Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Safeguarding Adults Review

Adult Z

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Glossary

This report includes a significant number of abbreviations.

While each abbreviation is preceded by the full title on the first occasion of its use in the document, it is felt to be helpful to include this glossary for those who are not fully familiar with all the terms.

AMHP	Approved Mental Health Professional
CCG	Clinical Commissioning Group
ECT	Electro-Convulsive Therapy
EDT	Emergency Duty Team
LAS	London Ambulance Service
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
SCAIT	London Borough of Lewisham Social Care Advice and Information Team
SLaM	South London and Maudsley NHS Foundation Trust

Summary:

This report has been anonymised to protect the confidentiality of the person who is the subject of the report and their children. This review looks at the care and support received by Adult Z in November 2018. Adult Z lived with their son (Adult Child 2 (AC2)), who provided care and support. They also have a daughter (Adult Child 1 (AC1)) who also provides care, and who has been granted by the Court of Protection deputyship for finances.

Adult Z has a long-term mental health diagnosis with compulsory admissions to hospital in the past, but had disengaged with services in the early 2000's. They also de-registered from their GP practice around the same time.

Adult Z had very brief contact with services in the intervening period and did not accept support when it was offered.

Adult Z's daughter identified signs of deterioration in Adult Z's mental health in spring 2018 and attempted to refer Adult Z back to the mental health service but this was unsuccessful. Adult Z was advised to call an ambulance if it was an emergency but was told the mental health service could not respond as Adult Z was not registered with a GP.

Adult Z fell and fractured their nose and cheek in mid-October 2018. Adult Z attended hospital with AC1 and AC2 but would not remain to accept treatment and did not return for a follow-up appointment.

Adult Z took to bed following this incident and stopped eating and drinking. Adult Z also began to express suicidal thoughts.

Adult Z's daughter attempted to refer Adult Z to the local authority social care but did not receive a reply to her emailed referral. Adult Z's daughter telephoned the social care team due to the increasing urgency of her parent's situation but was told that the case could not be re-prioritised. Advice was again to call an ambulance if the situation was an emergency.

Adult Z's mental and physical health continued to deteriorate and on 2 November, as advised, Adult Z's son contacted the London Ambulance Service (LAS) due to concerns for his parent's worsening condition.

Adult Z presented dehydrated and emaciated and told the paramedics that they were committing suicide by starving them self. The paramedics assessed Adult Z to have capacity and concluded that they had no powers to convey Adult Z to hospital, despite the high risk they presented to them self.

The paramedics sought advice from their own specialists and also other agencies. An advanced practitioner from the mental health service Acute Referral Centre attended but was unable to assess Adult Z due to tiredness.

A MHA assessment was arranged for the following day. The AMHP and psychiatrist attended with paramedics and police. The paramedics assessed Adult Z as lacking capacity to make decisions for their care and in immediate need of medical care. Adult Z was therefore taken to hospital under the authority of Sections 5 and 6 of the Mental Capacity Act (MCA).

The mental capacity assessment on 2 November was subject to a Section 42 Care Act Enquiry following an allegation of Neglect/Act of Omission on the part of the LAS. The outcome of this Enquiry was deemed 'Inconclusive'.

Adult Z declined to take any part in the Section 42 Enquiry, stating that they could not remember the night in question and that everything turned out alright in the end. Adult Z's son and daughter both participated in the enquiry.

It was agreed at the October 2019 Lewisham SAB Case Review Sub-Group that the mandatory criteria were not met for this case, but it was felt that there was sufficient concern about how agencies worked together and with the family (nearest relative), that a 'proportional review' will be conducted. This review will be conducted under Section 44(4) Care Act 2014.

Safeguarding adult reviews

Section 44 of the Care Act 2014 places a statutory requirement on Safeguarding Adults Boards (SABs) to commission and learn from Safeguarding Adult Reviews (SARs) in specific circumstances, as laid out below, and confers on SABs the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.

Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (Section 44 (5), Care Act 2014).

The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures - April 2019

All LSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

Brief chronology

A report was completed within the remit of a Safeguarding Adults investigation under Section 42 Care Act 2014. This review is using much of the information obtained in preparation of that report. The intention is not to repeat that report and therefore the chronology of events will be brief.

Adult Z has three children, two of whom they are in regular contact with. Adult Z lived with their son, who provided care and support. Their daughter also provides care and has been appointed by the Court of Protection as deputy in relation to Adult Z's property and financial affairs.

Adult Z has a diagnosis of schizophrenia dating back many years. It is reported that they had been admitted to the Bethlem Hospital at that time and had been treated with electro-convulsive therapy (ECT).

There is little information regarding Adult Z's mental health, care and treatment from that time until 2000, when they were admitted to the Ladywell Unit of University Hospital Lewisham. Adult Z was detained under the Mental Health Act 1983 (MHA) initially under Section 2 (for assessment, or assessment followed by treatment) and subsequently under Section 3 (for treatment). Adult Z was treated at that point with anti-psychotic medication.

The psychiatrist's report following his examination of Adult Z in November 2018 and review of Adult Z's notes states that they had also received a diagnosis of schizo-affective disorder. Both diagnoses indicate a psychotic illness, with the latter indicating a mood component.

Section 3 MHA triggers at point of discharge a joint duty on the Local Authority and Clinical Commissioning Group (CCG) to provide aftercare to prevent relapse and possible readmission to hospital.

It is not clear when Adult Z was discharged from hospital. Records state that they had a long history of non-engagement with services and there is no information regarding the level and duration of follow-up following Adult Z's discharge.

During the subsequent 18 years there was very little contact with either primary health or secondary mental health services.

Adult Z had brief contact with the mental health team in 2003.

Adult Z de-registered with their GP at the Jenner Practice in 2004. There is a suggestion that the reason for deregistration was to avoid the risk of being readmitted to psychiatric care, but this has not been confirmed.

Adult Z temporarily registered with the Jenner GP Practice in 2012 for “immediately necessary” treatment.

There was brief contact with the mental health team in 2012/13 following Adult Z's partner's death at home but no further details are available.

Adult Z's family made a referral to the mental health crisis line in March 2018 with concerns regarding Adult Z's mental health. Adult Z had cut them self on the neck with a knife and the family were concerned that Adult Z was feeling suicidal. Adult Z claimed it was an accident, but the family believed it was deliberate.

The mental health service advised by telephone that no response was possible and the Crisis Team could not become involved because Adult Z was not registered with

a GP. The mental health crisis line advisor suggested that Adult Z's daughter (AC1) call an ambulance.

An ambulance was called and attended. The crew assessed Adult Z as having capacity to make decisions regarding their care. They advised that the local authority be contacted but were unable to provide a telephone number.

Adult Z's daughter telephoned the mental health crisis line again and was this time given another telephone number to ring. However, this was a wrong number and then there was no answer when she rang back.

Adult Z fell and fractured their cheek in mid-October 2018. They attended the Accident and Emergency Department of University Hospital Lewisham.

Adult Z did not remain at the A&E department for treatment, insisting that there was nothing wrong. Adult Z was given an appointment to return the next day but did not do so.

AC1 emailed the Social Care Advice and Information Team (SCAIT) in the last week of October requesting support for Adult Z. She stated that someone needs to assess Adult Z's mental and physical health and that they probably need to be in care.

AC1 telephoned SCAIT at the end of October as she had received no response following her email one week earlier. She was advised that the referral was in the system and that there was no possibility of re-prioritising Adult Z's case. AT was advised to call an ambulance if it was an emergency.

Adult Z's son called 999 shortly before midnight 2 November 2018 due to his concerns for Adult Z's health. Paramedics attended and found Adult Z to be dehydrated and emaciated. Adult Z was refusing to be taken to hospital and the paramedics assessed them to have capacity to make that decision.

The paramedics remained at Adult Z's home for over 3½ hours, during which time they contacted the London Ambulance Service clinical support desk for further advice, NHS111 to speak to a doctor, the police and Lewisham Emergency Duty Team (EDT).

EDT requested the Crisis Team involvement from the mental health Acute Referral Centre and an advanced practitioner from that team attended. This professional was also an Approved Mental Health Professional (AMHP) but was not working in that role while on duty for the Acute Referral Centre.

Although the initial records state that the advanced practitioner agreed that Adult Z had capacity to make the relevant decision, it has been established that that practitioner did not attempt to reassess Adult Z's capacity and accepted the views of the paramedics.

The advanced practitioner attempted to engage with Adult Z but they appeared tired and weak, and did not engage. The advanced practitioner felt it was best to leave Adult Z to sleep as they had already undergone an assessment with the paramedics who had been at the property for over three hours.

Adult Z's son was staying with them and was advised to contact LAS if there was further change or if Adult Z changed their mind in reference to refusing medical treatment.

The advanced practitioner referred to the AMHP service for a MHA assessment. The duty AMHP obtained a warrant from a magistrate under MHA Section 135(1)[1]. The AMHP consulted with Adult Z's son and daughter and attended mid-afternoon the next day.

The AMHP applied for a warrant under MHA S135 as they were aware that this would permit them to remove Adult Z to a place of safety if thought fit. There was no requirement for the warrant to authorise a forced entry as the AMHP had agreed in advance that access would be granted by Adult Z's children.

The police and paramedics were also in attendance. Due to Adult Z's physical state, the paramedics undertook an assessment of their capacity to make decisions regarding their physical care. They found that Adult Z lacked such capacity and a decision was made in their best interests to remove them to the Accident and Emergency department of the general hospital.

A MHA assessment was not completed at this time as the primary need was for physical treatment and the MCA was the appropriate authority to use for this purpose.

The psychiatrist also completed a medical recommendation for MHA Section 2.

[1] MHA section 135(1) permits a police officer, AMHP and doctor to enter a property and, if thought fit, to remove a person to a place of safety, for the purpose of considering detention under the MHA, or for other arrangements for their treatment or care.

Views of Adult Z’s daughter

The reviewer consulted with Adult Z’s daughter (AC1) in relation to her contacts with statutory services. She had asked Adult Z whether she wanted to be involved in the review and to be interviewed but Adult Z declined, repeating their previous statements that they do not remember anything about the incident.

AC1 provided some further background information regarding her family history, some of which has relevance to the chronology described above.

AC1 described her parent as always having a mistrust of mental health services. It is her strong view that the reason for her parents de-registration from the GP practice was to avoid further contact from mental health services.

AC1 explained that Adult Z’s partner died at home in 2012. The police and ambulance attended and felt that Adult Z needed assistance. As a result, Adult Z came to the attention of the social services department. The local mental health service became involved and prescribed medication but AC1 stated that Adult Z did not take it.

AC1 became her parent’s deputy for property and financial affairs at this point.

Adult Z’s case was closed after approximately six months. AC1 was told that she could re-refer Adult Z if necessary.

AC1 described her contacts with the mental health service in March 2018, when she attempted to refer Adult Z due to concerns regarding possible suicidal ideation and risk.

AC1 stated that she and her brother both believed that Adult Z had deliberately cut them self with a knife. Adult Z said that it had been an accident but her son, who was living with them at the time believed it was deliberate. They had caused a wound on their neck.

AC1 had a telephone conversation with a mental health professional when making the referral. The person had looked up Adult Z’s mental health history, consulted with their manager and rang AC1 back to tell her that no action could be taken by the mental health service because she was not registered with a GP.

AC1 was advised to call an ambulance if it was an emergency. Although she did not feel it was an emergency warranting a ‘999’ call, AC1 called an ambulance which attended.

AC1 described the ambulance crew as very sympathetic. They told her that they wanted to take Adult Z in but they could not, as they had assessed her as having capacity. AC1 asked them what they advised as next steps.

AC1 stated that the ambulance crew told her she needs to ‘say the right words’. AC1 reflected at the time of this consultation that it was “almost as if you need to use these special trigger words”.

AC1 described feeling powerless to take the correct action. She was aware that her parent was resisting offers of help and felt there was no route of referral. All the doors she was trying appeared to be closed to her.

AC1 related her ambivalence regarding referrals to the mental health or social services. Her parent was saying they did not want any help and appeared to be getting better, and AC1 did not want to cause any further stress.

Adult Z's son was present when she fell and fractured her cheekbone in October 2018. AC1 also attended the Accident and Emergency Department. Adult Z would not cooperate with the staff and would not remain on the bed. AC1 stated in her view she was clearly in denial that anything was wrong.

When Adult Z insisted on going home, an appointment was made for her to attend the next day. AC1 stated that she knew that her parent would not attend and informed the staff of this.

AC1 stated that the injury to her parent's cheekbone affected their ability to eat. Adult Z took to their bed following this and while AC1 believed they needed medical assistance, Adult Z consistently refused it. Adult Z began to talk about wanting to die and to be 'euthanized'.

AC1 emailed the local authority Social Care Advice and Information Team (SCAIT) on 24 October to request assistance and when she did not get a response she contacted her own employer's employee assistance helpline.

The advice provided was no different to the routes that AC1 had already followed. AC1 stated that the advisor suggested she contact SCAIT again, but ensure that she uses 'key words' the person advised that AC1 stress the words "self-neglect".

AC1 telephoned Lewisham Council on 31October and spoke to an officer in the SCAIT. AC1 explained that she had made a referral a week earlier, she had not received any response and she believed that the situation was urgent.

AC1 told the SCAIT officer that she did not believe her parent had capacity to make decisions and that she had not been eating.

AC1 stated that the SCAIT officer was emphatic that the referral could not be re-prioritised. There was no negotiation possible. AC1 was advised to call an ambulance if it was an emergency.

AC1 was not present during the night of 2 November when the paramedics attended Adult Z, so was unable to comment on the issues raised at that time.

Thematic analysis

The review has identified several factors which warrant further exploration in the context of the care and treatment provided to Adult Z, and to the responses to the family when attempting to re-refer Adult Z to services.

Some factors are historic and predate the events of 2/3 November by many years. However, it is the opinion of the reviewer that all the factors have a bearing on the events in question and the responses of the various agencies to Adult Z's family during the latter half of 2018.

MHA Section 117

MHA section 117 places a duty on local authorities and CCGs to provide mental health aftercare to certain categories of patients who have been detained for treatment for their mental disorder.

The qualifying sections of the MHA include section 3, under which Adult Z was detained in 2000.

In 2000 and until 2015, there was no definition of aftercare in this context, but case law at that time provided suggestions regarding the sort of provision that may be considered aftercare[2].

There is no requirement for patients to accept the aftercare which is being offered. However, an unwillingness to receive aftercare is not to be equated with an assumption that such services are not needed.

A person continues to be subject to section 117 and the local authority and CCG remain under an obligation to provide aftercare until and unless the responsible authorities agree that the person is no longer in such need.

It is important to be aware that the MHA Code of Practice has been updated twice since 2000[3] and the current Code at that time was issued in 1999. Guidance on ending section 117 aftercare services was expanded in the 2008 edition of the Code.

However, Local Authority Circular LAC 2000(3) stated *"Social services and health authorities should establish jointly agreed local policies on providing S117 MHA after-care. Policies should set out clearly the criteria for deciding which services fall under S117 MHA and which authorities should finance them. The S117 MHA Aftercare plan should indicate which service is provided as part of the plan. After-care provision under S117 MHA does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when after-care provided under S117 MHA should end, taking account of the patient's needs at the time. It is for the authority responsible for providing particular services to take the lead in deciding when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted"*.

This quote is included to illustrate that even in 2000 there were clear expectations on local authorities and the NHS to have policies and procedures for patients subject to section 117 aftercare, and to decide on a case-by-case basis when the aftercare should end.

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[2] See Clunis v Camden and Islington Health Authority [1998] 3 All ER 180

[3] The current Code of Practice was issued in 2015. The previous Code, issued in 2008 replaced the 1999 edition.

It appears that Adult Z was never discharged from section 117 and the duty was therefore never ended. There was no documentation confirming the ending of aftercare and no consultation with Adult Z regarding its ending.

There is no doubt that Adult Z was reluctant to remain in contact with services following their discharge in 2000. Adult Z appears to have gone to some lengths to disengage with services including possibly de-registering from their GP practice.

However, this does not absolve the local authority from maintaining an awareness of their needs, even if they were refusing services. The local authority could have decided to consult with the relevant NHS body (at the time) and with Adult Z to end the aftercare but this did not happen.

Therefore, when Adult Z came into contact with services in 2012 the aftercare duty was still active. Services were offered at that time, in the way of medication, but Adult Z did not take the prescribed medication, as was their right.

More importantly, when a further referral was made to the mental health service in March 2018, the aftercare duty remained active. Although scrutiny of Adult Z's records by a mental health professional would have identified a previous section 3 detention, it is unlikely that this would have alerted them to the possibility of ongoing aftercare duties as their case had been closed to the service for five years.

In fact, the response of the mental health professional to Adult Z's daughter, that no Crisis Team response was possible due to Adult Z's lack of GP registration makes it clear that no consideration was given to their section 117 status.

While Adult Z's qualifying MHA detention was 18 years before the incident which led to this review, it is the reviewer's experience that many local authorities and NHS trusts struggle to maintain contact or records of patients who are subject to section 117 when they are no longer in contact with secondary mental health services.

It is important that the local multi-agency section 117 policy is agreed by all agencies and understood by all professionals. The Association of Directors of Adult Social Services (ADASS) has produced guidance and principles for aftercare under section 117[4]. It suggests the document complements local policies.

It is also important that both health and social care are able to easily identify those people who are subject to section 117 aftercare, even if they are not currently receiving any services.

[4] Guidance and Principles for Aftercare Services Under S117. London ADASS 2018.

De-registration from GP care

Adult Z deregistered from their GP practice in approximately 2004. Although the notes are incomplete due to a change of computer system in the practice, it appears that Adult Z was registered with the practice from 1998 until their deregistration.

Adult Z had been given diagnoses of schizophrenia or schizo-affective disorder, both of which feature psychotic symptoms and are generally considered to be severe mental illnesses. As a result of this, it is suggested that Adult Z was a patient with a particular vulnerability, and it is important to make every effort to maintain contact with such patients, notwithstanding their rights to disengage with services.

It must be acknowledged that the de-registration was many years ago. Organisational arrangements and recording systems have changed considerably in the intervening period. However, it is important to consider the current policies and procedures for the CCG in relation to patients who deregister from their GP practice.

During the course of the review, it was confirmed that at least one GP practice in Lewisham has no policy regarding patients who de-register from the practice.

The British Medical Association has guidance on its website for GPs who may wish to de-register patients[5], which mainly focuses on patients who are abusive or violent. Other reasons will be if the patient has died or has moved out of the area.

Lewisham has a policy for patients with a history of violence. They are registered with a particular practice in Catford.

It was noted by a local GP during the course of this review that “it is incredibly rare for a patient just to ‘de-register’. The most common reason a patient leaves a practice list is because they have actively registered elsewhere and under the regulations we have no power to prevent them.”

The example of Adult Z illustrates that although de-registration without registration with a new GP is very rare, such occurrences may well be caused by the vulnerability of the individual, and as a result they are left without any healthcare support.

Adult Z was known to have a specific and severe vulnerability, considered widely to be long term and requiring ongoing support. As discussed above, the local authority and NHS retained a duty to offer aftercare, although Adult Z was under no obligation to accept it.

The lack of any monitoring system in relation to patients who deregister from GP practices means that particularly vulnerable individuals who may have significant needs may continue to deregister without registering with a new GP, and no alert is raised to consider whether any follow-up may be required.

[5] https://www.bma.org.uk/advice-and-support/gp-practices/managing-your-practice-list/removing-patients-from-your-practice-list

Access to services without GP registration

It is concerning that Adult Z's daughter was given information in March 2018 that the local mental health service could not respond to an apparent mental health crisis due to Adult Z's lack of GP registration.

It has been confirmed that the statement to Adult Z's daughter was not correct and should not have been made. While GP registration is important to determine who pays for the NHS care provided to the patient, it is not a bar to provision of care.

Adult Z's daughter informed the reviewer during the preparation of this report that the mental health professional had checked Adult Z's history, spoken to their manager and telephoned her back before confirming that no action could be taken as Adult Z was not registered with a GP.

It is vital that all staff in the local authority and mental health service are aware that access to mental health services is not dependent on GP registration.

This issue is also covered in the section below 'Legal literacy: The Mental Health Act 1983', in relation to both the rights of the nearest relative to request an AMHP considers their relative's case, and also the duty of the local authority to arrange for an AMHP to consider a person's case in certain circumstances.

SCAIT response to the referral on 24 October and follow-up telephone call on 31 October

The original safeguarding enquiry identified and commented upon the limitations of the SCAIT response to AC1's referral and follow-up telephone call. This review has little to add to the comments made in the previous report.

The email sent to SCAIT identified a person who would appear to be clearly in need of care and support and eligible for a social care assessment under the Care Act. It also identified a number of specific risks, including deteriorating mental health, history of compulsory admission to hospital (being 'sectioned'), possible history of self-harm in the past six months, fainting and falls resulting in serious injury, refusal of treatment following a recent injury, non-concordance with prescribed medication, likely lack of capacity for at least some decisions (in the context of a deputyship for finances), failure to obtain help from either mental health or primary healthcare services, belief that the person needs to be in care.

The initial report stated that the referral was passed on to the mental health service on 1 November. This was within 6 working days of the original contact and considered by the SCAIT manager to be within a reasonable timescale.

It is noted that the referral on to mental health services was made after the follow-up telephone call by AC1. It is not clear whether that onward referral would have been made on 1 November, or at all, if AC1 had not made her telephone call on 31st October.

At no time did staff from SCAIT inform AC1 that the original email had been received, or that it had been passed on to the mental health service following the telephone conversation on 31 October.

It is important to consider this process from the point of view of the referrer. The email was sent on 24 October and contained details of significant risks involving Adult Z's mental and physical health.

During the following seven days, AC1 as referrer received no confirmation of receipt of the email. She would have been unaware of whether the email had been opened or read.

One week (five working days) after the initial email was sent, AC1 made telephone contact with SCAIT. She clarified the details in the original referral and told the SCAIT worker that Adult Z was not eating and may lack capacity. The response from SCAIT was that the case had been opened and could not be re-prioritised.

No date was given for an assessment and AC1 was advised to take Adult Z to Lewisham Accident and Emergency or call an ambulance if necessary.

AC1 had already been given advice by her employer's assistance helpline that she should use 'trigger words' such as 'self-neglect' but this made no difference to the response.

During the multi-agency 'learning event' which was held in November 2020, it was noted that SCAIT receives hundreds of emails each day, so it is difficult to be confident that such an event could not be repeated.

It is important that SCAIT is able to identify cases where there is significant risk and which may need re-prioritisation. An escalation process and sufficient staff with professional expertise is required to minimise the likelihood of this being repeated.

The need to use ‘trigger words’ to elicit a response from services

This was raised by Adult Z’s daughter in the context of her failed attempts to refer her parent to services.

On two occasions and by two very different services, AC1 was told that she needed to use “key words” or “the right words” to elicit a positive response.

On the first occasion, this comment was made by paramedics attending Adult Z in March 2018.

On the second occasion, AC1 was given this advice by her employer’s employee helpline.

While it is helpful that certain words and phrases can accurately reflect the degree of urgency and risk, and assist an initial assessment or triage of a referral, it is concerning that failure to use such words and phrases could result in a negative response to requests for help.

This is a difficult issue, there is no simple answer and it is not something that policies and procedures can adequately address.

Services increasingly use algorithms to create consistency in responses to requests for assistance, and it is important to ensure a reliably high quality service.

However, such consistency should not be at the expense of engagement with the public. Referrers may not be familiar with NHS and local authority systems and may not possess the language skills or understand the jargon that is used in such organisations.

This is particularly important for people for whom English is a second language, many of whom already face additional difficulties in communication. This was not an issue in this case, but the fact that the referrer was an articulate person for whom English is her first language further illustrates the point.

Legal literacy: The Mental Health Act 1983

1) The Nearest Relative

A patient's nearest relative is an important person within the context of mental health care, as they have specific rights and responsibilities granted to them by the MHA.

The nearest relative is strictly defined using a complex set of rules in MHA section 26. It is generally the role of the AMHP to identify the nearest relative during the course of a MHA assessment, considering whether a person needs to be compulsorily admitted ('sectioned') to hospital.

The concept of the nearest relative has been widely criticised and is considered an anachronism from the previous Mental Health Acts which were passed in the middle of the 20th century[6]. The current review of the Mental Health Act recommends removing the nearest relative and replacing it with a Nominated Person, who the patient can choose themselves[7].

However, until and unless the MHA is changed, the current legislation will continue to require identification of the nearest relative, and their roles and responsibilities will remain.

The MHA requires the nearest relative to be informed before or as soon as practicable after a patient has been detained on MHA section 2, and they must be consulted (if practicable) before an assessment for detention under MHA section 3.

The nearest relative has a number of other legal rights, the most relevant in this context is the right to request that an AMHP "consider the patient's case" in relation to possible compulsory admission to hospital[8].

However, it is widely accepted that most nearest relatives are unaware of their rights[9], until and unless provided with that information by an AMHP or another mental health professional.

Adult Z's son lived with them and her daughter provided care, evidenced by the fact that she was Adult Z's financial deputy. This placed both at the top of the legal hierarchy in determining who is the nearest relative. Adult Z's daughter is the elder of the two and therefore takes priority over her younger brother.

The AMHP who attended Adult Z on 3 November and would have considered compulsory admission if the paramedics had not determined that they lacked capacity in relation to their medical needs, appropriately contacted both Adult Z's son and daughter before the assessment. The AMHP consulted with them and correctly identified that Adult Z's daughter (AC1) was in law the nearest relative and informed her of her rights as such.

AC1 confirmed to the reviewer that this conversation with the AMHP, during which she was provided with information about her rights as nearest relative, was the first time she was made aware of her legal right to request an assessment.

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[6] The NR and the Nominated Person. Tim Spencer-Lane, Journal of Mental Health Law 2011

[7] See Modernising the Mental Health Act: increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Open Government Licence 2018.

[8] MHA section 13(4)

[9] Reflections on 'A Relative Affair', J Rapaport. Kings College London SCWRU 2012..

As discussed above, AC1 made a referral to the mental health service in March 2018 due to severe concerns regarding her parent's mental health, and again in October 2018 to the local authority SCAIT. On neither of those occasions did she couch her requests in such a way that she was explicitly asking for consideration of admission under the MHA.

It may be that AC1 did not want to 'up the ante' and request consideration of compulsory admission. She expressed understandable concern at requesting help against her parent's wishes.

However, if AC1 had been aware of her statutory rights under MHA section 13(4), she would have had the opportunity to exercise those rights following the rejection of her other requests. This would have enabled a careful consideration of Adult Z's mental health either in March 2018 or in October before her physical state reached a critical point.

The main question following from this is how best to ensure that nearest relatives legal rights are protected. It is unrealistic to attempt to provide this information to everyone who could possibly be put in this position.

It is more realistic to consider which professionals are most likely to come into contact with relatives of people in mental health crisis, and to ensure that those professionals are aware of this important legal right.

While the accurate identification of the nearest relative can be a complex matter, a broad understanding of the existence of this power will enable the decision to be made by the most appropriate team, which is likely to be the local authority AMHP service.

2) The duty on the local authority to consider a patient's case

While the focus of this section has been rightly on the specific rights of the nearest relative under the MHA, it is also important for all staff to be aware of the general duty placed on the local authority to arrange for a local authority to make arrangements for an AMHP to "consider the patient's case" if it appears that the person ***may*** need compulsory admission to hospital.

> "If a local social services authority have reason to think that an application for admission to hospital … may need to be made in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patient's case on their behalf."[10]

This is separate to the particular duty placed on the local authority by a request from a nearest relative.

This does not mean that every request for mental health support should be directed to the local authority AMHP service, as the majority of people with mental health needs will require a less intrusive and potentially less restrictive response.

However, it is vital that staff who receive referrals from the public are aware that there is a statutory duty to respond to information suggesting a person may be experiencing a mental health crisis which may require hospitalisation.

[10] Mental Health Act 1983 section 13(1)

The law places this duty on the local authority, although many services, including those in Lewisham operate close and effective partnership arrangements between the local authority and the mental health trust.

Therefore, it is reasonable that less restrictive responses, such as Crisis team involvement or Home Treatment are considered in the first instance.

It is important however that artificial barriers are not created to referrals which indicate a mental health crisis or require an urgent response.

It is not acceptable and arguably not legal for an insistence that a patient is registered with a GP before a response is made to a potential mental health crisis. It is also suggested that it is not legal for a requirement that all referrals for mental health crisis are made by a particular service, such as within primary care.

Assessing capacity

Both mental health professionals who attended Adult Z on 3 November expressed major concerns in relation to the mental capacity assessment undertaken by the paramedics the night before.

Both AMHP and psychiatrist made statements questioning the likelihood of Adult Z having capacity to make decisions in relation to their medical care during the night of 2/3 November, given their critical condition just twelve hours later.

The psychiatrist questioned whether the paramedics were able to differentiate the ability to understand the information, and the ability to use or weigh it to come to a decision. These are two separate elements of what is generally described as the 'functional' part of the capacity assessment[11].

Steven Richards, trainer in mental capacity, CQC reviewer and specialist adviser in relation to the MCA has acknowledged that the assessment of whether a person can use or weigh the information to come to a decision may be the most challenging part of the capacity assessment. This can be particularly difficult if the person is showing a high degree of understanding[12].

It is also remarkably difficult to make retrospective decisions regarding a person's mental capacity. The Mental Capacity Act 2005 (MCA) specifies that capacity is both time-specific and decision-specific[13]. A professional is required to hold a 'reasonable belief' that a person does or does not have capacity to make a particular decision at a particular time. The standard of proof is on the balance of probabilities[14].

Adult Z's physical and cognitive condition was inevitably deteriorating over time, due to their failure to eat or to take fluids. This was compounded by their beliefs fuelled by their mental disorder. It is reasonable to believe that whatever their level of cognition during the night of 2/3 November, it will have deteriorated further over the ensuing 12 hours, given their lack of food and fluids.

The paramedics who attended during the night of 2/3 November spent over 3½ hours at the address and during that time consulted with the full range of professionals and agencies. They appropriately took advice from the LAS clinical advice line, which is designed to support paramedics in these difficult circumstances.

The paramedics reported to the advanced practitioner from the Crisis Team that Adult Z had been responsive and engaged in conversation with them when they had assessed their capacity. They added that Adult Z was "clear about refusing treatment knowing that the result may be death."

It is noted that no record of the detail of the mental capacity assessment is recorded on the LAS form 'LA5'. All relevant boxes are ticked to indicate that Adult Z had capacity to make the decision, and the free text box below was left empty. However, the form only requests notes to be made in that box if any of the answers indicated a lack of capacity. The adequacy of the form LA5 will be discussed in the next section below.

[11] Mental Capacity Act 2005 s3(1)

[12] Analysis of case study for West of Berkshire Safeguarding Adults Board (2015) http://tinyurl.com/y96mux5n

[13] Mental Capacity Act 2005 s2(1)

[14] Mental Capacity Act 2005 Code of Practice 4.44.

The psychiatrist who examined Adult Z during the afternoon of 3 November noted that at this point Adult Z reported that they had lost their vision. He also noted that Adult Z told him that they would "be fine" if left alone, and that their pain would "go away".

This is a significantly different description to the one provided by the paramedic the night before. There is no suggestion that both descriptions are not accurate and reflect what was said at the time.

It is noted that the paramedics spent a considerable period of time at Adult Z's home, including after determining they had capacity to make the decision. They contacted NHS111, the mental health Crisis team and the local authority EDT. They did not abandon Adult Z and completed a range of actions to ensure that care would be followed up by other agencies.

Adult Z's son also commented to the investigating officer during the initial section 42 enquiry that he had no concerns about the intervention of the paramedics who attended that night. He stated that he felt that they did "everything they could have done" to support his parent, that one paramedic in particular established a good rapport with Adult Z, that they provided Adult Z with relevant information and encouraged them to go into hospital. They explained the implications if they did not go and he stated that his parent was "receptive".

This praise for the paramedics does not provide evidence in relation to the quality of the mental capacity assessment, but is important to include in this report in relation to the care that was taken to support Adult Z at the time.

The reviewer cannot come to a conclusion regarding the accuracy of the mental capacity assessment undertaken during the night of 2/3 November. It was clearly a difficult assessment with an individual who was expressing wishes which indicated a very grave outcome.

Wishes and feelings are not indicators of capacity. A judge has stated that "it is vital that wishes and feelings are strictly confined to the best interests analysis and do not act subtly to undermine a capacity assessment"[15].

In this case, there is evidence that the paramedics did not simply rely on Adult Z's expressed wishes and feelings. They explained to Adult Z the likely outcome of their refusal to eat and drink, or to accept help, and it appears that Adult Z was able to relay to them their understanding of the risks.

After obtaining further advice, the paramedics appropriately arranged for a MHA assessment to be undertaken as the MHA would potentially provide authority to intervene against Adult Z's wishes, which they had determined was not available under the MCA.

During the 'learning event' in November 2020 it was stated that the LAS was updating its mental capacity training. It is important that the training is not restricted to theoretical and legal training, but includes a focus on the practice of assessing capacity, particularly in borderline and high risk circumstances which paramedics are likely to experience on a regular basis.

[15] A Hospital Trust v CD [2015] EWCOP 74 {para 28)

LAS mental capacity tool and form

At the 'learning event' in November 2020, it was acknowledged that the LAS mental capacity tool needed to be amended and was currently being worked on.

The LAS patient report form (LA4) makes a brief reference to the MCA and refers the paramedic to the 'Assessment of Capacity' form LA5 if necessary.

It is noted that the reference to the MCA in form LA4 references the four elements of the 'functional' test (the ability to understand, retain, use or weigh the information, and to communicate the decision). However there is no reference to the 'diagnostic' test. That is, the inability to complete any of the four elements of the functional test must be ***because of*** an impairment of or disturbance in the functioning of the person's mind or brain. This has been referred to in case law as the "causative nexus"[16].

Whilst there is no requirement in law for the person to have a formal diagnosis, the capacity assessor must have a reasonable belief that there is some impairment in the person's mind or brain which is causing the inability to make the decision.

The impairment may be temporary (such as inebriation or concussion), episodic (mental illness), life-long (learning disability) or progressive (dementia). Where there is no evidence of impairment, there is no authority to take action using the authority of the MCA, even if the person is finding it extremely difficult to make a decision.

Equally, a person with an impairment may be finding a major, life-changing decision particularly challenging, but the difficulty may be due to the gravity of the decision rather than the nature of their impairment.

Form LA5 in which the capacity assessment is recorded makes no reference to the evidence of an impairment or disturbance in the functioning of the person's mind or brain.

The form asks whether the person is free from coercion to make their own decision. This is an important question to ask, but it is suggested that this is relevant to safeguarding issues rather than a capacity assessment.

A person may have capacity to make a decision but be prevented from exercising their free will due to coercion or other influences. This does not indicate a lack of capacity in relation to the MCA. It may however indicate the need for other action such as a safeguarding referral or police involvement.

The assessment of capacity is represented by seven yes/no tick boxes. Some of them accurately reflect the functional element of the capacity test, but it is not clear in the form whether a failure to tick all boxes will indicate a lack of capacity.

The assessment of whether the person is able to understand the information relevant to the decision is represented by three different questions:

- Do you feel that the patient understands what is proposed and why?
- Do you feel that the patient is able to understand the principal risks and benefits of what is proposed?
- In your opinion, does the patient understand the reasonably forseeable (sic) consequences of receiving the proposed treatment?

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[16] PC and NC v City of York Council [2013] EWCA Civ 478

While each of these elements are relevant to the question of understanding, it is not clear whether failure to achieve one of these but to manage the other two would indicate a lack of a capacity.

The assessments regarding retention of the information, using and weighing the information, and communicating the decision are each covered by one question.

There is a further question which asks “have you been able to have a rational conversation with the patient about the pros and cons of what is proposed?” The footnote to this question states “This question is designed to ensure there has been a conversation involving feedback to evidence understanding, rather than a series of ‘Yes/No’ answers.”

It is suggested that the ability to discuss and appreciate the pros and cons of what is proposed fits most appropriately with the ability to use and weigh the information, rather than understanding it.

Beneath these tick boxes, there is a free text field with the instruction “Please make a brief note of the reasons for your ‘No’ answers”. There is therefore no expectation or requirement to make any note of reasons why ‘Yes’ answers have been obtained.

It may be that this decision was made to reflect the first key principle of the MCA, the assumption of capacity. A person must be assumed to have capacity unless it has been established that he lacks capacity[17]. If that is the case, it is suggested that this is a misunderstanding of this principle.

The MCA Code of Practice provides guidance on when an assessment should be undertaken regarding a person’s capacity to make a decision. This is when there is some question or doubt over their capacity[18]. However, the assumption of capacity means that the burden lies with the assessor to show evidence that the person lacks the relevant capacity. There is no requirement on the patient or service user to prove their capacity[19].

It is suggested that in cases where mental capacity is in doubt and a capacity assessment is required, it is equally important to record the evidence of the assessment, whether it concludes that the person has capacity or lacks capacity for the decision.

This case, where the decision is particularly grave, clearly illustrates the importance of evidencing the assessment, even when the conclusion is that the person has capacity to make the decision.

It is also suggested that tick box questions, which are a helpful aide memoire of the various elements of the test, should simply reflect the different legal elements of the diagnostic and functional tests. Further guidance can assist on how to address the complexities within each element.

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[17] Mental Capacity Act 2005 s1(2)

[18] Mental Capacity Act Code of Practice 4.35

[19] This is well illustrated in Cardiff City Council v Ross and Davies (2011) unreported, case no. 12063905

Conclusions

Disengagement with and loss to services

Following Adult Z's discharge from MHA section 3 and discharge from psychiatric hospital in 2000, they were subject to section 117 aftercare but rapidly disengaged with services. They de-registered with their GP and this was not identified as cause for concern as most people who de-register will register with another GP.

There appears to have been no section 117 aftercare plan or any review of Adult Z's section 117 status. While it may have been reasonable to consider whether Adult Z continued to require aftercare, this decision was not made.

Adult Z's loss of contact with primary care meant that there was no monitoring of their physical or mental state for over ten years.

The brief contact with services during 2012/13 at the time of Adult Z's partner's death did not alert any agencies of the lack of support for Adult Z who appears to have had ongoing needs.

It is important to note that Adult Z had the legal right to refuse services which were offered, even if Adult Z was considered to be in need of care and support.

The referral from the police and ambulance services at the time indicates a concern for Adult Z's welfare by the emergency services. However it is outside the remit of this review to comment on whether further action should have been taken to offer support at this time.

The impact of Adult Z's disengagement from all health agencies directly impacted on the ability of their daughter to re-refer them to the mental health service in 2018. Despite being told in 2013 that they could be referred back to mental health services, Adult Z's daughter found it impossible to elicit a positive response.

Difficulties in re-referral to services

The difficulties Adult Z's daughter found when attempting to re-refer her parent to services have been clearly set out above. This was not restricted to either the NHS or local authority but applied in both cases and for different reasons.

It is acknowledged that all services are extremely busy and operating at or near capacity. However, it remains important that people are able to access services when their needs increase, and in particular that staff are aware of the statutory duties which are placed on their services to respond to referrals.

It is important that effective escalation processes are available and used to ensure that front-line staff are able to gain further support when it appears that a case may require re-prioritisation due to additional information becoming available. This requires sufficient staff available, with the appropriate levels of skill and expertise to support front-line staff when required.

Assessments of mental capacity and interface with the Mental Health Act

Numerous documents from government and other agencies have repeatedly reported difficulties in understanding and implementation of the MCA. In addition, it is widely acknowledged that the interface between the MCA and the MHA is particularly complex and challenging, even for those people who are considered experts in the field.

There is no doubt that Adult Z's presentation posed considerable difficulties to the paramedics attending on the night of 2/3 November, in relation to their assessment of Adult Z's capacity to make decisions regarding their care.

It is clear that the paramedics worked hard and for an extended period of time to attempt to persuade Adult Z to agree to be taken to hospital, and when they refused and they determined that they did not have the legal authority to remove them against their will, they contacted the appropriate agencies and arranged further assessments which eventually resulted in Adult Z being admitted to hospital 12 hours later.

There is no clear evidence that the paramedics failed to correctly assess Adult Z's capacity on the first occasion. The recording is limited and was not assisted by the form which they were required to complete.

However, their description of the assessment with Adult Z, combined with the description provided by Adult Z's son suggests that they did actively consider whether Adult Z was able to use and weigh the information relevant to the decision.

It is also true that Adult Z's presentation at the assessment 12 hours later was significantly different and there was clear evidence of them being unable to understand, or to use and weigh the information.

Even if Adult Z had been assessed as having the relevant capacity at the assessment on the 3 November, the presence of an AMHP and psychiatrist approved under the MHA, and a warrant issued under MHA s135(1) meant that the professionals had the authority to remove Adult Z to a place of safety for a further assessment of their mental health.

This had not been available to the paramedics the night before and they correctly alerted the EDT service to mobilise the AMHP service to initiate actions under the MHA.

These are most challenging assessments for paramedics (and other professionals) and it is important that the proposed mental capacity training that the LAS is planning this year addresses these very difficult issues. Practical examples such as these should be used to allow staff to work through these dilemmas in a protected environment.

Recommendations

Section 117 aftercare

1) The Local Authority and NHS Trust ensure they are aware of all individuals for whom they hold responsibility to provide section 117 aftercare, whether or not they are currently receiving services. This information should be easily available at the front of the respective client databases.

Assessment of capacity

2) The LAS ensure that the new capacity assessment tool fully reflects the legislative requirements, and requires evidence to be provided for all outcomes of assessments.
3) The LAS ensures that mental capacity training for their staff includes practical elements including complex and borderline decisions where there is doubt over the person's ability to use or weigh the information.

SCAIT case prioritisation

4) The SCAIT has a procedure in place in which high risk cases can be escalated to a more senior professional to consider re-prioritising and increasing the urgency of response.

Legal literacy in relation to the MHA

5) All public facing services within the mental health service and adult social care are aware of the nature of the nearest relative role in the MHA and the rights of the nearest relative to request an assessment of their relative. Detailed knowledge of identification of the nearest relative is not necessary, but there should be an escalation process to ensure the case is considered by someone who has sufficient knowledge of the legislation to make a defensible decision.
6) All public facing services within the mental health service and adult social care are aware of the duty under MHA section 13(1) of the need for an AMHP to consider a patient's case if it appears that they may need compulsory admission to hospital.