

## **TOWER HAMLETS SAFEGUARDING ADULTS BOARD**

### **EXECUTIVE SUMMARY OF A SERIOUS CASE REVIEW REGARDING MR X & MR Y**

#### **Sections 1& 2: Introduction & Reasons for the Serious Case Review**

This sets out that the Serious Case Review (SCR) examines agency responses and support given to Mr X and his son Mr Y prior to the death of Mr X and another adult, not known to agencies, following an incident of arson carried out by Mr Y in March 2011.

The key purpose for undertaking an SCR is to enable lessons to be learned from serious injury or death of an "adult at risk" and for those lessons to be learned widely and thoroughly and to reach an understanding of what needs to change to reduce the risk of further such tragedies.

Following the deaths, because both Mr X and Mr Y were known to both Tower Hamlets Council's Adult Health & Wellbeing services and the East London NHS Foundation Trust (which provides Mental Health Services within the Borough), each agency individually undertook a review of the services they had offered. One of the conclusions of the Council's review was that a significant number of agencies had been involved with either Mr X or Mr Y or both and that the Tower Hamlets Safeguarding Adults Board should commission a Serious Case Review. This should examine how well all the agencies had acted both individually and collectively, to support and safeguard the wellbeing of Mr X and also Mr Y, as he too was an "adult at risk" as well as the perpetrator. This recommendation was accepted by the Safeguarding Adults Board.

#### **Section 3: Details of Serious Case Review Process**

This sets out the membership of the Serious Case Review Panel, when it met and the terms of reference established by the Panel on behalf of the Safeguarding Board. These are as follows:

- To establish the involvement of agencies with Mr X & Mr Y in order to understand the circumstances.
- To take account of findings of each agency's internal management review, and review how inter-agency working accorded with the Tower Hamlets Safeguarding Adults Board Multi-Agency Safeguarding Procedures.
- To request that the authors of the internal management reviews obtain further information or make other enquiries within their own agency as necessary within the remit of this case review, in order to properly review the circumstances of the case.

- To ascertain as far as possible the facts of the case indicating the source of information. In situations where it is indicated that events other than those recorded took place, the Panel should include this information, but clarify that there was no written evidence. Where these relate to important issues or incidents, the Panel should attempt to establish any corroboration. Where conflicting accounts are given, areas of consensus and dispute about events should be detailed.
- To obtain further information or make other enquiries within these terms of reference as necessary to properly undertake the case review. In particular, information relating to the adult's history which should be included as part of the review, regardless of the time frame.
- To provide feedback to a senior manager of a specific agency about any important issues which arise from the overview process, which may not have been known or addressed in the individual agency review report.
- To establish whether the inter-agency safeguarding procedures were adhered to, and whether any changes are necessary in relation to these, or in the guidance or training associated with them.
- To consider, in liaison with police if criminal proceedings are pending, how to seek the views of family/carers of Mr X & Mr Y on services provided by agencies, for consideration within the case review.
- To prepare a report outlining the circumstances, key issues and conclusions of this case in accordance with the Serious Case Review protocol and make recommendations to the Tower Hamlets Safeguarding Adult Board.
- To make other recommendations as appropriate to this review and commission/identify the author of the Overview Report.
- The author of the Overview Report to prepare an Executive Summary.

It also lists those agencies requested to undertake an individual management review (IMR) and provide a report to the SCR Panel.

#### **Section 4: Family Background Information**

This provides contextual information about Mr X and Mr Y placing them within their family and community. It describes the family as having been well established within Tower Hamlets having lived there for more than 45 years. It explains how Mr Y came to be living again with his father in the 5 years before the fire and how his 3 siblings, though no longer living in London, maintained contact and support with their father and brother. At the time of his death Mr X was 82 years old and Mr Y was 52.

#### **Section 5: Chronology of Agencies Involvement**

This section sets out in a chronological way events from 1999 and in some detail from 2007 and are summarised here.

Mr X was known to the Mental Health Trust since 1999 following an in-patient period after the death of his wife, seeing an Older Age Consultant Psychiatrist regularly until his (Mr X) death. He had also been in receipt of social care support services from Tower Hamlets' Adult Care & Wellbeing department since 1999 because of chronic health problems.

Mr Y's marriage broke down in early 2006 and for most of the subsequent time he lived with his father at the family home. The relationship was volatile with Mr Y being "kicked out" by his father, with reports of Mr Y's alcoholism appearing in 2007. In January 2009 police were called to the home to intervene in a domestic incident between Mr X and Mr Y and Mr Y was escorted from the home. In July 2009 Mr Y had a period of residential de-tox at a specialist unit but took his own discharge after 4 weeks. Later in the same year Mr X was offered and accepted a period of in-patient detox by his Consultant Psychiatrist. This was unusual in that all the records suggest that though a regular and heavy drinker, Mr X was not physically dependent on alcohol.

Throughout 2010 Mr X discussed the "intolerable" home situation with his psychiatrist and requested, but did not receive a further in-patient detox episode. During 2009/10 both men were regular attendees at the Royal London Hospital, Mr X usually for various planned out-patient appointments and Mr Y as a fairly chaotic user of A&E facilities. Mr X was also a frequent attendee at his local GP practice and Mr Y was registered at and attended the same practice. In June 2010 Mr Y sought help from the Community Alcohol Team (CAT), received a full assessment and was offered a residential detox period followed by community based rehabilitation which he declined. 2 months later Mr X also attended the CAT requesting in-patient detox for himself as he wished to give up drinking completely. He was offered and agreed to a referral for community based support but this was not followed up by the CAT and Mr X "fell out" of the service.

The home situation deteriorated rapidly towards the end of 2010 with Mr Y's brother frequently travelling to London to try and sort things out and seek help for Mr Y. There was contact with the Police, Ambulance and Social Services after various events including one (accidental) fire and expressed concerns about Mr Y being a fire risk due to his behaviour when intoxicated. He again attended the CAT in early November 2010 following a GP referral, who noticed a significant physical deterioration in his condition. Mr Y's brother also made a safeguarding referral to Social Services as the family were increasingly concerned at the impact of Mr Y's behaviour on their elderly father.

The safeguarding referral after initial telephone assessment was not pursued, apparently because the main problem was seen as Mr Y's need for help with his alcoholism. After further deterioration in the home circumstances with various brief interventions by agencies, Mr Y eventually accepted a brief period of residential detox. Shortly afterwards he was found unconscious in the street and taken to Croydon Hospital with acute hypothermia. Following some ground breaking physical treatment which attracted national publicity and after 5 weeks in hospital with 4 psychiatric assessments because of erratic and strange behaviour, Mr Y was discharged to his father's address with minimal discharge planning and against the expressed wish of the family.

A specialist drug and alcohol team Social Worker began to support Mr Y in January 2011 and concerned about his mental health, sought immediate help from mental health services. Whilst that was being organised a physical assault by Mr Y on Mr X was witnessed and reported by the home care assistant for which Mr Y was later charged. As a consequence a second safeguarding referral was raised, but subsequently closed with no further action because Mr X was "allowing" Mr Y to remain at in his home. Following a further (accidental) fire at the home on Jan 20th 2011, Mr Y was taken to A&E and from there, admitted to a mental health in-patient unit for assessment. After 10 days Mr Y left the unit and was eventually discharged in his absence. Although aftercare was discussed, the referral was not made until March 4th and a discharge note was received by the GP on 1st April, 2 months after he left the ward.

Mr Y was sentenced for the assault on his father and given a supervised community order on Feb 28th, he saw his Offender Manager on 3rd March and on 7th March deliberately set fire to his father's home. Mr X and another man not known to agencies died in the fire. Mr Y was subsequently found guilty of manslaughter with diminished responsibility and is currently serving a prison sentence.

## **Section 6 & 7: Findings/Issues Arising and Conclusions**

This section details the main findings of the Overview Author and draws conclusions, about what needs to improve, the latter of which are repeated here.

Mr X was well known and with an unusual degree of continuity, to health and social care agencies for 12 years prior to his death yet this had little impact on the actions and decisions when his health and social situation began to decline quite rapidly during 2010.

Numerous agencies had frequent contact with Mr X & Y from 2009 with very little or no contact between the agencies. For example, psychiatric interventions were fragmented within and between Trusts with no evidence of sharing information appropriately and some non-compliance of agreed protocols. The Police attended several "domestic incidents" but again did not adequately link them and/or refer on to other agencies. Two safeguarding referrals were made to social services and closed without appropriate assessment of the circumstances. The GP practice responded frequently but reactively and didn't take an overview of what was happening.

It is not possible to conclude that the arson that tragically killed 2 people could have been avoided and that the actions of any one agency could alone have made a difference. There were however, numerous opportunities for agencies both separately but more importantly together, to have had a more positive impact on the lives of Mr X and Mr Y which may have made a difference. The following are the key areas that need to improve:

*Safeguarding awareness* was demonstrably lacking in all of the agencies involved with Mr Y & Mr X, starting with the Lead Agency: London Borough of Tower Hamlets. However, in the absence of that lead, others, many of which are signed up members of the Tower Hamlets Safeguarding Adults Board could/should have pressed for a

strategy meeting to pull the whole picture together as things began to deteriorate rapidly. This is a serious issue that the Board will need to consider.

*Communication* between teams and staff within agencies was often poor and between agencies, even worse. Many of the mistakes and misunderstandings were founded on people making assumptions about each other's individual and agency's roles and actions, without clarifying what was really going on (or not going on and should have been). Written communication and record keeping was poor across all agencies and didn't assist and support good communication. The consequences of this are particularly acute in a complex inner-city environment with multiple agencies and agency boundaries.

*Domestic Abuse:* If the death of Mr X had occurred 3 weeks later it would have fulfilled the criteria for a statutory Domestic Homicide Review, which became mandatory on 01.04.11. However awareness that the strong parallels to traditional domestic violence scenarios in the Mr X/Mr Y relationship were not spotted. Because of this a significant factor in understanding what was going on and when assessing risks, was lacking by all except Probation whose Offender Manager clearly identified it as a risk in the pre-sentence report. The Police superficially responded within a Domestic Abuse framework, but then did not follow their own protocols which if they had, should have led to a Multi Agency Risk Assessment Conference (MARAC) being held.

*Discharge policies/arrangements* following in-patient episodes were inadequate in every case. Summaries and follow up arrangements either didn't happen, were too late to be useful and/or contained inadequate or incorrect information.

*Mental Capacity Act and Deprivation of Liberty Safeguards:* Knowledge and use of this legislation was variable and it's misuse particularly by the Local Authority and Croydon University Hospital apparent. This is not uncommon at this stage of implementation of the MCA and the need for improvement is likely to reach across most agencies.

*Use of information:* Throughout their contacts with Mr X and Mr Y, those agencies who could have or should have informed their decision making by considering the whole history that was or could have been made available to them for both Mr X and Mr Y didn't do so. All the Psychiatric services failed to obtain collateral histories and Social Services show no evidence of having reviewed their own 10 years of contact with Mr X to inform their thinking. The GP surgery had a long record of frequent contact particularly with Mr X but with no evidence of having reviewed their contacts in a holistic way or of reviewing the contacts with father and son alongside each other to give a better picture. Too many of the contacts with professionals elicited reactive "in the moment" responses, even though some had extensive history and contacts available to inform their practice.

*Risk Assessments:* Across the piece these either did not happen, were based on inadequate information and/or were not updated as circumstances changed.

*Multi-disciplinary/inter-agency working:* A number of opportunities to initiate inter-agency working, where knowledge could be shared, a fuller risk assessment

undertaken and inputs to both Mr Y & Mr X coordinated through a shared plan, were missed. When considering (with the benefit of hindsight) how much time and effort went into all the different and, uncoordinated individual agency responses to and contacts with Mr X & Mr Y, the investment of time into a multi-agency meeting must have been more efficient and effective had one taken place. It may also have prevented some of the false assumptions and miscommunications that took place when individual cross-agency contact was made.

### **Sections 8: Individual Agency Recommendations**

This reports each agency's own proposed actions required as a result of their individual management reviews.

### **Section 9 : Recommendations from the Overview Author**

This section identifies the key practice issues identified as requiring improvement from all agencies and are as follows:

1. There was insufficient basic knowledge and awareness of Adult Safeguarding, both in terms of vulnerability of some adults and the processes and procedures to protect them .
2. Too many people/agencies made assumptions about the other's role(s) and interventions without checking.
3. No agency took control of or assumed responsibility for the situation or challenged their colleagues for not doing so.
4. No agency undertook a proper analysis of the situation using the extensive history that was available if sought.
5. Decisions relied on poor, out of date or non-existence risk assessments.
6. Too much reliance was placed on Mr X's and family members' re-assurances that Mr Y would not harm Mr X.

Makes the following recommendations to address them and apply to each agency involved:

1. Implement and/or review internal training on Safeguarding Adults.
2. Establish protocols and training to improve intra and inter agency communication and understanding of respective roles and responsibilities.
3. Reinforce individual and collective professional responsibilities in multi-disciplinary and multi-agency service delivery, including the need for early multi-disciplinary and inter-agency sharing/pooling of knowledge.
4. Through management and/or peer supervision ensure the importance of historical knowledge and history to all forms of assessment (medical, social and risk) is recognised. Each agency to ensure access to their own records is facilitated.
5. Each agency to ensure they have a robust process for undertaking and using risk assessments and protocols for timely triggers to instigate them.
6. Implement training to ensure the application of knowledge about Domestic Abuse to Adult Safeguarding. Develop a more sophisticated knowledge of the Mental Capacity Act in relation to Adult Safeguarding (i.e. the concept of "Situational Capacity").

It makes some additional specific recommendations for individual agencies and concludes with some multi-agency recommendations for the Tower Hamlets Adult Safeguarding Board as follows:

1. The Safeguarding Adults Board to revise its training strategy to:
  - Improve knowledge and awareness of Safeguarding Adults at all levels.
  - Improve knowledge and awareness of Domestic Abuse and its relationship to adults at risk.
  - Improve understanding and use of the Mental Capacity Act appropriate to each organisations' needs.
2. The Safeguarding Board to formulate a strategy to improve inter-agency practice in relation to the following:
  - Risk assessments
  - Communication
  - Thresholds for multi-agency meetings
3. Each agency to report to the Safeguarding Board on how it is improving internal practice around:
  - Recording
  - Communication
  - Risk assessments
  - Holistic assessments

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21/08/2012