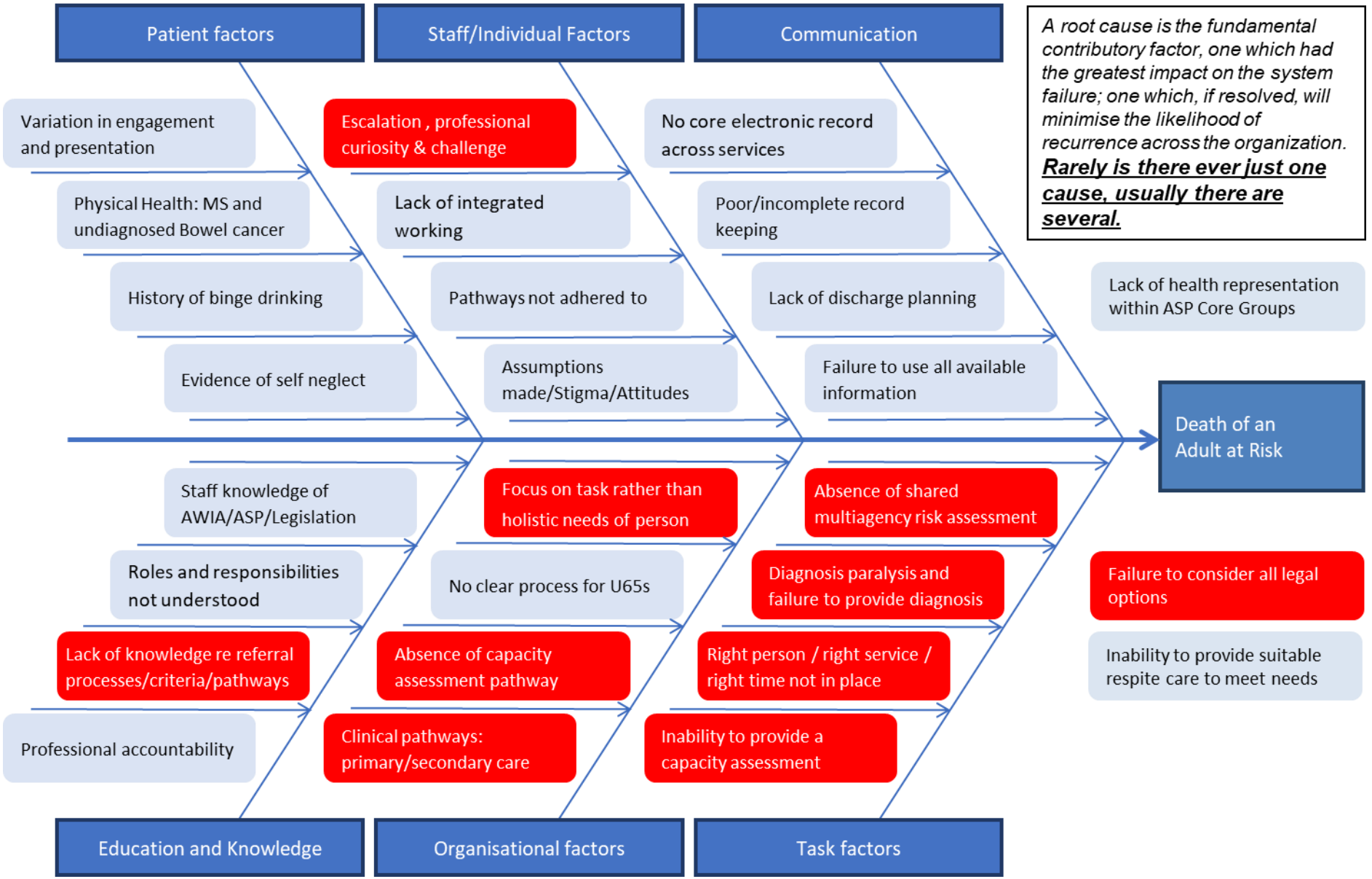
Mental Welfare Commission for Scotland, Good Practice Guide - Alcohol Related Brian Injury (ARBD) (2019)

This guide recognises that working with individuals with ARBD can be challenging for everyone involved in an individual's assessment, care and treatment. The guide was written to support professionals working with people who have ARBD and includes specific advice in relation to diagnosis and treatment. There are a number of points within the guide that are relevant to this SCR:

- The MWC believe that ARBD is often not recognised and is under diagnosed. Patients can be stigmatised, with a perception that they are difficult to help, and a feeling in some cases that their problems are self-inflicted. In relation to P19 there is no evidence to indicate the ARBD was recognised and no diagnosis was undertaken.
- The guide recognises that people with ARBD are more likely to develop social and health problems and to require services due to problems with memory, judgement and the ability to live independently. These were all identified in relation to P19.
- The guide recognises that people with ARBD may become socially isolated and anti-social behaviour may become a feature, particularly with those individuals who are still consuming alcohol. There was evidence of both these characteristics in relation to P19. People with ARBD are therefore more likely to be excluded from services and from society more broadly.
- The assessment of incapacity is of crucial importance and can be difficult to assess because the person is either intoxicated or, people with ARBD can have preserved verbal abilities which can cause practitioners to underestimate deficits. There were a number of difficulties obtaining an assessment of capacity for P19 including that they were often intoxicated and, when sober, appeared to some professionals to have the capacity to make and understand decisions.

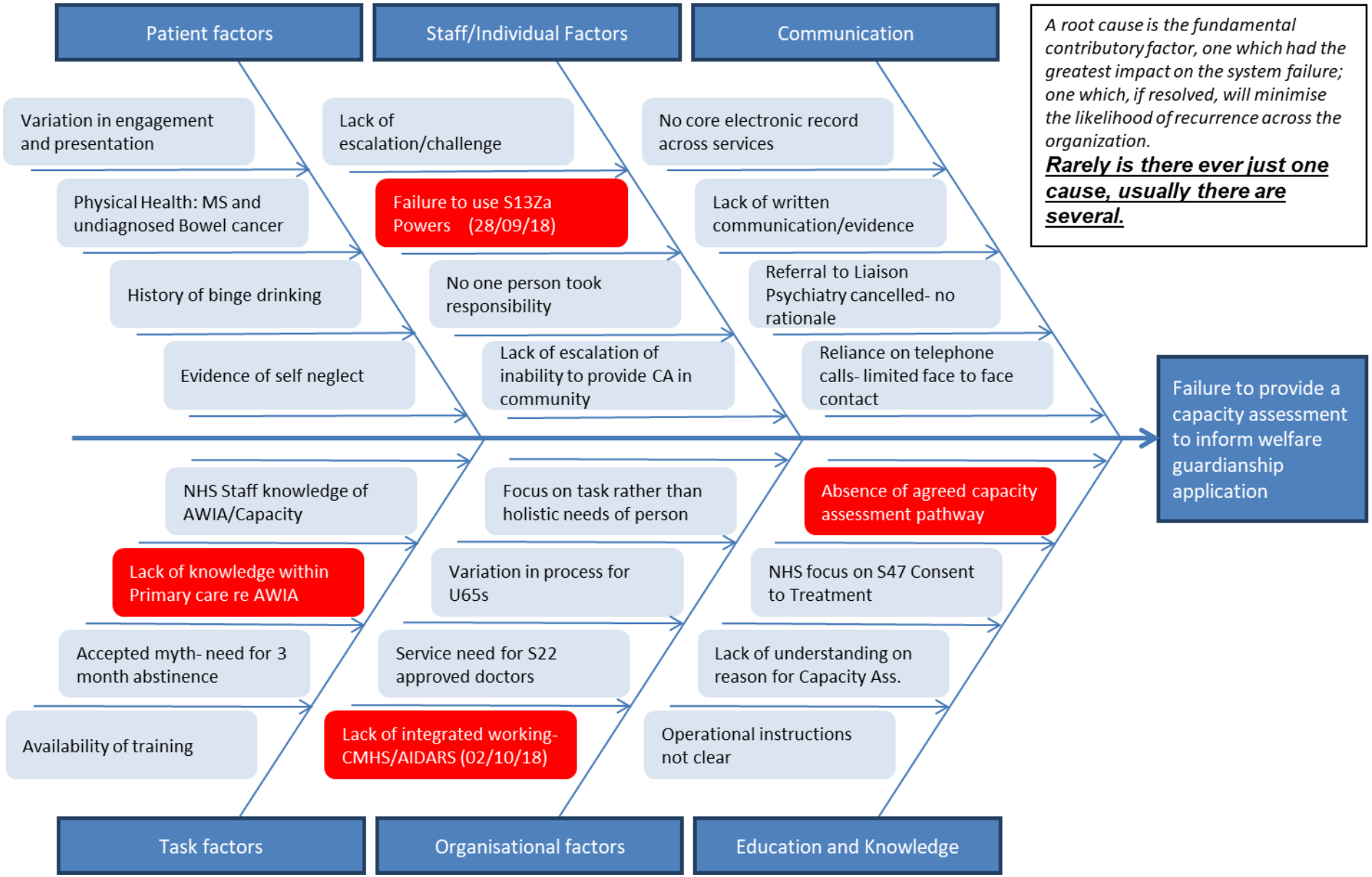
Death of an Adult at Risk

Appendix 4



A root cause is the fundamental contributory factor, one which had the greatest impact on the system failure; one which, if resolved, will minimise the likelihood of recurrence across the organization. ***Rarely is there ever just one cause, usually there are several.***

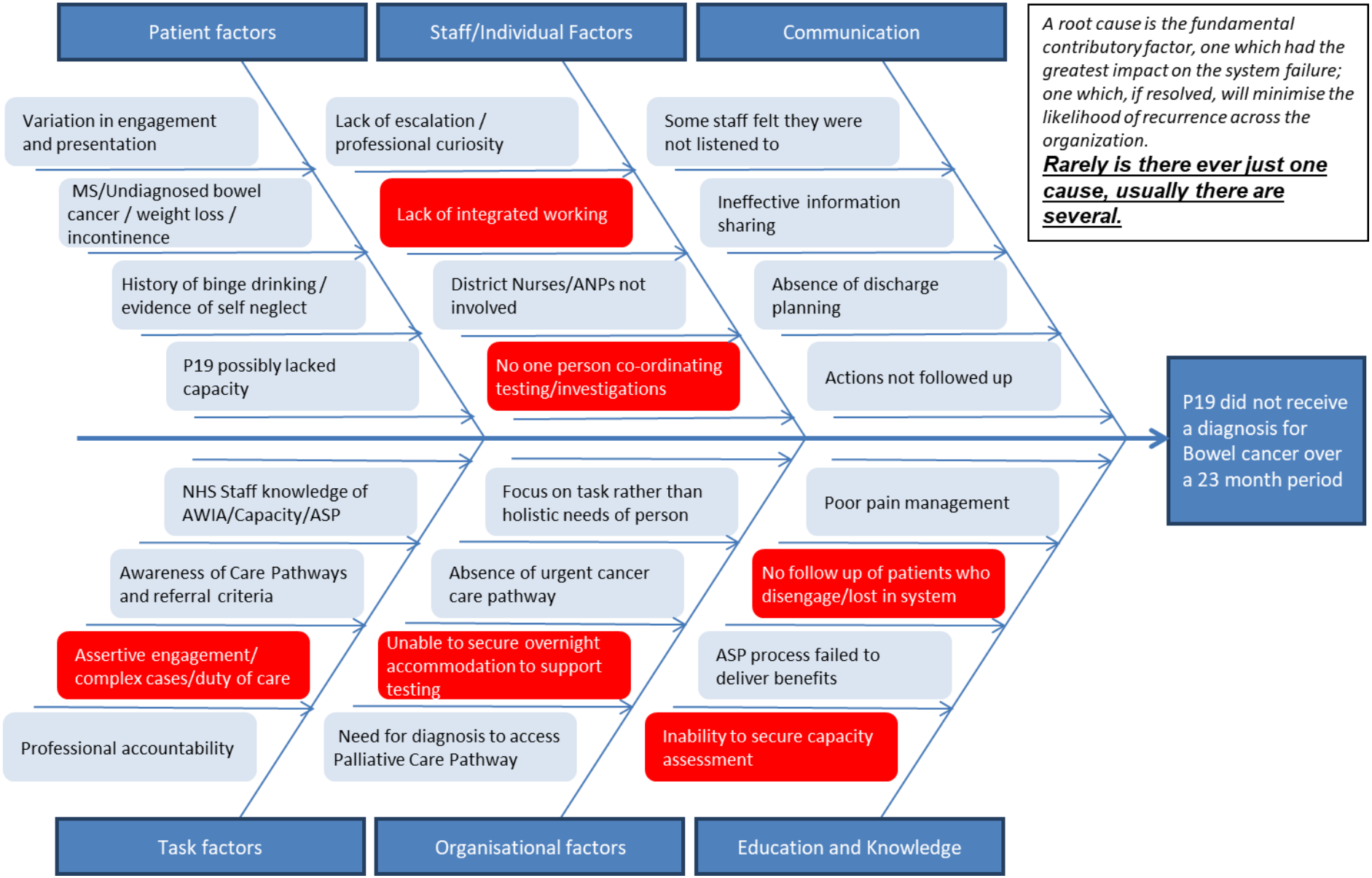
Bowel Testing and Diagnosis (Relevant Timeline Jan 2017 to 18 Dec 2018)



A root cause is the fundamental contributory factor, one which had the greatest impact on the system failure; one which, if resolved, will minimise the likelihood of recurrence across the organization.

Rarely is there ever just one cause, usually there are several.

Capacity Assessment (Relevant Timeline 27 Sep 2018 to 18 Dec 2018)



Glossary of Terms and Abbreviations **Appendix 5**

AAPC	Angus Adult Support and Protection Committee
ACP's	Anticipatory Care Plans
ADP	Angus Alcohol and Drugs Partnership
AHSCP	Angus Health and Social Care Partnership
AIDARS	Angus Integrated Drug and Alcohol Recovery Service
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
ARBD	Alcohol Related Brain Damage
ASP	Adult Support and Protection
ASPA	Adult Support and Protection (Scotland) Act 2007.
AWIA	Adults with Incapacity (Scotland) Act 2000.
BMI	Body Mass Index
C diff	Clostridium difficile (C. diff) is a specific kind of bacterial infection that causes mild to life-threatening forms of diarrhoea and colitis. It is caused by a bacteria, not a virus.
CEO	Chief Executive Officer
Colonoscopy	A test to find out what is causing bowel symptoms.
COPFS	Crown Office and Procurator Fiscal Service
Creon	A prescription medicine used to treat people who cannot digest food normally because their pancreas does not make enough enzymes.
CT	A computerised tomography (CT) scan using X-rays and a computer to create detailed images of the inside of the body.
ECHR	European Convention on Human Rights.
ECS	Enhanced Community Support

eHealth	Use of digital technologies and telecommunications, such as computers, the Internet, and mobile devices, to facilitate health improvement and health care services.
EMIS/Trak	Electronic Patient Tracking, developed to support delivering unscheduled care in settings such as urgent care centres, walk-in centres and minor injury units.
EPA	Environmental Protection Act 1990.
Fentanyl	A prescription drug, typically used to treat patients with severe pain or to manage pain after surgery.
Gastroenterology	The branch of medicine that looks at diseases of the oesophagus (gullet), stomach, small and large intestines (bowel), liver, gallbladder and pancreas.
GP	General Practitioner
HARSAG	Housing First and Rapid Rehousing outlined in the Homelessness and Rough Sleeping Action Group.
HRA	Human Rights Act 1988.
HSS	Homelessness Support Service
ICR	Initial Case Review
MAPPA	Multi-agency Public Protection Arrangements
MDT's	Multi-disciplinary Teams
MHA	Mental Health (Care and Treatment) (Scotland) Act 2003.
M.S.	Multiple Sclerosis
MWC	Mental Welfare Commission
NAPC	National Adult Protection Co-ordinator
NHS Tayside	National Health Service Tayside
NMC	The Nursing and Midwifery Council
O.T.	Occupational Therapy
PF	Procurator Fiscal
PM	Post Mortem

PPE	Personal Protective Equipment
qFIT	Faecal Immunological Test
SAS	Scottish Ambulance Service
SCO's	Social Care Workers
SCR	Significant Case Review
Sigmoidoscopy	A diagnostic test used to check the sigmoid colon, which is the lower part of your colon or large intestine.
Sigmoid Colon	The last section of the bowel that attaches to the rectum.
S13ZA	Section 13ZA assists Local Authorities in the provision of community care services when someone has been assessed as needing a service but lacks the capacity to consent to receiving a service.
S22 approved	To be eligible for S22 approval you must be a registered medical practitioner who is either: A member or fellow of the Royal College of Psychiatrists or have four years of continuous experience in the specialty of psychiatry and are sponsored by your local medical director.
S47 Consent to Treatment	Doctors should ask you if you consent to their recommended treatment, if appropriate. But if you're in hospital under section 47 of the Mental Health Act, you can be given treatment for up to 3 months without your consent. During this time, the hospital should still involve you in decisions about your treatment.
T4 Tumour	T4 cancers represent advanced tumours.
Venalink	A sealed medication management solution that enables the Pharmacist to group patient medication according to the day and time dosage requirements.
VPR	Vulnerable Person Report
WHO	World Health Organisation