**Portsmouth Safeguarding Adults Board**

**'Mary' Safeguarding Adults Review**

## What is a Safeguarding Adults Review?

The primary purpose of a Safeguarding Adults Review (SAR) is to draw out organisational learning about how the local agencies are working together, to support improvement.

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

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

The PSAB SAR subgroup considered the case referral for Mary on 8th February 2023 and concluded that the above criteria had not been met. It was decided to carry out a discretionary review under section 44(4) of the Care Act. The subgroup considered that there would be useful multi-agency learning opportunities, particularly about the issue of cross-border working.

## Who was Mary?

- Mary was a 35-year-old White British woman.
- Her sister said that when she was well, Mary was a very caring person who liked to help others and wanted to be a volunteer. She enjoyed spending time with her sister and helping her with her children.
- Mary had several long standing mental and physical health conditions.
- Southampton was responsible for her Section 117 aftercare, but she was accommodated in Portsmouth and received care from Portsmouth mental health services.
- Hampshire and Isle of Wight Integrated Care Board (Southampton Place) was responsible for her health Section 117 aftercare and Southampton City Council was responsible for her social care Section 117 aftercare.
- Mary was accommodated in Portsmouth and received secondary mental

health care from Portsmouth mental health services.

- Mary had previously been accommodated in a care home in Portsmouth but was evicted after assaulting staff, and police were involved.
- Mary then became homeless and was accommodated in temporary accommodation, and at times stayed with her partner. She had several hospital admissions due to drug overdoses and a decline in her mental health.
- In early October, her partner found her unresponsive following a suspected overdose.
- It is understood that both her sister and partner do not believe it was a deliberate suicide.

**Aims and objectives**

a. Examine local protocols for interagency working.
b. Make recommendations for change.

**Scope**

The SAR covers the following timeframe: 1/10/21 to 07/10/22. Contextual information is also included outside this time period.

The SAR addresses the following key themes:

1. The effectiveness of interagency working to manage risk across local authority boundaries.
2. Barriers to communication
3. Discharge planning
4. Did agencies act in accordance with their statutory duties?
5. Consideration of how race, culture, ethnicity, and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

**Background**

Mary committed an arson offence in 2008 which resulted in a prison sentence and being subject to the forensic sections of the Mental Health Act 1983 i.e., S37/41. Consequently, the aftercare duties under S117 of the Health Act 1983 applied. She had an extensive history of offending behaviour.

She had a diagnosis of emotionally unstable personality disorder (EUPD), borderline type, Cannabis Dependence Syndrome, alcohol harmful use, and history of polysubstance abuse. Her EUPD, borderline type was a mental health disorder within the meaning of the Mental Health Act. Her illness was characterised by emotional instability, low stress tolerance, chronic feeling of emptiness, vulnerability to become engaged in intense and unstable relationships, chronic expression of suicidal thoughts and maladaptive coping mechanisms which include deliberate self-harm by various means.

## Key events leading up to Mary's death in October 2022

In April 2019, Mary moved to a care home registered for up to nine adults with mental health needs in Portsmouth and remained there until May 2022. During the earlier period, she joined a walking group and a netball club, enjoyed going to the local market to purchase fruit for the service and for herself and also made gem art and wrote poetry.

A Mental Health Tribunal discharged the sections and the Community Treatment Order (CTO) on 18 November 2021. A marked deterioration in Mary's mental health occurred after this date. She stopped taking some of her prescribed medication. The care home worked hard to manage Mary's behaviour utilising positive behaviour plans and their specialist staff. However, there was conflict with another resident, her behaviour became more challenging, and she wanted to leave.

In May 2022, Mary was evicted from the care home due to multiple incidents of verbal and physical aggression to staff members and conflict with another resident. When she felt her needs were not being met quickly enough, she had smashed items in communal areas, thrown water and coffee at staff, smashed glass in a door and then banged her head against glass, placed her hands around a staff members' neck. She was arrested in early May 2022 for actual bodily harm (ABH) and criminal damage.

The period from leaving the care home until her death five months later was reported to be very unsettled. She spent several nights at a hotel in Portsmouth in early May. Following an overdose, Mary was in a coma and sedated for 20 days. In early June 2022, she was detained under Section 2 of the Mental Health Act (for assessment for up to 28 days) and transferred to Antelope House in Southampton (there were no other clinically appropriate beds available at the time and she had previously been a patient in the unit). Very soon after being discharged later in the month, she returned there again under Section 2 of the Mental Health Act. In late July 2022, she was discharged and returned to Portsmouth where she was of No Fixed Abode (NFA) although she mainly sofa surfed at her partner's home. Following an overdose, she was readmitted to Queen Alexandra Hospital and placed on Section 2 of the Mental Health Act and transferred to St James Hospital. It was soon decided that hospital admission was not helpful for her condition. Following discharge she returned to sofa surfing. In early October, her partner found her unresponsive following a suspected overdose. Mary died in hospital four days later.

The cause of death determined by the Coroner was Severe Hypoxic Brain Injury and Methadone Toxicity.

## Review Methodology

- Review of scoping information detailing each agency's involvement with Mary
- Dialogue with Mary's family to ascertain their views - Mary's sister was sent a letter inviting her to have some input into the review but only responded with a very helpful telephone conversation as the report was being finalised.
- Interviews with senior managers from the key agencies. This took longer than anticipated because of the work pressures, particularly being experienced by

Southampton staff. Towards the end of the review, some frontline staff were interviewed, including a joint conversation with the key professionals.

- Discussion of the evidence, gaps in information and analysis at the SAR Panel meetings.

**Independent facilitator**

The review was facilitated by David Jones, who had no connection with any of the services involved at the time of Mary's death. The review was overseen by a SAR Panel.

**Preliminary Findings**

The Review identified some positive practices, including a high degree of engagement and regular risk assessments by NHS staff. Whilst Mary's fluctuating mental health and the complexity of her presenting needs were recognised, there were some gaps in agency responses. The delays in undertaking a Care Act assessment and developing plans to meet her accommodation and support needs had an impact on Mary's mental health and wellbeing although it is not possible to infer how significant they were in relation to her death. There were clearly missed opportunities and some important learning which has been highlighted in the Review.

The findings are summarised under the main themes but as would be expected, there is a lot of cross over which should be recognised.

**The effectiveness of interagency working to manage risk across local authority boundaries.**

The mechanism for delivering integrated mental health services in Southampton is through a **Partnership Agreement under Section 75** of the National Health Service Act 2006 between Southern Health NHS Foundation Trust and Southampton City Council for the delivery of an integrated mental health service in Southampton for working aged adults.

Schedule 2 details the scope:

Southampton City Council (SCC) functions and services in relation to adults who meet the criteria for secondary mental health care support.

The functions under the Care Act 2014 include:

- the duty to assess and arrange services for both service users and carers
- the responsibility to offer direct payments as a means of meeting care and support needs
- the responsibility to monitor and review care and support plans for service users and carers
- the provision of information and advice relating to care and support services
- co-operation with SCC in relation to financial assessments, income generation and the management of resources

It also includes - Developing and reviewing after-care plans in accordance with S117 (Mental Health Act 1983, 2007).

The S75 is a very comprehensive **Partnership Agreement**. However, as it has been **decided in Southampton not to extend it after the end of March 2024**, there would be little value in examining in detail its effectiveness in relation to Mary. Some differing views have been expressed over whether the specific Partnership. Agreement had a negative impact on the way services were delivered to Mary. There are different ways of delivering mental health services across the country e.g. integrated service delivery via a S75 (regardless of the details) or the separate delivery; the actual local arrangements should not have a direct impact on the effective discharge of S117 responsibilities.

Southampton managers highlighted to the reviewer the financial challenges they have been facing which has impacted on the lack of staff, recruitment difficulties, especially of permanent professionals, and significant waiting lists.

The issues regarding increasing referral rates and patient acuity, staff vacancies, organisational challenges with recruiting new staff and limited responses from agencies and changes in leadership were escalated to a governance meeting of Southampton directors and executives but a satisfactory resolution was not achieved. However, it has to be acknowledged that these challenges are very common across the country.

The issue of escalating concerns regarding the delays in meeting Mary's care and support needs is covered later in this report.

**The aftercare duties under S117** had applied to Mary for over 10 years.

Section 117 of the Mental Health Act 1983 places a joint duty on the Integrated Care Board and the Local Social Services Authority (LSSA) to provide aftercare services for people that have previously been sectioned under the treatment sections of the Mental Health Act, i.e., Sections 3, 37, 45A, 47 and 48. The duty to provide aftercare services begins at the point that someone leaves hospital and lasts for as long as the person requires the services.

The Act does not define what constitutes “aftercare” but the national Code of Practice states: After-care is a vital component in patients’ overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital and reduce the likelihood of the person being re-admitted to hospital.

The Care Act 2014 defines after-care services for the first time: After-care services must have both the purposes of meeting a need arising from or related to a person’s mental health disorder and reducing the risk of a deterioration of the person’s mental health condition and so reducing the risk of a person requiring re-admission for treatment for mental disorder.

A package of care and support will be developed based on the aftercare support plan. A key principle for agreeing funding should include working in collaboration.

(The above is an extract from Guidance & Principles for Aftercare Services under S117 - ADASS London; November 2018 - Updated as ICBs subsequently established).

Although not referred to in the interviews, the SAR Panel was informed of the existence of the Southampton City Council / Hampshire and Isle of Wight ICB 'Section 117 - Mental Health Aftercare Practice Guide' (34 pages last amended in November 2023). This was completed after Mary's death. Included in this report's recommendations is the adoption, promotion, and training of aftercare practice guidance across the system e.g. the Southampton City Council / Hampshire and Isle of Wight ICB 'Section 117 - Mental Health Aftercare Practice Guide'. This should also contribute to an improvement in legal literacy amongst mental health staff.

**Southampton City Council accepted continuing responsibility for the S117 duties. The findings and recommendations relate to how they were delivered.**

The responsible authority is required to discharge these duties wherever the subject is currently living.

The uncertainties over where Mary wished to live and practical issues e.g., distance between the two cities and limited knowledge / availability of care outside Southampton, should not have been significant issues.

It seems that in effect some of the aftercare responsibilities were by default being undertaken by the Portsmouth community mental health team; for example, utilising local knowledge of potential placements. This is understandable in relation to day-to-day support and practical matters. However, the assessment, care planning and funding responsibilities are central to the S117 duties and remained with Southampton City Council.

Regarding **assessing risk,** Southern Health NHS Foundation Trust and Solent NHS Trust gave priority to fulfilling this responsibility and it is evident this was used to inform decision making. For example, a comprehensive risk assessment (including different categories e.g. harm from others, to others, to self and risk behaviours) was undertaken in August 2022 and shared with the newly allocated social worker. It is recognised that the risks were fluid and Mary's presentation varied throughout the period in scope for the review.

**Barriers to communication**

A commonly raised issue has been the fact that there are separate case management recording systems - Rio for Southern Health NHS Foundation Trust, SystmOne for Solent NHS Trust, and Care Director (previously Paris) for Southampton City Council. It should be noted that multiplicity of systems means that practitioners have to record on several systems, none of which speak with each other, so there was data being stored across three systems in the case of Mary, none of which could be read by other teams. Arrangements to minimise dual recording but ensuring there is ready access to information to facilitate safe working

and support an integrated person-centred approach is an issue across the country. Solutions are beyond the scope of this review.

However, basic practices to facilitate effective communications are very relevant. The records indicate that calls / emails were not always responded to in a timely way and there were significant delays in the follow up of agreed actions. During the period in scope for the SAR, the worker in the Southampton Community Mental Health Team was working with Mary 'as part of a yearly review not regular case holding ' until 3 August 2022. Whilst this may account for the limitations of the responses, it seems inappropriate to have sought to meet statutory responsibilities without an allocated worker given the level of need and volatility since the breakdown of the care home placement in the spring; even though the team manager and Crisis Team had had some limited involvement.  Other professionals reported their work had been limited by the delay in completing a Care Act assessment and securing funding for supported accommodation.

During the interviews, it became increasing apparent that the main barriers to communication was as a consequence of the limited review role of the Southampton worker / lack of an allocated social worker. There had been more continuity within the Portsmouth team.

The Senior Mental Health Nurse within the Portsmouth Recovery Team was only working with Mary for the last 10 weeks of her life and the Southampton Social Worker for only 6 weeks. When the reviewer met with them together, it was apparent that they communicated appropriately but felt that they would have needed a longer period to progress the work and arrange the required care and support for Mary. It was acknowledged that face to face conversations involving Mary would have helped them to follow a person-centred approach and complete the assessment, care and support / after care plan and achieve more clarity on the funding requests.

Efforts were made by Portsmouth managers to escalate concerns over lack of action / delays. However, they should have been to the most senior levels - senior nurse to senior nurse / senior local authority manager to senior local authority manager. There are established procedures so the recommendation regarding escalation is intended to act as a reminder. It should also be useful to circulate the organisational escalation processes. This is included as a recommendation.

**Discharge planning**

There is no doubt that Mary had very complex needs and at times her behaviour was challenging. It seems that it was more difficult for the various professionals to respond because of the changes related to her emotionally unstable personality disorder (EUPD).

The discharge from inpatient care should have triggered at the very least desk top reviews of Mary's S117 aftercare. This did not always happen and were important missed opportunities. Even though a new assessment of need was required, pending completion, there should still have been more proactive discharge planning with updated plans agreed with Mary and shared with the various professionals. The provision of temporary supported accommodation or a support package when she

was sofa surfing may have mitigated some of the risks and could have been arranged while a new assessment was underway. Actions in parallel rather than being contingent on the completion of processes would have been a more person-centred approach. These issues are picked up within the recommendations. There may not always have been sufficient understanding of the interface between the Care Act requirements and the S117 duties; with the latter emphasizing the importance of reducing the likelihood of readmittance to hospital.

It was unclear at times whether Mary wanted to live in Southampton - near to her gym and other sports activities but associated with her history of trauma in the area or in Portsmouth - near to her partner. Notes from professionals' meetings in August 2022 showed she did not wish to return to Southampton. However, during the final weeks of her life, Southampton professionals say that Mary wanted live in Portsmouth, but the SystmOne notes and conversations with professionals in Portsmouth indicated that she did not want to remain in Portsmouth.

There was appropriately a lot of focus particularly by Portsmouth professionals on the importance of undertaking a new Care Act assessment. This should have then led to the development of a care and support plan / aftercare support plan. A more person-centred approach, directly involving Mary in face-to-face conversations during September 2022, would have increased the likelihood of achieving greater clarity on her needs and preferences, including whether she wished to live in the Southampton or Portsmouth areas.

**Did agencies act in accordance with their statutory duties?**

There should have been at least annual reviews as part of the S117 and Care Act duties, and good practice and a more risk-based approach ought to have triggered more frequent reviews in the last months of her life. There had been annual reviews prior to the period in scope for this review. However, the last reviews were undertaken by Southampton on 25 August 2020 and 29 March 2021 while Mary was living at the care home in Portsmouth. At the time, the placement met her needs and she said she was happy there. It has been reported that Mary was added to the Southampton Community Mental Health Team's review list in October 2021. The next annual review was due in March 2022, around the time when the placement was breaking down. No further reviews - annual or risk-based - were undertaken which was a failure to meet statutory duties. There are, therefore, recommendations relating to these requirements.

This SAR has particularly focussed on the work of the Solent NHS Trust Mental Health Nurses, Portsmouth City Council's Housing Needs Advice & Support (HNAS) and Southampton's Community Mental Health Team.

During Mary's last ten weeks, the work of the Senior Mental Health Nurse concentrated on practical matters such as accessing benefits, debt reduction, monitoring medication, liaison with GP and hospital and listening to her concerns. Mary was generally positive about this support. It was limited by her being of no fixed abode (NFA) and the frustration over the delays on moving forward with the allocation of supported accommodation (she had never lived independently). Her

mood varied from being low, feeling angry and let down regarding delays with accommodation. The Senior Mental Health Nurse stated:

> 'The main issues were that the Care Act assessment drives funding for accommodation based on any recommendations following the assessment. This was at the time the most pressing issue as being of No Fixed Abode made it difficult for professionals to help Mary look towards her future and use her coping skills effectively. It was difficult for her to trust that she was going to be housed which impacted on her mental health greatly.'

Mary applied to **Portsmouth City Council's Housing Needs Advice & Support (HNAS)** as homeless on 2 August 2022.

S188(1) Housing Act 1996 states: *"If the local housing authority have reason to believe that an applicant may be homeless, eligible for assistance and have a priority need, they must secure that accommodation is available for the applicant's occupation."*

HNAS were satisfied that although Mary was homeless, accommodation was available for her occupation at her partner's address.

Whist acknowledging that Mary repeatedly reported that she felt *"unable to keep herself safe"* at her partner's address, she was not considered to be at immediate risk of rough sleeping.

The homeless legislation directs a local authority, where it is satisfied that a person is eligible for assistance and homeless, to take reasonable steps to help the person to secure accommodation. This may not necessarily involve providing them with accommodation directly, although in many cases that is what may happen. In this particular case, HNAS took steps to urge other agencies, through escalation, to progress plans to arrange suitable supported accommodation.

Mary contacted HNAS several times during August and September 2022 and Housing officers made follow up contact with professionals in Southampton and Portsmouth

On 16 September 2022, Mary presented at HNAS reception to report that she could no longer stay at her partner's address. The Social Worker was asked to provide a copy of the Care Act Assessment and risk assessment. A risk assessment was provided stating that a key protective factor from risk was the provision of 24 hour staffed accommodation, something HNAS were unable to provide. This would have been a social care responsibility of Southampton City Council given that Mary had assessed eligible needs under the Care Act.

A manager from HNAS approached an Assistant Manager in PCC's Adult Safeguarding Team for advice who agreed that B&B accommodation, without confirmation of a wraparound support package, was not suitable or appropriate.

The main reflections from HNAS were:

- The delay in completing a Care Act assessment frustrated attempts to reach a longer-term solution to meet Mary's housing and support needs.
- There wasn't a formal plan, although this was under development it had not been shared with HNAS.
- Although there had been professionals' meetings, earlier escalation to gain senior management ownership and the convening of a MARM (Multi Agency Risk Management) meeting, involving Mary, may have better supported earlier actions.

**The importance of a timely new Care Act assessment and aftercare review** - Whilst reviews may trigger a new assessment, it ought to have been apparent that the breakdown of the care home placement and the related events, would have required a new assessment of Mary's needs. Despite the numerous requests over the summer of 2022, this assessment did not commence until September 2022.

The Managers from Southampton that were interviewed referred to significant difficulties in recruiting both permanent and agency workers and the challenges of responding to a long waiting list of work requiring allocation.

The reviewer was informed that despite Southampton's Community Mental Health Team being an integrated team, the Care Act assessment needed to be allocated to a qualified social worker. The view of Southampton City Council's Service Manager is that social care work can be allocated to any suitably trained or qualified practitioner who may or may not be a registered social worker, nurse, occupational therapist, or mental health practitioner. Also, Southampton employ up to 6 Band 4 Case Workers to assist with the Local Authority duties under the Care Act 2014 who are also available. At the time of Mary's death, all Case Worker, and Social Worker posts in the particular CMHT were fully staffed.

There were three Social Workers posts in the team; the two males did not have capacity to undertake the assessment and the new person, a female, was a newly qualified social worker in her first week with SCC. Mary was allocated to her, and she commenced her work on 25 August 2022. The social worker was new to mental health work and unfamiliar with S117 duties.

As she had just commenced her assessed and supported year (ASYE), a controlled caseload and a higher level of support and supervision should have been provided.

The reviewer is less concerned over whether the work should have been allocated to a qualified social worker. The complexity and urgency of the work would have required a worker with more experience. Ready access to support and a high level of supervision would have been essential but this was not made available. This requirement is included within the recommendations.

It should be noted that the Service Manager wrote to the Team Manager asking him to 'consider reallocating to a more experienced Mental Health Practitioner or to have a co-worker' because of her 'extensive forensic background and as she is a high-risk client'; this email was sent on the day Mary died.

It seems there wasn’t a transfer summary / handover, and her part time manager was not able to provide the required level of supervision (weekly, access to support, quality assurance of assessments, plans, reports for the funding panel) in accordance with Southampton's ASYE and supervision policies. These are compliance issues although it is recognised that financial and workload pressures presented very real challenges for operational managers.

The reviewer was very concerned over the very limited level of support provided to the inexperienced newly qualified Social Worker. It was apparent during the interviews that 18 months later, her practice has developed considerably, and she reflected that with this experience, a rather different approach would have been taken.

The social worker acknowledges that she would now undertake more preparation, including gathering background information and talking to other professionals rather than as she did, immediately contact Mary to arrange a meeting. The Care Act assessment commenced in early September 2022, was worked on over a weekend, but not completed. It was conducted over the phone as requested by Mary - and the new social worker never had any face-to-face contact with Mary. This is not considered acceptable practice as there were no Covid-19 restrictions at the time. The social worker acknowledges this was inappropriate, and did raise this with her supervisor, but did not then have the confidence to explain the benefits of face-to-face meetings.

There had been professionals' meetings, some involving Mary or her advocate, a solicitor, prior to this period. They had, however, been hampered by Southampton not being represented on occasions and because the dominant issue was the delay in undertaking the Care Act assessment.

As stated earlier, a more person-centred approach, directly involving Mary in face-to-face conversations during September 2022, might have increased the likelihood of achieving greater clarity on her needs and preferences, including whether she wished to live in the Southampton or Portsmouth areas. It could also have reduced some of the delays, given Mary more confidence that the professionals were actively working on implementing an agreed plan and supported a more collaborative approach.

The Care Act assessment should feed into a care and support plan / aftercare support plan, which details how the outcomes were to be met and what funded care and support was required. The plan was commenced in September 2022 but also was incomplete.

There had been a tentative proposal for seven hours a week of care for support with medication, access to community activities (sport, voluntary work) and practical tasks but this was not formally requested. It could have been a useful way of supporting Mary for a short time while she was sofa surfing and an appropriate way of meeting the S117 after care duties.

If there had been a plan for another care home placement but before this became available, an interim short-term arrangement was required e.g. temporary housing /

B&B with a wraparound support package, Housing / the other agencies could have worked together to put this in place as part of the care and support plan / aftercare support plan.

The social worker was aware that Mary wanted care and support to enable her to become more independent. However, she was new to mental health work, unsure on the available options and what should be proposed for funding. This, together with the competing priorities of other work, contributed to the delays in meeting Mary's pressing needs.

The lack of support for the social worker in preparing for the Aftercare Forum (funding panel) was a significant issue. Two days before Mary died the Southampton Forum deferred a decision pending discussion with Portsmouth. The actions were to finalise the Care Act assessment (clarify eligible domains) / Support Plan and formulate a new risk plan. It was noted that Mary 'admits that she does not have independent living skills' but the Forum (Panel) was unclear whether she needed just accommodation or accommodation plus. It does not seem to have been adequately recognised that Mary had always lived with a high level of support apart from unplanned responses to crises such as bed and breakfast and sofa surfing.

It is appreciated that funding panels have to ensure value for money and there can be a tension between this and taking a person-centred approach. It is also acknowledged that the report to the Forum was insufficiently developed, but the response did not fully recognise the risks and urgency of making a decision, even if only for temporary support. It was apparent that the social worker did not feel adequately supported by the Aftercare Forum and was not clear on how to proceed.

There was a request for consideration to be given to reallocation or providing a co-worker but in the immediate aftermath of the panel, the allocated social worker was not given an adequate level of guidance and support.

The Southampton Aftercare Forum is now weekly rather than fortnightly, and funding can be agreed outside meetings by senior Council and ICB managers.

There was considerable activity at the end of September / first week of October 2022. Some placements had been suggested to the allocated worker by Portsmouth managers, but actions had not moved forward. Communications arising from the escalation to senior Portsmouth managers suggested that if a supported accommodation placement could have been identified, Portsmouth would have funded and then requested that Southampton pick up the funding. Sadly, Mary died before this might that been a possible way forward.

The reviewer had a joint meeting with the Social Worker and Senior Mental Health Nurse. He was informed they had last spoken to each other to share the news of Mary's death. Portsmouth staff had been offered support at the time but the impact on the newly qualified Southampton Social Worker does not seem to have been recognised. The conversation was painful for both professionals as they reflected on their work with Mary and her death. It is important to offer timely individual support and possibly also on a group basis. It is recommended that very soon after a patient

/ service user's death, frontline staff should be offered support and the need for follow up action such as counselling identified.

**Consideration of how race, culture, ethnicity, and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.**

It is not apparent that these responsibilities and considerations had any direct impact on the work with Mary.

**Concluding comments**

Initially it seemed to the reviewer that the main concerns related to practice rather than system issues. During the period within the scope of the review, the lack of an annual review or a risk-based review and the absence of an allocated social worker were critical. The impact of the delays in undertaking a new Care Act assessment and aftercare review were significant and affected Mary and the other professionals seeking to respond to her needs.

The Senior Mental Health Nurse within the Portsmouth Recovery Team was only working with Mary for the last 10 weeks of her life and the Southampton Social Worker for only 6 weeks. When the reviewer met with them together, it was apparent that they communicated appropriately but felt that they would have needed a longer period to progress the work and arrange the required care and support for Mary. It was acknowledged that face-to-face conversations during September 2022 involving Mary would have helped them to follow a person-centred approach and complete the assessment, care and support / after care plan and achieve more clarity on the funding requests. The frontline staff demonstrated commitment and have reflected on their practice.

Over the last year of Mary's life there were significant missed opportunities and delays. It became very apparent during the review that these would have been reduced if adequate management support and supervision had been made available, especially from the managers responsible for fulfilling the Care Act and Aftercare duties. The recommendations seek to address these issues.

**Developments since Mary's death - Information provided by Southampton City Council**

- Southampton City Council (SCC) has moved towards holding weekly Aftercare Forums with the ICB to avoid there being a 2-week gap between cases being heard at the Forum.
- SCC has written an Introduction to the Mental Health Act 1983 (and the role of an AMHP) 1 day course, which shall be open to all Adult Social Care staff, with a view to increase knowledge and awareness of our legal and statutory duties.
- The Southampton City Council / Hampshire and Isle of Wight ICB 'Section 117 - Mental Health Aftercare Practice Guide' has been developed.

- SCC will be designing a separate Section 117 Aftercare awareness course after feedback has been received from the Introduction to the Mental Health Act course.
- There is now a clear senior manager on call 5 working days a week in the Council to consider and approve emergency funding under the Care Act 2014 or for care and support provided as part of S117 aftercare. The ICB has a similar system in place.
- Allocation of work shall now consider the level of competency required with regard to the Professional Capabilities Framework for Social Workers.
- All ASYE Social Workers shall have regular supervision in accordance with the new supervision policy and supervisors are responsible for ensuring that time is made to support newly qualified staff or escalate concerns to their manager where this is not possible.
- SCC signed up to the Pan-Hampshire agreement of sharing Approved Mental Health Professionals (AMHP) assessments for individuals who live in other areas.

**Recommendations**

1. The adoption, promotion, and training of aftercare practice guidance across the system e.g. the Southampton City Council and Hampshire & Isle of Wight ICB 'Section 117 - Mental Health Aftercare Practice Guide'.
2. Escalation protocols to be reviewed and promoted to ensure all agencies are clear on how to escalate concerns relating to an adult with care and support needs who is at risk of harm.
3. Portsmouth Adult Social Care, in partnership with Solent NHS Trust, to review all current out of area placements made within the city where the clinical input comes from Solent NHS Trust but the social care responsibility sits with another local authority.
4. **The Southampton Safeguarding Adults Board should assure itself within the Southampton system of the following:**
    a. A person-centred strength-based practice approach, fully involving the service user, and followed when making funding decisions, should be embedded by senior managers, and supported by supervision and training.
    b. A MARM (multi-agency risk management) or equivalent meeting, involving the service user, should be considered as a means of mitigating risks and supporting care planning.
    c. Annual reviews should be a minimum requirement with a risk-based approach, triggering more frequent reviews or a new Care Act assessment.
    d. There should be up to date care and support plans / aftercare support plans
    e. Regular management support and supervision should be provided to all frontline staff. It is essential that ASYE (assessed and supported year) procedures for newly qualified staff and supervision policies should be followed. If there are difficulties in complying because of

financial and workload pressures, this must be escalated to senior managers.

**f.** Consideration of funding temporary aftercare to mitigate risks rather than awaiting the completion of assessments / new care and support / aftercare support plans.

**g.** Very soon after a patient / service user's death, frontline staff should be offered support and the need for follow up action, such as counselling, identified.

The Reviewer thanks everyone who has been interviewed and contributed to this Review.

**Glossary**

- The organisations involved in Mary's care were:
  - Southern Health NHS Foundation Trust
  - Solent NHS Trust
  - Southampton City Council
  - Portsmouth City Council
  - Hampshire & Isle of Wight Integrated Care Board (ICB): the statutory NHS organisation responsible for developing a plan to meet the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the area. ICBs replaced Clinical Commissioning Groups in England from 1 July 2022.
  - Antelope House, a mental health hospital in Southampton (Southern Health NHS Foundation Trust)

- Legal framework:
  - Mental Health Act 1983, S117 aftercare duties, Community Treatment Orders; MHA forensic sections include S37 & S41, S2 order for assessment for up to 28 days, S3 order for treatment for up to 6 months
  - Care Act 2014 S9
  - National Health Service Act 2006, S75 - a mechanism for delivering integrated services through a Partnership Agreement

- AMHP - Approved Mental Health Professional
- ASYE - assessed and supported year for newly qualified Social Workers
- EUPD - Emotionally unstable personality disorder. This is a condition that affects how people think, feel, and interact with other people.