Westminster Safeguarding Adults Board

A Serious Case Review in Respect of Mr BB

Died 2011

Executive Summary

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Contents

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1. Background

1.1 Mr. BB died in 2011. He had been admitted to a mental health unit under Section 2 of the Mental Health Act and was subsequently transferred into the care of an acute hospital where he died. The Coroner gave the cause of death as pneumonia.

1.2 He had been known to mental health services since the early 1960's. He had a diagnosis of paranoid schizophrenia. In 2009 Mr. BB suffered a subarachnoid haemorrhage and was diagnosed with dementia. In addition to these challenges Mr. BB was also receiving treatment for hypothyroidism. Mr. BB was variably compliant with treatment regimes.

1.3 Mr. BB lived with his wife. He was well known to agencies including: Westminster City Council, Adult Services Department; Central, North West London Foundation NHS Trust ; Imperial College Healthcare NHS Trust; Metropolitan Police; Central London Community Healthcare NHS Trust; an independent care provider, Health Vision; London Ambulance Service ; the local GP service.

1.4 The perspective of these agencies on the presenting issues was often very much at odds with that of Mr. and Mrs. BB.

1.5 This was a complex situation within which professionals were challenged to work in the best interests of Mr. BB and his wife and in a way that was sensitive to their life choices.

1.6 The period scrutinised by the Serious Case Review panel was the period from April 2009 (when Mr. BB was admitted to hospital with "confusion and decreased mobility" and subsequently suffered a subarachnoid haemorrhage) until Mr. BB's death in January 2011.

2. Purpose of Serious Case Review

2.1 The purpose of the Serious Case Review is:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard adults.
- To identify what those lessons are, how they should be acted upon and what is expected to change as a result.
- To improve inter-agency working and better safeguard vulnerable adults.
- To learn from good practice and effective inter-agency working.

The process is about learning lessons, not about apportioning blame. It is not an inquiry into why Mr. BB died or who is culpable. That is a

matter for the Coroner's Court, criminal courts and employment procedures as appropriate.

2.2 The Terms of Reference of this Serious Case Review are:

- To establish and analyse the chronology of events in relation to Mr. BB between April 2009 and 1st January 2011.
- To examine the information that was known to agencies about Mr. BB between April 2009 and January 2011.
- To examine the adequacy of the collaboration and communication between all the agencies involved in the care of Mr. BB or in the provision of services to him (including any issues relating to sharing of information) between April 2009 and January 2011.
- To examine the care and treatment provided including where relevant: multidisciplinary decision-making; risk assessments and risk management; assessment of mental capacity; health and social care needs assessments.
- To examine the relevant policies and protocols in operation at the time including determining whether practice by all agencies was in accordance with national and local policy for safeguarding adults as set out in "No Secrets", 2000 and other safeguarding-specific guidance.
- To identify legal matters relevant to this review (for example in relation to Mental Health Act; Mental Capacity Act).
- To identify the care and service delivery issues and the factors associated with them.
- To prepare an independent overview report based on the findings and conclusions and make recommendations that can be implemented by the Westminster Safeguarding Adults Board.
- To ensure conclusions are evidenced.
- To cascade any lessons learned to all agencies to improve practice.

3. Methodology

Senior managers were nominated by the organisations that had been involved in Mr. BB's care and support to form a panel which was chaired by the Independent Chair of the Westminster Safeguarding Adults Board. An independent overview report writer was commissioned to work with the Serious Care Review panel and to prepare a report informed by their work. This provided external objectivity. The panel considered internal management reports and other relevant information in order to fulfil the above terms of reference. Mrs BB produced a report in August 2011 to inform the Serious Care Review report. She spoke twice on the telephone with the Chair of the panel but declined to meet with her.

Mrs. BB was invited to comment on the draft report to correct any points of factual accuracy. Mrs. BB wrote extensively, as well as sending several e-mails and having a telephone conversation with the

Chair, again she declined any invitations to meet. As a result of this the Chair on behalf of the panel has added some of Mrs. BB's comments to the report. An appendix written by Mrs BB is also attached (Appendix 3). It should be noted that these are solely the views of Mrs. BB some of which are not condoned by the panel. These views are attached so that Mrs. BB's voice can be heard.

4. Pen Picture of Mr. and Mrs. BB

4.1 Mr. BB was an 86 year old man of east European origin. He moved to the UK in the mid 1940's and worked as an artist from that time. He lived in shared bedsit accommodation on two floors with his wife of some 45 years. Mr. BB was an artist. In fact, art was of great importance in both of their lives. Mrs. BB was running a language school and a publishing company at that time. She considered caring for her husband to be a very important role after his haemorrhage. The couple are described by agencies as leading a bohemian lifestyle. Mrs. BB is wary of this description but does say that some of the younger, less experienced carers may have found it difficult to work with people who had 'unusual personalities'.

4.2 Mr. BB had a past history of mental health problems and a diagnosis of paranoid schizophrenia. It is reported that Mr. BB's war experiences were traumatic and that these experiences influenced the nature of his psychiatric illness.

4.3 Mrs. BB was adamant that whilst those experiences had been traumatic, Mr. BB had succeeded in overcoming the effects of this period of his life. She said of her husband "there had been a total recovery from the paranoia he had suffered as a much younger man".

4.4 Mrs. BB, in a report to the Serious Care Review panel, said of her husband "anyone could see he was greatly loved by me and my people". This was borne out by professionals. The minutes of the meeting of the Serious Care Review panel on July 13 records one panel member saying that Mrs. BB "deeply loved her husband ….She wanted to care for him in the way she felt best" and another that "she clearly loved her husband". At the same time, the relationship between Mr. and Mrs. BB was described as volatile, although Mrs. BB strongly opposes this view.

4.5 Against this background agencies had serious concerns that his care and health needs were being neglected and that this was in a significant part due to his wife's actions.

4.6 Mr. and Mrs. BB were reluctant to accept support from those outside of their family and often forcefully resisted support from statutory agencies. Mrs. BB is an intelligent and well-read woman who took the trouble to read about her husband's medical conditions in order to inform her support and care of him. They had support from Mrs. BB's

sister, a qualified nurse. A daughter and five grandchildren are also mentioned in records but featured only once in discussions with professionals.

4.7 Mrs. BB must have faced significant challenges in caring for her husband. There were many conflicting pressures which must have been difficult for her to reconcile (his rejection of care at times; advice and instruction from professionals; advice from her own reading and experience; her own concern for him).

5 Case outline

5.1 The Serious Care Review considered the period April 2009 to January 2011. During this time Mr. and Mrs. BB had contact with those organisations set out in 1.3.

5.2 The integrated chronology including exhaustive records of contact with all agencies is too lengthy to reproduce in full in this report. An overview of key events/extracts from the chronology is given in Appendix 1. This overview reflects repeated episodes in the context of Mr. BB's care and support needs where:

- Mrs. BB sought help on behalf of her husband. There were, for example, many calls to Police and Ambulance services.
- Mr. BB and Mrs. BB rejected support.
- There was refusal of and resistance to Mental Health Services and hospital admissions and in respect of compliance with anti-psychotic medication.
- There were concerns relating to neglect / self neglect in relation to Mr. BB.
- The above were considered at Safeguarding meetings and review meetings.
- There was steadily declining acceptance of care services especially from summer 2010 until Mr. BB's death.

5.3 Planned admissions presented opportunities to undertake checks/assessments and to monitor the effectiveness of the protection plan. These opportunities were often not exploited.

5.4 The outline of key events and decisions in Appendix 1 gives an overview of a situation where risk existed in a number of dimensions. The areas of risk identified at various points (but not all brought together in a holistic assessment) were as follows:

- It was perceived that Mr. BB was at risk in the context of his mental health and risk of deterioration because he was not receiving the prescribed medication consistently.
- There were concerns about risk in relation to his physical health and wellbeing: his weight and diet; his skin condition (rashes); poor

hygiene; he was understood not to be taking thyroxin medication prescribed by his GP.

- There were concerns as to Mr. BB's safety as he was prone to go out and become confused and lost. There were many occasions when he was returned by the Police and/or ambulance services.
- There were Safeguarding concerns connected to Mrs. BB neglecting Mr. BB's care needs by not allowing access to Mr. BB by carers; by withholding medication and concern because she placed him at risk when she had padlocked him in his bedsit. Mrs. BB has since explained that this was on one occasion following advice from a policeman. She did not think it good advice and did not fully close the padlock.
- There was a risk of self-neglect although the term was seldom used in the records.
- Mr. BB posed a risk to formal carers. He was at times aggressive to them both verbally and physically.
- Mr. BB was at times aggressive towards Mrs. BB both verbally and physically. Whilst this is an accurate reflection of the records reviewed it is not Mrs. BB's recollection. She strongly refutes this comment and describes Mr. BB as a very loving husband.
- There were times when Mr. BB was aggressive towards members of the public.
- There was a risk to Mr. BB's rights and freedoms.

Mrs. BB is in possession of a carer's report, not seen by the panel, which has examples of her husband's good humour and sweet nature when carers called. She felt that this report would have given a more balanced impression of his demeanour.

5.5 Professionals struggled with the necessary balance between those risks, and the rights and responsibilities of Mr. and Mrs. BB and of professionals. The tension between safety and choice was at the heart of the difficulties faced by everyone involved in this situation including Mrs. BB.

5.6 The complexity of the challenge seemed to lead to paralysis rather than to a recognition and resolve that, in order to shed light on the right balance in this situation, particularly high quality interventions would be required and pursued. Section 6 will explore the elements of practice which might have contributed to more effective assessment and decision-making.

5.7 There were a number of positive elements of practice in this situation:

- Despite challenging circumstances most agencies showed tenacity in continuing to commit high levels of time and energy to working with the situation. For example, the ongoing commitment of police and ambulance services in highlighting concerns at intervals (but this needed a structure around it so that it was checked that something happened as a result of concerns being raised).

- Mrs BB experienced aspects of the relationship with several agencies as positive, notably: the care agency; the care manager and the police who engaged with her on a regular basis to offer support with specific issues and with ongoing care; the support of the out of hours GP service.
- The persistence of the care agency carers and managers in their efforts to deliver personal care despite the growing resistance of Mr. BB was a vital and impressive element of the efforts to keep Mr. BB at home with reasonable levels of risk.

There are also notable examples of positive engagement in this Serious Care Review process indicating particular strength of commitment to addressing shortcomings:

- The engagement of Primary Care Trusts in providing independent reports in respect of the role of GPs in cases which have been subject to Serious Case Review has been problematic in some adult social care areas. The independent report by the local Primary Care Trust into the role of the GP in this situation has been objective and productive in setting out clear actions for future improvement with an assurance that implementation will be monitored.
- The engagement of independent providers has also been problematic elsewhere. The home care agency involved here has invested time to make a positive contribution to the learning from the Serious Care Review process.
- The learning outlined by the community health care trust is extensive and work has already begun in implementing an action plan (for example a safeguarding adults' lead for the trust is being recruited at the time of writing). The implementation of the action plan will make a significant difference to practice in situations such as this.

6 Analysis and lessons learned

6.1 The situation of Mr. and Mrs. BB identifies a range of lessons to be learned in relation to:

- The working relationship between professionals and Mr. and Mrs. BB.
- Risk assessment and risk management process and practice.
- Multiagency cooperation.
- Safeguarding adults process and practice.
- Practice in relation to legal options.

6.2 Practice in relation to the working relationship between professionals and Mr. and Mrs. BB

6.2.1 The relationship between Mr. and Mrs. BB and professionals and

the extent to which they were partners in care is central in this review. The community health care trust highlights in its Internal Management Review, "The importance of patient engagement in the assessment and care planning process".

6.2.2 "The fundamental point is that public authority decision-making must engage appropriately and meaningfully both with P and with P's partner, relatives and carers. The State's obligations under Article 8[1] are not merely substantive; they are also procedural. Those affected must be allowed to participate effectively in the decision making process. It is simply unacceptable – and an actionable breach of Article 8 – for a adult social care to decide, without reference to P and her carers, what is to be done and then merely to tell them – to "share" with them – the decision." (Lord Justice Munby, July 2010)[2]

Lord Justice Munby goes on to say: "The wishes and feelings of the incapacitated person will be an important element in determining what is, or is not, in his best interests. Where he is actively opposed to a course of action, the benefits which it holds for him will have to be carefully weighed against the disadvantages of going against his wishes, especially if force is required to do this."

Judge Munby proceeds to outline the necessary considerations in deciding the weight and importance to be attached to P's wishes and refers us to Section 4(2) of the Mental Capacity Act which states that we must have regard to all the relevant circumstances. These include, he says:

- "the degree of P's incapacity: the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings …particularly if they are of an intensely private and personal nature;
- the strength and consistency of the views being expressed by P;
- the possible impact on P of knowledge that her wishes and feelings are not being given effect to;
- the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and
- crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within our overall assessment of what is in her best interests"

6.2.3 This requires a respectful relationship which facilitates understanding of the wishes and feelings of people who use services and their carers along with the outcomes they are seeking so that their perspective of their own situation can be embedded in the risk assessment and risk management process.

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[1] Human Rights Act, 1998, Article 8, The Right to Private and Family life

[2] What Price Dignity? Keynote address by Lord Justice Munby to the LAG Community Care Conference: *Protecting Liberties, 14 July 2010*

6.2.4 It requires that professionals question an individual's capacity (and where appropriate undertake formal mental capacity assessments) where there are clear indications that this may underlie decisions and choices which are clearly problematic.

6.2.5 Mrs. BB is highly articulate and an educated woman. She was forceful in her opposition especially to mental health professionals. Professionals struggled to find a constructive way to understand and to work with her. The strength of opposition from Mrs. BB often deflected attention from Mr. BB and frequently led to paralysis in respect of action plans or contingencies which had been put in place by professionals to address heightened risk.

6.2.6 The Internal Management Review presented by the mental health trust illustrates the impact of the relationship with Mrs BB. It states: "the biggest complicating factor in frustrating attempts to look after Mr. BB was his wife. Mrs. BB proved to be a resolute and implacable obstacle to all manner of services. She did not think that Mr. BB had any illness and regarded any offers of help as an affront to her ability to look after him." The report goes on to say "One might postulate that none of the professional services felt courageous enough to take on Mrs. BB, who protected and protested her rights loudly, often in pursuit of professionals involved" and "… Mrs. BB appears to have caused a failure of morale on the professional side leading to a failure of will to follow the appropriate process."

6.2.7 Of Mr. BB the same report says: "it was nearly impossible to gain a sense of what Mr. BB might have wanted himself" and "It was unknown…what Mr. BB's capacity was or what he might have wanted. One might suspect that Mr. BB lacked capacity by the final year of his life, based on the severity of his mental illness and the dementia but that conclusion cannot be assured. Gaining access to ascertain this was nearly impossible"

6.2.8 Mrs. BB's recollection of events and in particular her relationship with her husband and his demeanour differs from the view given in this report, although the report does accurately reflect records made available at the time. This highlights the challenge for professional staff in understanding the view of the people that they work with. In Mrs. BB's words 'The point is that one constantly needs to place oneself in the other's shoes to retain some inkling of another's wishes and retain a bond of humanity'.

6.2.9 Despite numerous examples of Mrs. BB refusing access to carers and professionals, she was at times cooperative, seemingly in the best interests of her husband. There was one period in particular where Mrs. BB was expressing regular concern about Mr. BB refusing to take his thyroxin medication. This was largely directed at the GP. It was regrettable that, in an area where Mrs. BB was seeking help in her

husband's best interests, support / engagement was not forthcoming. Indeed the engagement of the GP service with Mrs. BB throughout was minimal. In addition, Mrs. BB was keen to have the support and assistance of the Police, particularly when her husband went out at night and became lost. She acknowledged the help received from them despite what she saw as a grave error of judgement on their part in applying section 136 of the Mental Health Act (MHA) in October 2009.
Mrs. BB bought a satellite GPS tracker for her husband so that she could go out by taxi to find him if he wandered too far from home and got lost. Mr. BB enjoyed walking and Mrs. BB supported him by giving him the freedom to do what he enjoyed whilst helping him to be safe. Mrs. BB bought a wheelchair for her husband when she felt he needed one on being discharged from hospital. Mr. and Mrs. BB also enjoyed going out together taking the wheelchair as it was often needed.

6.2.10 The following table gives examples of Mrs. BB seeking help; accepting support willingly; admitting that she needs help/support. These examples illustrate concern for her husband as well as an ability to work with professionals.

9.4.09 to 13.10.09	Mrs. BB called out the police and/or ambulance services on at least 21 occasions
22.6.09	Mrs. BB agrees with care manager that pressure mat be provided *[electronic device alerting to occasions when Mr BB leaves bedsit]*
29.10.09	Adult social care file note. Care manager states "Mrs. BB has Mr. BB's best interests at heart and tries to meet his physical and general medical needs. Mrs. BB's opposition to mental health services is disproportionate and this is the main problem"
14.5.10	Mrs. BB calls district nurse advising of rash and that she is applying talcum powder. Requests district nurse visit
26.7.10	Community health care trust notes record that "Mrs. BB tried to convince Mr. BB to have his BP taken (but) she was hit and shouted at"
18.8.10	Mrs. BB "complies with all aspects except psychiatric medication. Mrs. BB contacts [care manager] regularly with updates and for advice"
12.9.10	Mrs. BB calls care manager about "how to solve problem of Mr. BB's non-compliance with thyroxin"
11.10.10	Mrs. BB calls GP asking for letter to Mr .BB stressing importance of taking thyroxin

6.2.11 Despite supporting her husband in the above ways and despite a level of cooperation with some agencies there were also many occasions (see Appendix 1 for examples) where Mrs. BB and/or Mr. BB declined and resisted services or visits from professionals. There is ample evidence of the significant difficulty that this presented. There were real concerns for the wellbeing of Mr. BB. There were reports of significant concerns and risk to Mr. BB for example: a nursing report from the mental health trust reports to the mental health review tribunal in October 2009 (following a Section 2 compulsory admission) "When examined…on this admission, 20.10.09, he was found to be in a state of severe neglect, there was also concern that his wife was not administering his medication as prescribed. He had no insight into his

care needs, and was deemed vulnerable requiring admission to hospital".

6.2.12 Efforts needed to be directed at exploiting the opportunities which presented for working positively with Mrs. BB. This needed in part to include exploration of Mrs. BB's reasons for declining services on behalf of her husband.

There are a number of reasons given by Mrs. BB for declining services:

- Following the subarachnoid haemorrhage in April 2009 she says in a report to the Serious Care Review panel that, "We wished to be alone with our grief over what had happened and adjust to another plane of life. [Mr. BB] needed time to recover his awareness of space, time and direction. The only way I could be assured of having peace to nurse [him] back to something like himself was to refuse community and social services and manage single-handed except for my nurse sister. I wanted [him] to have neurological checkups … of course…We just needed the laundry service as in a small London rooms there was no space to keep a washing machine".

- On one occasion there is evidence that Mrs. BB gives finance/unwillingness to pay as a reason.

- It might have been that compliance with Mr. BB's wishes was a further reason for Mrs. BB turning people away. There is evidence of his aggression (including towards his wife) in the face of service provision at times. There is no evidence in the records that this possibility is ever explored with her. Examples of the aggression are given in the table below.

- Mrs. BB refers to a time before the period considered in this Serious Care Review where Mr. BB was on fortnightly injections (presumably for psychosis). We are told that once these stopped "a tremor had ceased in his hands and he was able to paint, producing some very fine works of art". This gives further enlightenment as to her reasons for refusing to cooperate with prescribed medication.

- We know from Mrs. BB that she felt the medication made her husband drowsy and made it unsafe for him to cross the road and that it was not the right medication for someone who has had a stroke.

There is little evidence in the chronology of conversations with Mrs. BB exploring and attempting to resolve these issues. The records do not demonstrate that these reasons were explored in Safeguarding review meetings.

Mrs. BB wishes it to be recorded that there is a record of the medication she administered to Mr. BB every day, which was not seen by the review panel. This was Mrs. BB's personal record and was not shared with the panel. This was a 25mg dose, lower than the prescribed amount at that time but Mrs. BB felt that this was the best dose for her husband as it did not affect his ability to paint or to cross the road safely. It was the amount prescribed by a consultant involved in Mr. BB's care in the summer following his haemorrhage

6.2.13 Mrs. BB felt that challenges she made to decisions were unwelcome. For example, she researched the anti-psychotic drugs prescribed for her husband and challenged consultants about the appropriateness of using this medication. She says in her report: "The point I am making is that consultants have no right to condemn objective enquiries by relatives in the best interests of those they love. Obviously, all enquiry is open to discussion and I passed on everything I learnt about drugs to [Mr. BB] himself so that he could make his own decisions".
It is unclear as to the extent of any balancing information offered to her by professionals to supplement what she already knew and to support her in making judgements. There is no record of such conversations.

6.2.14 There are examples of missed opportunities for dialogue with Mr. and Mrs. BB about the reasons for the actions/decisions of professionals and exploring these alongside their own perceptions/judgements.

6.2.15 Mrs.BB formed her own views as to the rationale on which professionals were acting. She expressed the opinion that her husband's past mental health history was driving current reactions to his welfare. She says in a report to the Serious Care Review panel: "I surmise that the consultants in general based their decisions on historical notes from *[his]* medical records…medical psychiatric history should not be a reason for radical action in the present…".

6.2.16 Mrs. BB's views may have been so intransigent that no amount of discussion would have influenced her. Her views required discussion. There is no evidence of any such sustained dialogue.

6.2.17 Offers of a carer's assessment to Mrs. BB were lacking. One panel member saw "the lack of carer's assessment as a missed opportunity to work with the wife". Whilst a carer's assessment was offered and declined on one occasion, this offer needed to go hand in hand with efforts to engage with Mrs. BB and to respect her point of view. The offer needed to be repeated at intervals.

6.2.18 Agencies focussed a great deal on the obstruction of care by Mrs. BB. Mr. BB resisted care too on many occasions. What was the extent of the part he played in services being turned away? The community health care trust Internal Management Review refers to Mr. BB's part in obstructing care alongside that of his wife. "The multi-professional care package intended to help Mr. BB was challenged in no small part due

to his behavioural responses and the actions of his wife." Mrs. BB was, we know, at times on the receiving end of aggression from Mr. BB. Her reactions and actions may well, in part, have been complying with his wishes and actions. This possibility is not explored in the records.

6.2.19 Examples of Mr. BB refusing/being obstructive to support/help

9.4.09	Community health care trust notes and assessment state that Mr. BB is verbally aggressive and abusive when asked to cooperate. Refuses to stand to allow pressure area checks .
12.5.09	Adult social care notes refer to "self-neglect".
1.7.09	Police report notes that Mrs. BB calls police to "persuade her husband to comply with her". He is arguing with her over taking medication.
26.1.10	Disagreement between Mr. and Mrs. BB. He is lying on the floor being verbally aggressive to her.
26.3.10	Care agency note to adult social care that Mr. BB is resisting care and kicked one of the carers .
13.4.10	Records call from care agency to the adult social care which took place on 9.4.09: "Mr. BB has been refusing personal care, shouting at them and being threatening for the last 7 days".
6.5.10	Ambulance service respond to call from Police "Mr. BB refused any assessment or OBS to be taken".
10.5.10	Mr. BB refuses conveyance to hospital or assessment by ambulance service.
11.6.10	Care agency report to care manager that "Mr. BB has been uncooperative for the last 3 weeks and it has not been possible to provide personal care".
16.7.10	"Mr. BB shouting and stamping his feet at carers. Increasingly difficult to give care" according to care agency report to care manager.
21.7.10	Mrs. BB advises community psychiatric nurse and consultant psychiatrist that Mr. BB has been refusing medication for a week.
26.7.10	Community health care trust notes record that "Mr. BB verbally aggressive and shouting. Refuses to have BP taken. Hits wife" "Mrs. BB tried to convince Mr. BB to have his BP taken where she was hit and shouted at".
10.9.10	Mental health trust note of home visit by community psychiatric nurse and adult social care team manager. Mr. BB "shouting and verbally aggressive to Mrs. BB and waving fist at her".
23.11.10	GP notes record district nurse not able to examine rash because Mr. BB aggressive.

6.2.20 Any real focus on Mr. BB and on his capacity to make decisions and any associated assessment of his best interests was missing. At a panel meeting it was observed that Mr. BB almost "disappeared" amidst the challenges with which agencies struggled in working with Mrs. BB. The panel underlined the need for a focus on Mr. BB's best interests.

The only records of attempts to test mental capacity in relation to Mr BB are:

- 9.11.09 Mental health trust records test results as "unable to engage in assessment but has likely cognitive impairment". (This relates to a decision to test Mr. BB's mental capacity on adult social care file 3.11.09)

- 25.11.09 Adult social care file note refers to Fair Access to Care Capacity Assessment which determines Mr. BB lacks capacity to make decisions about his care (not clear whether the assessment is Mental capacity Act compliant because details are not available).

The community health care trust Internal Management Review identifies: "the records do not identify whether he was capable of making and maintaining valid and informed decisions".

6.2.22 The principle of presumption of capacity seemed to be followed without question. Mr. BB's decision making was clearly problematic and he made a number of decisions which left him vulnerable. This should have led to a challenge as to whether indeed Mr. BB had mental capacity (for example, to decide where he wanted to live; to decline support; to decline medication). His refusal of support/actions was consistently taken at face value. Whilst lack of access may, on occasions, have precluded capacity assessments there were many missed opportunities.

6.2.23 Records in respect of best interests are at times contradictory and do not evidence Mental Capacity Act compliant assessment. For example the social care report to the mental health review tribunal in November 2009 states: "Despite what can appear as abandonment of Mr. BB to outsiders there is no intentional deprivation of assistance from Mrs. BB…**It is my opinion that Mrs. BB has his best interests at heart.** In regards to personal hygiene Mr. BB past lifestyle must be acknowledged". The report from the mental health trust to the same tribunal states: "it was the view of the team that **Mrs. BB does not act in his best interests** and often dissuades him from taking medication…". A formal assessment and consensus on this issue was required.

6.2.24 There was a lack of biographical information to inform understanding of Mr. BB's wishes and best interests. There are occasional insights in the records but no concerted effort to pull together information to support best interests decisions. It is significant that the biographical information in the Internal Management Review report produced by the mental health trust is taken from information available on the internet rather than from records on file. There is no evidence in records that a biographical perspective was actively sought. In her report to the Serious Care Review panel Mrs. BB underlines the importance of understanding Mr. BB's history in understanding the present.

6.2.25 There was no recorded analysis of significant issues with Mr. BB. For example, there seemed to be no analysis of what might be causing increased aggression. Was it the lack of compliance with taking anti-psychotic medication or were other factors such as the dementia and/or the subarachnoid haemorrhage contributing? Might support in managing the dementia have assisted?

6.2.26 Mrs. BB feels that too little attention was given to Mr BBs physical health. For example:
'A report on the blood tests to Mr. BB himself would have been helpful. He would most likely have discussed the results with me.
At no time, did my husband receive a report about his own blood tests.'

'I recommend educational leaflets upon stroke discharge so that the kin and carers become highly conscious of all types heart symptoms and response.'

Mrs. BB felt that her requests for her husband to have an urgent electrocardiogram (ECG) in December were not taken seriously.

Mrs. BB was willing to engage with professional staff on her husband's physical condition. Better co-ordination between agencies may have resulted in a more holistic assessment and meaningful engagement with Mr. and Mrs. BB. Perhaps attention to some of these issues which Mrs. BB felt were important might have contributed in some small way to supporting the establishment of a more positive relationship.

6.2.27 An emphasis on relationships, building trust, assessing and re-assessing over time should have been at the heart of agencies' working with Mr. and Mrs. BB. It became lost in the drive to find "services"; "solutions"; specific "actions" of a more tangible nature.

6.2.28 Sometimes issues in the relationship between professionals and service users are so entrenched that it is necessary to bring in an independent person to facilitate more positive progress. Evidence is developing as to the effectiveness of interventions such as family group conferencing; restorative practices in working with adults, particularly in the context of safeguarding adults. Such practices seek to restore relationships in order to enhance safety and wellbeing. These approaches recognise the strengths and abilities of every individual and respect the rights of all.

6.2.27 These more independent and specialised interventions, alongside advocacy, would potentially offer a way forward in situations such as this. An Independent Mental Capacity Advocate was considered on 26.11.09 but it was decided that they would not to be involved as Mr. BB's wishes were not being contravened. This option needed to be explored more fully.

6.2.29 These possibilities for intervention also enable engagement with individuals in the context of their own culture and background. This can have a significant impact on the choices that they make and is therefore crucial within assessments. Again we learn much more from Mrs. BB's report to the Serious Care Review panel than we do from agencies' records about this important context. Positive engagement with Mrs. BB at the time would have allowed this information to be drawn into the assessment process.

6.2.30 There was a lack of focus on engaging with members of their family both to inform the risk assessment and to support the managing of the risks. There is only one mention in the chronology of a telephone conversation between a professional (the care manager) and Mr. and Mrs. BB's daughter. There is little contact with Mrs. BB's sister although Mrs. BB describes her as significant in supporting care of her husband.

6.3 Risk assessment and risk management processes and practice

6.3.1 The part that people who use services and their carers have to play in the risk assessment and risk management process is crucial. "A key part of risk assessment is establishing both the individual's perception of and attitude towards specific risks" Scourfield, P, 2010[3].

6.3.2 Mr. and Mrs. B needed to inform and be informed by the risk assessment process and they should have been a key part of strategies for managing the risk. As adult social care's Care Management Procedures underline: "Risk assessment is about a collaborative approach to working with the person, carers, families and other involved professionals. It takes account of the Person's wishes, abilities, coping strategies, and that of their network, in deciding the plan."

6.3.3 There was a range of risks identified both explicitly and implicitly and these have been listed in 5.4 (above). Not all risks were formally acknowledged; identified risks were not always evidenced and plans to evidence or keep track of them were not always followed up.

	Lack of follow up and evidencing of issues
15.12.09	Adult social care file note and copy of minutes states that referral to GP re weight monitoring is still outstanding. If weight had been an issue actions in relation to identified risk not being followed up.
28.11.10 community health care trust notes	Nurse advises GP on feedback sheet that challenging behaviour and aggression are impacting on ability to deliver patient care effectively. Recommends inpatient/respite care.
	No record of GP follow up on this.
Minutes of Safeguarding meeting 12.11.09	Records a report on Mr. BB admission to XX ward on 2 November which said he was "unkempt, soiled, underweight, and very subdued" ***There is no detail as to what "underweight" means. This is a constant theme (ie checking weight and food intake is prominent in care/protection plans).*** These minutes state on page 4 that he is "within the healthy BMI range of 23-24. Yet the same minutes under the heading risk assessment state that there is a danger of malnutrition from inadequate dietary intake. ***Where is the evidence for this? (The only evidence on weight in all of the records submitted is in a protection plan review dated 15.4.10*** where it is recorded "Weighing is difficult – last weight 18.1.10 – 70.6kg (11/09 weighed 70.9kg).) ***The risk assessment detailed in these minutes is weak in terms of direct evidence.***

[3] "reflections on the SCR of a female adult (JK) JAP vol. 12 issue 4, Nov 2010 page 25

(Comments in bold italics in tables are observations rather than extracts from records)

6.3.4 There was a need to differentiate the various elements of risk in this situation. Clarity was required on how risky was *each* potential hazard or danger and how likely was it to happen. Alongside this what did each area of risk mean in the context of the individual's wishes and values. What benefits were they trying to achieve in taking the risks? (in line with the adult social care's risk assessment and risk management guidance).

6.3.5 Professionals struggled to coordinate their efforts within an agreed framework. There was a failure to collate single agency risk assessments into a holistic risk assessment to inform shared decisions and actions.

6.3.6 There was a tendency to attend to immediate support needs rather than managing the significant ongoing risks and seeing the pattern which was emerging. Assessments and decisions failed to respond to a pattern of steadily declining acceptance of care by both Mr. BB and his wife. Although this decline was noted in case notes and in minutes of meetings and although a contingency was in place should compliance with the care plan decline there seemed to be no overall recognition of deterioration nor any commitment to carry through plans which had been discussed and agreed.

6.3.7 Illustrations from records and reports in relation to risk assessment and risk management issues:

Source of observation	**Observation**
	Failure to implement agreed action plans
Community health care trust IMR Page 20	"safeguarding protection plan meetings had variable perspectives on risk and safety and were unable to escalate or take definitive actions in response to identified concerns".
	Lack of a comprehensive and holistic risk assessment
Mental health trust IMR page 12	Makes recommendation that "there be a clear plan not only detailing actions required and by whom, but with timescales for review. Allied with this is a consideration of what to do if plans fail and to have action plans for those outcomes as much as one can plan ahead".
Police IMR page 76	Tendency for "Merlin" reports to be closed "without much by way of follow up…sometimes without the benefit of an oversight of the steady growing number of incidents" .
	Failure to integrate new emerging issues into the risk assessment
Minutes of 13 July Serious Care Review panel meeting	When there are dementia issues emerging how is this managed and how did this impact? Was there any change in plan when the new issue of dementia emerged?
	Inconsistency in risk assessments across and within agencies
15.8.09 Police MPS merlin	Grades Mr. BB as **low risk**. This is in relation to calls re Mr. BB missing. Several call outs to police follow for same reason

19.8.09 Police MPS merlin	Grades Mr. BB as **high risk** ***We are now aware that this represents only the risk in relation to Mr BB being missing and the risk of harm presented in relation to this issue alone. A more holistic view of the risks is required.***
15.11.09 Mental health trust case notes	Risk assessment recorded as: **serious apparent risk of self neglect** and **significant risk** of elder abuse; wandering; violence and harm to others; polypharmacy; daily activity/routine.
4.12.09 Mental health trust notes	Record "**not considered to be at risk** of harm to self or others.
	Failure to act in response to increasing level of concern
11.6 10 Home care provider record	Mr. BB not received care for 3 weeks; concern re mental state; Mrs. BB sometimes locks him in room.
27.7.10 Home care provider record	Carers not gaining access: "we may not be meeting ...needs because of frequency when access is denied and infrequency with which he receives personal care".
	Care plan is not working and yet no change in decisions/pattern of addressing concerns.
13.10.10 Home care provider record	Carers unable to give care for over a month
28.10.10 Adult social care email	Email between community psychiatric nurse and care manager. "[community psychiatric nurse] will arrange for a MHA assessment "the minute Mr. BB doesn't allow carers to assist with personal care" ***And yet personal care has been lacking a great deal over the past 4-5 months (as above).***

6.3.8 There was, at various points, an outline of possible measures to be taken if concern about key areas of risk heightened. At no point were clear timescales and risk thresholds put against the measures that might be taken. This led to inaction even in the face of clear evidence that the risk was increasing. Implicit in this is the importance, in the context of risk, of reviewing information and decisions. The Guidance on Eligibility Criteria for Adult Social Care is helpful in this respect.[4]

6.3.9 Professionals perceived that Mrs. BB's decision not to support Mr. BB in taking the dose of antipsychotic medication recommended by the Mental Health Trust was a key area of risk. However, an assessment of the level of risk posed by this was never recorded. Measures put in place (blood tests) to monitor compliance with medication were not followed through and, indeed, late in the day were seen to be ineffective in any case. Late in the chronology there was still lack of clarity over this issue across agencies.

Chronology: 27.5.10	***It is clear that risk of Mr. BB not getting medication is not clarified at this point***. The adult social care team manager asks of community psychiatric nurse "what is the severity of not getting his MH [mental health] meds? This needs to be weighed against his overall wish to remain at home and the relative success of the care package?"

6.3.10 There was a need for responsibility to be taken by named professionals

[4] Prioritising need in the context of *Putting People First*: A whole system approach to eligibility for social care, Guidance on Eligibility Criteria for Adult Social Care, England, DH, *2010*

for specific issues as they emerged. For example there was clear concern from Mrs. BB in terms of the need for Mr. BB to take thyroxin. There was no adequate response from the GP and no harnessing of the GP input by other professionals who were aware of the concerns. This oversight by the GP is a serious concern and is addressed in the relevant Internal Management Review report.

6.3.11 Not all risks were identified and recorded across agencies. For example there were instances where Mrs. BB was subject to abuse by her husband. This did not feature in risk assessments. In addition, Mr. BB's self neglecting behaviour seemed to be subsumed under the issue of Mrs. BB refusing care on his behalf. The two issues needed to be considered separately in order to understand the motivation and look at potential resolutions.

6.3.12 Risk to staff from the aggressive behaviour of Mr. BB received insufficient attention in planning the management of the situation. The community health care trust has included in its recommendations that the Trust is to re-launch its managing violence and aggression policy to raise awareness on this issue.

6.3.13 There was a need for a longitudinal perspective on risk facilitating a recognition across agencies when concerns escalated. Recording in the home care agency facilitated this and they always alerted adult social care when refusal of care escalated. Recording for example in the ambulance and police services does not facilitate this in the same consistent way (although on occasions they did alert the care manager to increased activity at the home of Mr. and Mrs. BB). The Police Internal Management Review recognises the need for some of the individual concerns to be accommodated in a more detailed report so that this longitudinal perspective is made possible. This is being addressed by them.

6.3.14 The London Ambulance Service set up a frequent callers unit in 2007. The aim of this seems to be to facilitate multi-agency working to address the underlying issues and reduce frequent calls. It may be worth considering whether the criteria for applying this policy might include a perspective on level of risk alongside number of calls. Mr. and Mrs. BB would in general have fallen outside of this policy which covers those for whom there are 10 calls or more in a month to the ambulance service.

6.3.15 There is a need for recognition of the important part that care providers have to play in risk assessment and risk management and the need to include them as equal partners in these processes.

13.11.09 Adult social care file note	*Referral to [care agency] does not advise [them] of any of safeguarding concerns thus meaning that [they]cannot effectively monitor the risks*
Home care provider IMR	Closer links need to be established between care providers and other professionals. Information passed to other professionals by [the care

section 11	agency] needs to be respected and responded to. [the care agency] could have sought feedback more strongly from other professionals as to what action was being taken to safeguard Mr. BB.

In the panel meeting of 13 July 2011 the care provider reported a lack of information from other agencies so that at times they were unclear what was happening. There was an acknowledgement from the mental health trust that they are not sufficiently proactive in establishing and strengthening links with domiciliary care providers and in inviting them to Care Programme Approach meetings. There was seemingly no link between district nurses and care agency staff.

6.3.16 Staff at all levels in organisations should be engaged in managing risk. There were issues about ownership of decisions as well as the need for challenge across agencies which required consistent input at a senior level. Consideration should be given to links to other policies which reflect the need to escalate critical risk issues and indicate how this should be done. Examples of such policies include: Serious Untoward Incident policies; Serious Case Review policies.

6.3.17 Staff supervision needed to offer objectivity and challenge around whether the appropriate procedures were being followed as well as support in what was a challenging situation. There were times when social care and health staff were not supported by managers and felt isolated. The community health care trust Internal Management Review report recommends the launch of a staff supervision policy to ensure robust line management for staff. It was underlined in a panel meeting that the fact that consultant psychiatrists are not routinely offered supervision needs to be addressed.

6.3.18 Organisations should consider the effect of one member of staff managing risk in a particular situation over a lengthy period and the need for external objective scrutiny. In some situations there may be an argument for co working or a change of worker.

6.4 Multi-agency cooperation

6.4.1 Inadequacies in effective multi-agency working were a key failing in the circumstances surrounding Mr. and Mrs. BB.

There was a lack of:

- Holistic consideration of all aspects of the risk and of the legal options. Professionals sitting down *together* to look at all aspects of the risk and all legal options systematically.
- Specificity about who was going to do what and when in relation to each area of concern/risk.
- Timely sharing of information.

- Consistency of assessed level of risk at any given time.
- Consistency in understanding of what the next steps were to be following key meetings.
- Coordination by one specified lead: one person holding the total picture and ensuring its effective communication.
- Shared understanding as to the outcomes being sought.
- Effective communication and sharing of information across agencies so that the situation could be "tracked" over time across multiple systems.
- Use of any information that was shared to develop coherent actions.
- Sufficient inclusion of those providing front line care in the risk assessment and risk management process.
- Constructive challenge leading to change in approach.

6.4.2 Some of these issues are illustrated in the table below.

Community health care trust IMR page 26	"This complex case would have benefitted from more robust mechanisms for communication and care co-ordination between all involved in care provision".
Community healthcare trust IMR page 27	records and minutes identify "that services seemed to provide interventions in relative isolation to one another".
Community healthcare trust IMR page 27	"it does not appear that one single agency took overall accountability for the robustness of the care package or a care co-ordination function….The adult protection meeting minutes, where available, do not provide a sense of care co-ordination, monitoring and/or responsive action" .
13.11.09 Adult social care file note	Referral to [the care agency] does not advise… of any of safeguarding concerns thus meaning that [they] cannot effectively monitor the risks
28.10.10 Mental health trust case notes	Community psychiatric nurse email to care manager "I thought it was agreed by everyone at the end of the last meeting that Mr. BB could no longer continue to live at home" ***(this does not appear to be the case from the 18.8.10 meeting notes)***
IMR in respect of GP involvement	"the practice needs to build bridges with the community mental health team so that joint working and patient outcomes are improved"

Further examples are represented in the tables in Section 6.3.

6.4.3 The lack of involvement in the multiagency team by the GP was notable and this has been highlighted in the primary care trust's Internal Management Review report. The report highlights issues including: a lack of follow up on referrals e.g. community mental health team asking for physical examination and no attendance at Care Programme Approach or Safeguarding meetings. The

recommendations of the GP report specifically include actions to improve communication with other agencies including actions around:

- Follow up of out-of-hours contacts.

- Building bridges with the community mental health team to improve joint working and patient outcomes (named contact for ease of access, invitations to community mental health team to attend Practice meetings, attendance at mental health and safeguarding assessments where possible).

6.4.4 There were some positive aspects of multiagency working but these were not organised and sustained. For example there was close contact, particularly at points of crisis between the care manager and the community psychiatric nurse and between the team manager and the consultant psychiatrist. It would have been beneficial to formalise some of those conversations in safeguarding review meetings so that all could contribute and be party to information.

6.4.5 The acute hospital trust showed some positive aspects of multiagency working in respect of investment in a psychiatric liaison specialist as well as timely and helpful discharge summaries.

6.4.5 The home care provider repeatedly contacted adult social care to advise of inability to provide care. On isolated occasions the LAS and Police made direct contact with adult social care to express their concerns about *repeated* contact with Mr. and Mrs. BB.

6.4.6 What was required was sustained, formalised and structured information sharing across all agencies so that there was a shared understanding of the situation at any given time and of what needed to happen next.

6.5 Safeguarding adults procedures and practice

6.5.1 The Safeguarding Adults' process should have been an effective vehicle through which to achieve effective multiagency working. It should have facilitated agencies coming together to share responsibility for assessing and planning how best to manage the risks to Mr. BB, including pooling collective knowledge of the duties and powers available to the agencies represented at the strategy meeting. It was ineffective in this case in doing so.

6.5.2 The Safeguarding process was initiated because it was believed that Mrs. BB was neglecting the care needs of her husband. The risks associated with this were set out along with a plan to monitor and reduce those elements of risk through safeguarding review meetings. However, the community health care trust Independent Management Review report commented that "While a robust protection plan had been put in place to safeguard all concerned its co-ordination,

monitoring and execution was not sufficiently robust". It is clear that the process was not sufficiently rigorous to pick up on the escalation in Mr. BB's care needs not being met from the early summer of 2010.

6.5.3 There was a lack of understanding of the Safeguarding process across agencies and this led to a failure to refer Safeguarding concerns, as required by the policy and procedures, to the lead coordinating agency for Safeguarding, which is adult social care. It also led, particularly within the mental health trust, to the misconception that "Safeguarding" has inherent powers and that Safeguarding "would do its job" in addressing the presenting issues. There seemed to be a belief that Safeguarding had legal "teeth".

6.5.4 This lack of understanding of the purpose of the Safeguarding process may well have contributed to agencies failing to send staff of sufficient seniority to meetings. Unless the Safeguarding process gives confidence across agencies that it will add value to the assessment and management of risk this is unlikely to change.

6.5.5 The Safeguarding process was halted in January 2010 because, it was explained by the adult social care team manager, the investigation was completed and reviews could happen outside of the process. This decision was questionable; it was misunderstood by other agencies; it was never reviewed in the light of new safeguarding issues which came to light. The decision to halt the process meant that a Safeguarding Adults Manager would not be attending the review meetings.

6.5.6 Safeguarding is often seen in terms of "events". There needs to be clarity around chronic ongoing situations.

6.5.7 Some important issues are not acted on within the safeguarding process. Mrs. BB, for example, was abused on more than one occasion by her husband (see table section 6.3). This was witnessed by professionals. This was never addressed.

6.5.8 Mrs. BB's report to the Serious Care Review panel makes it clear that she did not welcome a safeguarding response. She was very much on the edge of the process and there is no record of a conversation with her about the reason for it and the part she might play in it.

6.5.9 Examples illustrating these issues from reports and chronologies:

	Inadequacies in relation to safeguarding processes and understanding of/ engagement in them.
IMR Primary care trust re GP involvement	"despite the complexity of the case no one from the practice attended any of the mental health assessment or safeguarding meetings".
Community health care trust IMR Page 34	Actions [required] in relation to acknowledgement that processes for management of adults at risk are not as robust

	as those in place for children and young people.
Police IMR page 73 section 7 Page 77	***Standard operating procedure for safeguarding of adults is set out. This appears to be flawed.*** It says "it would seem for the main part this policy did not apply as Mr. BB was being cared for by his wife who was not a professional or a person where there was an expectation of trust". The same section says that the safeguarding procedures apply "where adults at risk… have been subject to a crime that has been perpetrated by a person: who has been providing them with care either in a care setting or in their own home". ***This needs to be clarified. The Police IMR acknowledges with hindsight that Mr. BB did fall within the scope of the policy and that a report should be made in such circumstances on their system to this effect. The policy and training on safeguarding adults need to be clearer.*** "Need for greater understanding of the Safeguarding Adults at Risk Policy and firm direction from the IBOS….incident log should not be closed without it being clear where and who the safeguarding issue has been passed to (ie Adult Services)".
Minutes of July 13 meeting of Serious Care Review panel	Internal Management Review report writer for the mental health trust said there was an expectation that "safeguarding would do their job" i.e. that the safeguarding team would have taken this forward and that adult social care would lead on this. ***This is the opposite of what the Safeguarding process sets out to achieve: effective working together on safeguarding issues.***
2.6.10 email from consultant psychiatrist to adult social care team manager	"Safeguarding is an important issue and one that many of us in the community mental health team are not familiar with the details of the procedures. We have an informal low-key team teaching session twice a month and I wonder if someone from xxxx…could do a talk for us? ***Clear acknowledgement that the mental health trust are not as familiar as they might be with safeguarding adults procedures. Yet this does not appear in their Independent Management Review as a recommendation for the organisation.***
	Questions/issues relating to the ending of the safeguarding process
3.3.10 Adult social care note	Referral from neighbour re neglect of Mr. BB by his wife and that she locks him in. Noise at night as if he is crying in distress. Dealt with in phone call by care manager. ***Why is Safeguarding process not re instigated with new alert?***
	Safeguarding concerns in respect of Mrs. BB. Lack of engagement in Safeguarding process
6.8.10 Adult social care email	Email from home care provider updates Benita. Reported ""Mr. BB punching Mrs. BB on the side of face when she tried to pull up his trousers. " ***This ought to constitute a safeguarding referral***
10.9.10 Mental health trust case note	Mr. BB "verbally aggressive to Mrs. BB and waving fist at her". ***Safeguarding issue in respect of Mrs. BB. It seems that this was not passed on to adult social care***

6.5.10 It was particularly clear that there was little or no understanding of Safeguarding within the GP practice. This has been picked up in the Internal Management Review in relation to this practice which recommends:

- Updating of practice policy on "Protection of Vulnerable Adults" including clarity around how clinicians must respond to and record concerns and guidance on information sharing. It will respond to the new practice policy of identifying vulnerable household patients. This work is already in progress.
- Training in adult safeguarding.
- Adult Safeguarding to be discussed by GP appraisers with their appraisees (GP professional development is monitored through an annual GP appraisal system).
- Raise awareness of adult Safeguarding within primary care.

6.5.11 There is reference to the need to improve awareness of safeguarding adults and of the local procedures in a number of the Internal Management Reviews. Related actions need to be in place across *all* agencies.

6.6 Practice in relation to legal options

6.6.1 Policy and practice in risk work must be underpinned by legislation. The law supports service users, staff and organisations in working with risk. It is therefore important that staff are aware of the complex legal framework and that their awareness is kept up to date. Where there is doubt about legal issues, expert legal advice must always be sought. Organisations must be clear with staff about where and how advice can be accessed.

6.6.2 The table in Appendix 2 lists and explains the legal options that might potentially have been useful in supporting the situation or in making judgements relating to it. Examples are given of use of / consideration of these options and whether/if these actions were or could have been helpful. A discussion across agencies looking at *and reviewing* legal options in this way at regular intervals would have assisted. In section 6.2.2 reference is made to the importance and relevance of Article 8 of the Human Rights Act, 1998 (the right to private and family life) in underpinning risk work.

6.6.3 There is clear evidence of confusion across agencies regarding the legal options and implications in this case. For example, terms such as guardianship and appointeeship are used when it is clear that the professionals concerned are using the terms inaccurately.

Mental health trust IMR page 9	"it may have been powerful enough to go through the legal process to take over responsibility for him via appointeeship…the professionals…did not go ahead to take the next steps to have this option properly considered". ***This is inaccurate use of the term appointeeship.***

6.6.4 Clear and consistent legal advice from an agreed source should have been sought much earlier on in the process and throughout, particularly at review meetings. Instead, advice sought from an Independent Mental Capacity Advocacy service was repeated at several review

meetings but not followed up or reviewed in the light of emerging information. That advice was as follows:

19.1.10	Strategy meeting advice of Independent Mental Capacity Advocate was repeated as stated on 26.11.09 and 15.12.09, namely that: "Community mental health team can apply for guardianship to enter the property if needed. We can apply to the Court of Protection under the Mental Capacity Act for an interim order to remove Mr. BB if Mrs. BB continues to refuse access to care...A Best Interests Assessment under Deprivation of Liberty procedures would then be needed"

6.6.5 It was not until the very end of Mr. BB's life that the latter options under the Mental Capacity Act were actively considered. This followed further advice from the adult social care Deprivation of Liberty Safeguards advisor. On 8.11.10 a meeting took place between the care manager and the local authority's Deprivation of Liberty Safeguards advisor. The advice at this time was recorded and understood by the care manager as follows: "cannot proceed under Mental Capacity Act whilst Mr. BB mentally unwell. Mental Health Act takes precedence over Mental Capacity Act so a Mental Health Act assessment should be completed. This was relayed to community psychiatric nurse and consultant psychiatrist who felt that a Mental Health Act assessment is inappropriate due to the issues being 'social services issues'." This decision was reviewed and reversed 14/15 December 2010

15.12.10 Mental health trustcase note	Mental Health Act assessment to be carried out because Mr. BB deteriorating in mental state and vulnerable in view of upcoming eviction notice. ..Because of availability of coordinating agencies earliest it could take place would be 22 12.10
22.12.10 Adult social care file note	Mr. BB admitted Sect 2 to XXX Ward. To be medically and psychiatrically stabilised and displace Mrs. BB as nearest relative. If Mr. BB is found to lack capacity to progress to a Best Interests meeting and to make a decision as to the most suitable accommodation for Mr. BB

6.6.6 There was a failure to implement legal contingency plans in response to escalating concerns. For example, it was prescribed in the protection plan on more than one occasion that an application for guardianship be taken forward in the face of lack of compliance on the part of Mr. and Mrs. BB with the protection plan. There was no detailed consideration of the circumstances in which it would be taken forward and it was never taken forward as an option.

Community health care trust IMR page 7	"while a range of health and behavioural concerns were raised by all healthcare providers, at no time does it appear that the recommended application for guardianship under the Mental Health Act was taken forward."

6.6.7 Aspects of the Mental Capacity Act were significant in this situation: The principle of presumption of capacity seemed to be followed without question. Keywood, K, 2010 underlines the following in this respect:

"Professionals can and should consider the reasoning abilities of those

who benefit from the statutory presumption of capacity. Partly because it does not necessarily respect autonomy to make no inquiry of a person's decision-making abilities but equally significantly, an approach which does not ask questions of a person's presumed competent wishes can result in profound self-neglect"[5].

6.6.8 From the failure to see the significance of a capacity assessment followed other key omissions in the context of the Mental Capacity Act:

- Lack of a formal documented Mental Capacity Act assessment on Mr. BB. Any assessment appears to be based on superficial examination of his behaviour and of superficial conversations with him. There is no record of a Mental Capacity Act compliant assessment in any agency.
- Mental Capacity Act should have been used throughout as a framework: the principles and the possibilities for intervention it provides.
- There was no Mental Capacity Act compliant Best Interests assessment of Mr. BB evidenced in the records.
- Insufficient attention was given to the possibility of Section 5 of the Mental Capacity Act and a Deprivation of Liberty Safeguards assessment to allow actions in relation to care or treatment.
- Insufficient records of consideration of the issue of conveyance of Mr. BB (Section 5 of Mental Capacity Act) when he did not want to be conveyed to hospital.

Community health care trust IMR page 30	"The records do not identify whether he was capable of making and maintaining valid and informed decisions".
IMR re GP involvement	"it became apparent that they [the GPs] were not certain of their responsibilities if a patient or their relative refuses access or treatment….GP did not make any attempt himself to determine his capacity to refuse treatment, as he did not realise that this was his responsibility".

6.6.9 Decision-making in the acute hospital setting and by ambulance crews does not always evidence clear assessment of capacity in relation to decisions to treat/withhold treatment or to convey.

6.6.10 The fundamental importance of robust risk assessment and mental capacity assessment as a foundation in considering legal options was not grasped. The availability of most legal options would have depended on one or both of these.

6.6.11 Legal options may not have made any difference in the end to the decisions and outcomes. The same judgements would have to be confronted. However these are essential considerations in support of the assessment process.

[5] Keywood, K, 2010, Medical Law Review Case Comment: Vulnerable adults, mental capacity and social care refusal.

7. Internal Management Reviews

7.1 There is a clear commitment from agencies to addressing shortcomings both individually and collectively. This was evidenced in many of the Internal Management Reviews submitted by individual agencies.

7.2 In addition to the themes outlined in 6.2-6.6 there was particular emphasis in more than one Internal Management Reviews on record-keeping standards. This is vital in underpinning and evidencing the practice issues underlined above.

7.3 A very thorough Internal Management Reviews from the primary care trust reflected particular concerns around the part the GP service played in the situation of Mr. and Mrs. BB. Key issues/actions underlined in this Internal Management Reviews report include:

- Multiple entries in records but no visits.
- Safeguarding training issues.
- Lack of clarity about what to do if a patient refuses treatment.
- Continuity of staff/care.
- Inadequacy of records.
- Repeat prescribing system.
- Informality of Practice meetings (now formalised).
- Lack of follow up on referrals e.g. Community mental health team asking for physical examination but this not forthcoming.
- No attendance at Care Programme Approach or Safeguarding meetings.
- No significant event audit after death.
- A system of identification of vulnerable patients has been instigated by the practice.
- Confusion regarding Safeguarding: not so aware of adult Safeguarding. This to be raised with Director of Public Health.
- Most GPs responsible for own professional development. GP appraisers will discuss adult safeguarding with GPs now in annual appraisals.

There is a clear indication from the report that robust action is being taken to address the issues, this level of transparency enables the Safeguarding Adults Board to monitor progress.

This level of independent monitoring of and support for GP performance in safeguarding adults is important and should be present in all adult social care areas.

8 Conclusions

8.1 There was a range of risks to Mr. BB as well as some risk to Mrs. BB and to others. These are set out in 5.4. The perception of those risks by professionals was significantly at odds with that of Mrs. BB. The reasons for this were never fully explored or resolved. The extent to which the wishes, feelings and aspirations of Mr. and Mrs. BB were understood and integrated into assessments and action plans is a key issue.

8.2 The relationship of professionals with Mrs. BB was vital to effective intervention. There is ample evidence of the significant difficulty this relationship presented and the real concerns that resulted in respect of Mr. BB. Indeed, she was viewed by the mental health trust as the main obstacle to success in caring for Mr. BB. There is however little evidence in the chronology of conversations with Mrs. BB exploring and attempting to resolve these issues. There was little effort directed at exploiting opportunities to work positively with Mrs. BB and to understand and minimise her resistance. This needed to include an exploration of her reasons for declining services on behalf of Mr. BB.

8.3 An emphasis on relationship, building trust, assessing and re-assessing (alongside Mr. and Mrs. BB) over time should have been at the heart of agencies' working with this situation. Whilst there are glimpses of this in this situation particularly from the care manager and front line carers this was never planned and sustained.

8.4 Independent and specialised interventions, alongside advocacy, would offer a way forward in situations such as this where there is such a degree of paralysis in the relationship between service user/carer and professionals. This might include restorative approaches or family group conferencing.

8.5 Any real focus on Mr. BB and on his capacity to make decisions was missing. His constant resistance to services and professionals received little attention and it is never clearly identified whether he is capable of making decisions on key issues. The principle of presumption of capacity seemed to be followed without question. There was no evidence of Mental Capacity Act compliant mental capacity or best interests assessments.

8.6 Professionals struggled with the necessary balance between the risks they had identified, and the rights and responsibilities of Mr. and Mrs. BB and of professionals. It will never be known whether the right balance was achieved in this situation. However, the question is whether the processes and practices were sufficiently robust to ensure the right considerations in reaching conclusions.

8.7 Assessments and decisions failed to respond to a steady decline in

acceptance, by both Mr. and Mrs. BB, of care which had been deemed necessary to manage risk. There was a failure to collate single agency assessments into a holistic assessment to inform shared decisions and actions. In this context the lack of recognition of the important role of the home care agency and to include them fully in the assessment and management of risk was significant in this failure and must be addressed.

8.8 Within risk assessments and risk management plans not all risks were formally identified and there was a failure to integrate new information and patterns of deterioration into existing risk assessments. Practice in respect of reviews is found to be wanting.

8.9 Staff at all levels in organisations should be engaged in managing risk. There were issues about ownership of decisions and the need for challenge across agencies which required consistent input at a senior level. Front line staff should not be left exposed to managing high levels of risk alone and without the authority to manage them effectively.

8.10 The Safeguarding Adults' process should have been an effective vehicle through which to achieve effective multiagency working. It was ineffective in this case in doing so.

8.11 Policy and practice in risk work must be underpinned by legislation. Professionals were not sufficiently aware of the complex legal framework or of where and when to seek advice. The fundamental importance of robust risk assessment and mental capacity assessment as a foundation in considering legal options was not grasped. The availability of most legal options would have depended on one or both of these.

8.12 Working effectively in this situation required staff to use the guidance available in policies and procedures. Those most pertinent to this situation are those relating to: safeguarding adults; risk assessment and risk management; practice in the context of the Mental Capacity Act. Attention to these policy issues and to the associated training is central in learning lessons from this situation.

9. Recommendations

Empowering and including people who use services and their families/carers.

There must be a sustained effort to communicate with and to establish and develop relationships and trust with people who use services and their families/carers. This is especially important when those relationships are challenged by polarised views between individuals and professionals. Enabling the monitoring of situations which involve significant risk and any potential acceptance of responses depends upon this. Insights and information from people who use services and their families is crucial in the assessment and care planning process.

Recommendation 1

Member agencies to the Safeguarding Adults Board will ensure that person-centred principles are embedded in all relevant policies, procedures and guidance. This to include enabling service users to access advocacy services.

Recommendation 2

The Safeguarding Adults Board makes a commitment to exploration of and testing out of innovative ways of working where a high degree of risk is accompanied by significant resistance to services and support. This may include approaches such as restorative practice and family group conferencing.

Recommendation 3

Relevant agencies will ensure that carers' assessments are offered to all informal carers involved in providing support to individuals who use services. If this offer is declined it must be clearly stated in the individual's case records and subject to further review and repeated offers.

Mental Capacity

The approach to including the insights and information from service users and their carers will depend in part upon their capacity to make pertinent decisions. Dependent upon their level of capacity, efforts will focus on supporting decision making or on making decisions in the individual's best interests. Mental capacity assessments need to inform judgements about a service user's ability to assume responsibility for decision making.

Recommendation 4

A working awareness of the principles of the Mental Capacity Act 2005 must underpin all work in the context of managing risk in the lives of people who use services in Westminster.

Where decisions are leading to increased vulnerability and where there are issues which indicate questions as to an individual's capacity to make those particular decisions, professionals must carry out a formal mental capacity assessment and, where applicable, go on to undertake a Best Interests assessment. This must be compatible with the guidance in the Mental Capacity Act Code of Practice. Agencies will ensure that local guidance is in place so that assessments are undertaken in a consistent and effective manner.

Risk assessment and risk management

Practice in risk assessment and risk management was central in the circumstances surrounding Mr. and Mrs. BB. Those circumstances required a robust and joined up approach across agencies to understanding and keeping track of areas of risk and to ensuring appropriate and timely responses.

Recommendation 5

The Safeguarding Adults Board is committed to developing a joint approach to the assessment and management of risk across agencies in Westminster. This will build on existing guidance, agreeing common core principles and practice across agencies and it will identify the circumstances in which there is a particular need for a structured partnership approach.

- It will include a focus on working with individuals who decline services.
- It will include a focus on achieving effective review of action plans/protection plans over time.
- It will ensure that clear pathways are in place within and across agencies for escalation of concerns to senior managers.
- It is important that the crucial role of service providers in assessing and managing risk is recognised within this.

Practice in relation to legal issues

There must be greater familiarity across agencies in respect of the implications of legislation for practice.

Recommendation 6

All agencies must ensure, through training and supervision, that staff are aware of the complex legal framework and that their awareness is

kept up to date. That awareness must include awareness of the way in which legislation such as the Mental Capacity Act, the Human Rights Act and the Equalities Act underpin practice alongside an overview of potential statutory interventions commensurate with their role. Where there is doubt about legal issues, expert legal advice must always be sought by staff within organisations. Organisations must be clear with staff about where and how that advice can be accessed. The significance of risk assessment and mental capacity assessment in considering legal options will be underlined in guidance and in training/supervision.

Safeguarding Adults

Most agencies have policies and procedures in place in relation to safeguarding adults and yet they were unclear as to when to refer issues in to the process. They lacked clarity as to the purpose of the process or the potential value it would add to the situation. There is reference to the need to improve awareness of safeguarding adults and of the local procedures in a number of the Internal Management Reviews and this features in some internal action plans. Related actions must be in place across ***all*** agencies.

Recommendation 7

Westminster Safeguarding Adults Board partner agencies will review their internal Safeguarding Adults policies and procedures to ensure that these are mutually compatible and compliant with the London multi-agency policy and procedures to Safeguard Adults from abuse, 2011. All agencies will ensure that responsibilities and accountabilities in respect of adult safeguarding are clear and that links are made with other policies/processes (such as the Care Programme Approach). There must be particular attention to ensuring the involvement of adults at risk and of their perspective within the Safeguarding process.

Auditing of practice

Working effectively in this situation required staff to use the guidance available in policies and procedures. This needed to include policy and guidance on: safeguarding adults; risk assessment and risk management; practice in the context of the Mental Capacity Act. Action is required to ensure that staff are familiar with and have a working understanding of these.

Recommendation 8

Statutory agencies across the Safeguarding Adults Board will ensure that case file audits direct attention to the issues raised in this Serious Case Review and, in particular, the presence of a person-centred approach; the key elements of an agreed approach to assessment and management of risk; the assessment of mental capacity; an awareness

of the legal context of practice; an awareness of safeguarding adults procedures. The Westminster Safeguarding Adults Board will monitor this.

Staff development and support

Recommendation 9

Training across agencies in Safeguarding Adults and the related issues of risk and mental capacity will be monitored across all partner agencies by the Safeguarding Adults Board (alongside the above audit process) with a view to ensuring that all relevant staff have appropriate training and that the *effectiveness* of the training is evidenced. The Board will take a partnership approach to ensuring the availability of resources to implement the required training.

Recommendation 10

Agencies will review their policy and approach to supervision of staff involved in complex cases involving significant risk. This will facilitate management oversight, staff support, and identification of staff development needs. This will include facilitation of peer support, such as ensuring that group supervision opportunities are available to staff.

Recommendation 11

That the Westminster Safeguarding Adults Board highlights some of the learning and actions from this Serious Case Review in relation to GP practice in safeguarding adults with the GP Commissioning Boards. That it commends to the Department of Health /Association of Directors of Adult Social Services the requirement for independent reports to be provided in respect of the practice of GPs in adult safeguarding Serious Case Reviews so that positive learning and action such as came about in this Social Case Reviews can be more widespread.

11. Materials shared with the review panel

Andrews, Tony, Westminster City Council, Internal Management Review (IMR), August 2011[6]

DI Archer, Colin, City of Westminster BOCU Metropolitan Police, IMR, July 2011

Bassett, Gary, London Ambulance Service, IMR, 7 July 2011

Batterbury, Anthony; McKenzie, Maisie, Central London Community Healthcare NHS Trust, IMR, 30 June 2011

[6] All IMRs included a chronology of events

Mrs. BB report to Serious Case Review panel, August 2011

Central, North West London Foundation NHS Trust additional case records and meeting minutes

Central, North West London Foundation NHS Trust, clinical risk assessment and risk management policy & Care Programme Approach (CPA) Policy

Doherty, Chris, Healthvision UK Ltd, IMR, 21 June 2011

Dr Foreman, Pauline, NHS North West London, IMR 11 July 2011

Mitchell, David, Imperial College Healthcare NHS Trust

Westminster City Council additional case records and meeting minutes

Westminster City Council Care Management guidance: Mental Capacity Act and risk assessment and risk management & Safeguarding Adults Policy and Procedures

Dr. Woo, Lawrence, Central, North West London Foundation NHS Trust, July 2011

12. References:

Braye,S; Orr,D; Preston-Shoot,M; SCIE report 44, (2011), Self-neglect and adult safeguarding: findings from research;

DH (2010) A Vision for Adult Social Care

DH, *(*2010*)* Prioritising need in the context of *Putting People First*: A whole system approach to eligibility for social care, Guidance on Eligibility Criteria for Adult Social Care, England

Flynn, M, (2010) Sheffield Adults Safeguarding Partnership Board: Serious Case Review re 'Ann'

Flynn, M, (May 2011) Luton Safeguarding Vulnerable Adults Board, The Murder of Adult A (Michael Gilbert), A Serious Case Review

Keywood, K, 2010, Medical Law Review Case Comment: Vulnerable adults, mental capacity and social care refusal

Lord Justice Munby (July 2010*),* What Price Dignity? Keynote address by to the LAG Community Care Conference: *Protecting Liberties, 14*

Parliamentary and Health Service Ombudsman; Local Government Ombudsman (23 March 2009), Six lives: the provision of public services to people with learning disabilities

Scourfield, P (Nov 2010) Journal of Adult Protection vol. 12 issue 4, page 25, Reflections on the SCR of a female adult (JK)

Appendix 1

Extracts from the integrated chronology giving an overview of the circumstances between April 2009 and 1 January 2011

9.4.09 Mental health assessment of Mr. BB. Mrs. BB objected to suggestion of a Section 2 admission to mental health unit. She was not displaced as the nearest relative. Therefore Mr. BB was not detained under the Mental Health Act.[7] Referral was made to the home treatment team. This was later declined by Mrs. BB.

11.4.09 Mr. BB admitted to hospital via accident and emergency. He was found wandering by police and according to their records "appeared disoriented….he was of unkempt appearance, covered in dried faeces, was unable to give a history, had slow slurred speech..." A scan revealed a subarachnoid haemorrhage in the left frontal lobe. This was a short hospital stay. Mrs. BB believed that the haemorrhage was brought on by the "interrogation" of her husband: the mental health assessment.

7.5.09 Further admission to acute hospital. Mr. BB discharged himself 5 days later.

4.6.09 Report from landlord that Mrs. BB is padlocking Mr. BB's door to keep him in. Resolved with Mrs. BB through use of assistive technology. Mrs. BB is cooperative in taking this advice and support.

June 09 Two further admissions to acute hospital and 6 calls to ambulance and/or police services in which Mr. BB was missing/wandering /confused/distressed.

July 09 Letter from neighbour to adult social care expressing concerns in relation to Mr.BB specifically relating to self neglect, wandering, noise disturbance at night, risk of fire.

10.7.09 Mental health trust discharges Mr. BB from care of community mental health team to GP.

July 2009 7 calls to police and LAS from Mrs. BB or Police. Similar to the calls made the previous month.

August 2009 8 calls to Police Mr. BB missing/wandering. 19.8.09 Police email adult social care to ask for assistance in reducing incidents of wandering which have been daily over the past week.

Further frequent calls to Police in September/October. Police again contact adult social care with concerns about Mr. BB dishevelled and apparently uncared for.

[7] See table appendix 2 for detail of statutory interventions

9.10.09 Mr BB taken to mental health unit on Section 136[8] by Police following making a disturbance in a café. Placed under Section 2 of the Mental Health Act and transferred to ward. Assessed and discharged home due to no beds being available. At this point Mr. BB was assessed as "not psychotic but might be onset of dementia" (adult social care case file note) No record of detail of mental health assessment.

19.10.09 Mental health trust has Section 115 powers to enter property because Mrs. BB is obstructing a review of Mr. BB's condition. Mrs. BB prevents entry despite power being in place.

20.10.09 Approved mental health practitioner returns with Section 135 warrant and removes Mr. BB to mental health unit under Section 2 of Mental Health Act.

28.10.09 Independent Mental Health Advocate offered but declined.

2.11.09 Safeguarding alert received by adult social care from modern matron at mental health unit... Alert concerned "neglect by wife and prevention of access to care services" the adult social care file note states "Discharge plan to include safeguarding process to reduce risk."

9.11.09 Mental health trust records test results as "unable to engage in assessment but has likely cognitive impairment" (This relates to a decision to further investigate cognitive impairment of Mr. BB on adult social care file 3.11.09).

12.11.09 Safeguarding strategy meeting identifies concerns as: state of neglect on admission; access to care staff prevented by wife; Mrs. BB does not administer medication. An action plan is agreed to address the concerns. There is a statement in mental health trust notes that if key elements of the plan are declined by Mr. and Mrs. BB (namely personal care & incontinence management; meals and weight management; medication management) then "Mr. BB may need to stay in hospital under the Mental Capacity Act. Best interests assessment to be done….If the plan is not working at home referral to Independent Mental Capacity Advocate...by care manager." (Mental health trust case note)

24.11.09 Home treatment team discharges Mr. BB as Mrs. BB refuses access.

25.11.09 Adult social care file note refers to Fair Access to Care capacity assessment which determines Mr. BB lacks capacity to make decisions about his care (not clear whether the assessment is Mental Capacity Act compliant because details are not recorded).

15.12.09 Meeting to review protection plan states: "application for Guardianship to be considered by older persons community health team if

[8] See table appendix 2 for detail of statutory interventions

it is shown that medication is being withheld or access to care services denied."

18.12.09 Mr. BB admitted to acute hospital following a fall. Confused.

19.1.10 Safeguarding protection plan review meeting: level of cooperation reported as fluctuating and Mrs. BB refusing to be supervised with medication for Mr. BB.

Advice of Independent Mental Capacity Advocate was repeated as stated on 26.11.09 and 15.12.09, namely that: "Community mental health trust can apply for guardianship to enter the property if needed. We can apply to the Court of Protection under the Mental Capacity Assessment for an interim order to remove Mr. BB if Mrs. BB continues to refuse access to care...A Best Interests Assessment under Deprivation of Liberty procedures would then be needed". Meeting stated that safeguarding process to end immediately.

26.1.10 Mr. BB taken to acute hospital by ambulance: Mr. BB verbally aggressive towards Mrs. BB and lying prone on floor when ambulance arrives.

2.3.10 Review of protection plan. No significant change to plan of 19.1.10.

3.3.10 concerns reported by neighbour: neglect of Mr. BB by wife; wife locks him in his room; Mr. BB sounds distressed at night.

13.4.10 Record of home care agency stating not been able to give personal care for 6 days.

15.4.10 Protection plan review meeting: record of non compliance with care. Last care provided 10 days ago. Medication not being witnessed by carers. Care manager and community psychiatric nurse to visit.

17.5.10 Protection plan review meeting. Concerns about plan not succeeding. Community psychiatric nurse and consultant to visit.

11.6.10 Adult social care file note. Home care agency report that it has not been possible to provide personal care for the past 3 weeks. Mr. BB mental state is unpredictable; Mrs. BB apparently locks him in his room.

19.6.10 Mr. BB has refused his medication for 4 days according to Mrs. BB. When consultant and community psychiatric nurse visit he is verbally aggressive to them and hostile towards Mrs. BB.

6.8.10 Home care agency reports lack of compliance with care since 24.6.10 and carer has witnessed Mr. BB punching Mrs. BB on side of face when she tried to pull up his trousers.

18.8.10 Adult social care minutes of review meeting. This meeting was in response to concerns expressed by: consultant and community psychiatric nurse from the mental health trust; home care agency; LAS. Concerns in relation to: lack of access to carers; Mr. BB agitated and aggressive behaviour; concerns about compliance with medication (both antipsychotic and thyroid medications). Discussion about: legal options; about the need for assessment of mental and physical well-being of Mr. BB; about reassessment of capacity of Mr. BB to make decisions. These actions are reflected in the action plan.

10.9.10 Mental health trust notes. Home visit by care manager and community psychiatric nurse to follow up review meeting of 18.8.10. Mr. BB "shouting and did not allow [care manager or community psychiatric nurse] to sit in the room with him. Verbally aggressive to Mrs. BB and waving fist at her. Room smelt of urine and Mr. BB is described as unkempt".

Sept/Oct Mrs. BB concerned about Mr. BB not taking thyroxin and asking for support with this from GP on 12.9.10; 4.10.10; 11.10.10

13.10.10 Home care agency report that they have been unable to give Mr. BB any care for over a month. Mrs. BB has over the previous week cited cost as a reason for wanting to reduce/stop care.

15.10.10 Adult social care file note of joint visit by care manager and community psychiatric nurse. "Mr. BB screamed whenever (care manager) spoke; racial abuse from Mr. BB. Reports that Mr. BB refusing care and medication, particularly thyroxin".

October/November 2010 Threat of eviction. Landlord concerned he cannot carry out his responsibilities as agent because it is too intimidating to enter the premises.

8.11.10 Meeting between care manager and Deprivation of Liberty Safeguards manager. Legal advice sought and given. Advice is recorded as: cannot proceed under Mental Capacity Act whilst Mr. BB mentally unwell. Mental Health Act takes precedence over Mental Capacity Act so a Mental Health Act assessment should be completed. This relayed to community psychiatric nurse and consultant psychiatrist who feels that a Mental Health Act assessment is inappropriate due to the issues being "social services issues". This decision reviewed and reversed 14/15 December 2010

Police called out 19 and 20.11.10 to locate Mr BB who was reported missing. Police reported him to be shouting and struggling, and concerns for his safety.

22.12.10 Mr BB admitted under Section 2, Mental Health Act to mental health unit because: Mr. BB "had been deteriorating in his mental state and was vulnerable in view of upcoming eviction notice…and threats made by his wife that they would "take off and never be found again" (mental

health trust notes 15.12.10). On admission Mr. BB found to be dehydrated, unkempt and to have lost a significant amount of weight. There was a rash on his skin". Plan is to stabilize Mr. BB psychiatrically, care manager (once stabilized) to complete a mental capacity assessment around care and accommodation and if Mr. BB is found to lack capacity to progress to a Best Interests meeting and to make a decision as to the most suitable accommodation for Mr. BB

29.12.10 Mr. BB is transferred to acute hospital on Section 17 leave because he was dehydrated and very unwell. He was subsequently diagnosed with pneumonia.

1.1.11 Mr. BB died in the acute hospital.

Appendix 2

Consideration of the relevant statutory options/frameworks

Possible interventions and Statutory grounds	**Supporting factors / factors "against"**	**Implications of applying this intervention**
S.47 National Assistance Act 1948 Removal to a place of safety (eg institutional care) for up to 3 months where people with grave, chronic conditions are not receiving proper care and attention and are living in insanitary conditions.	Mr. and Mrs. BB were probably not living in "insanitary conditions". There are human rights issues to take into account.	Although S.47 allows removal from a person's home, it does not permit any further action to be taken, such as treating a person's physical condition. Use of it would potentially have contravened Mr and Mrs. BB's human rights.
Mental Health Act 1983 Section 2: assessment Section 3: treatment Compulsory admission to Hospital where defined forms of mental disorder exist and for the individual's own health or safety or to protect other persons.	Mr. BB's condition was assessed on more than one occasion as amounting to a mental disorder under the Act. He had a diagnosis of paranoid schizophrenia and dementia and there was concern at times for his own safety and that of others.	This was used where deterioration in mental state was assessed including increased level of agitation and aggression and where a significant risk to Mr. BB or others was identified at the point of admission. However, often the concern was around physical care and health needs and the MHA was, in those circumstances, not the appropriate means of addressing these issues. This was not a long term solution to all aspects of the situation.
Guardianship; S.7 Mental Health Act 1983 To require a person with a mental disorder: to reside at a place specified by the authority or person named as a guardian; to attend a specified place for treatment, occupation, education or training or to allow access to those providing care or treatment.	Mr. BB had a diagnosed mental disorder. This option was rightly considered as a contingency but it was never acted upon. It was considered as a possibility in order to gain access to Mr. BB by carers and other professionals and/or to keep Mr. BB in a place of safety when for example he was admitted to hospital and his wife wished to discharge him.	The limited powers under guardianship provisions may have assisted but would not in themselves have guaranteed access to Mr. BB if he/his wife were determined to obstruct professionals. Removal of Mrs. BB as the nearest relative would have been required to enable use of guardianship.
Mental Health Act 1983, s 29 Displacement of nearest relative: where a Mental Health Professional	Mrs.BB was obstructive of intervention and hospital care and this was seen as creating significant risk to Mr. BB. This option was	Would have allowed professionals to use the above Guardianship option or Section 3 (had it been necessary)where

believes a person is not suitable to act as the relative's 'nearest relative' because their involvement poses a risk to their relative's health or well-being.	therefore considered.	appropriate.
Section 115 of the Mental Health Act 1983 as amended by Schedule 2 Paragraph 8 of Mental Health Act 2007 An Approved Mental Health Professional is permitted to enter and inspect any premises (other than a hospital) in which a mentally disordered patient is living, if (s)he considers that there is reasonable cause to believe that the patient is not under proper care.	Could have been considered to gain access to Mr. BB on occasions where access had been denied for a considerable time and the risk was escalating.	Whilst grounds existed for using section 115 (and indeed it was used on one occasion on19.10.09), Mrs. BB was capable of and did obstruct despite this power.
S135 and S136 Mental Health Act Police Powers of entry into the home of a person believed to be mentally disordered, and a power for a constable to convey to a place of safety from there (s135)/from a public place (s136) if they think that someone is in need of immediate care or control by removal to a place of safety for their own protection or for the protection of others.	The S136 power was used in situations where Mr. BB was causing concern in a public place and on one occasion S135 was used because Mrs. BB was not allowing access (despite attempts to use a s115 power) and there was significant concern for the welfare of Mr. BB.	Both Sections 135 and 136 were used as short term interventions. This did not impact upon the longer term issues.
The Mental Capacity Act 2005 enshrines the presumption of capacity Declaration of mental incapacity is required if there is cause for concern that an individual is incapable of making a particular decision.	Mr. BB capacity for decision making was clearly problematic and left him vulnerable at times. An assessment of capacity was needed to support decision making as to the extent to which it was reasonable to go along with Mr. BB's decisions. This required updating at intervals and undertaking in the context of a range of decisions.	A declaration of incapacity in relation to specific decisions, if justified, might have resulted in staff being clear about whether they could act/perform certain care or treatment tasks without fear of liability in Mr. BB's best interests and whether action under the MCA might have been appropriate.
Mental Capacity Act 2005 Decisions and	There were many occasions on which professionals struggled with	This would have enabled transparency of decision making and supported

interventions in respect of people lacking capacity must be in their 'best interests'.	making decisions as to what course of action would be in Mr. BB best interests. If Mr. BB had been assessed as lacking capacity a formal best interests assessment would have assisted clarity and objectivity.	discussions between professionals who had opposing views and between professionals and Mrs. BB.
Section 5(1) of the Mental Capacity Act Provides possible protection for actions carried out in connection with care or treatment where an individual lacks the capacity to consent to them The actions must be in the person's best interests.	This might, where Mr. BB lacked capacity, include moving to a care home; conveying Mr. BB to hospital; giving Mr. BB antibiotics. These acts would have to be demonstrated to be in Mr. BB's best interests by referring to the best interests checklist in the MCA. There were some of the key risks related to social and physical issues for which the MHA was not relevant. The MCA was relevant and should have been considered in these circumstances.	If conditions were met then this might have enabled Mr. BB to receive care and attention in a number of contexts. However the key issue was whether this would be in his best interests weighing up his past and present wishes and feelings. This would have relied upon a robust risk assessment alongside a mental capacity assessment. Neither was present. The involvement of Mr. and Mrs. BB would be required as far as possible.
Deprivation of Liberty Safeguards, Mental Capacity Act, 2005 (DoLS) Applies where health/social care professionals are thinking about changing the way someone is looked after in a care home/hospital in a way that means they might be deprived of their liberty. If there is not a less restrictive alternative to meet the person's needs and the action amounts to a deprivation of liberty then a DoLS assessment will be required, including a best interests assessment.	If Mr. BB had been removed to a hospital or care home under Section 5 MCA for other than mental health needs/ assessment then the DoLS assessment would have been required to enable him to lawfully stay in that setting.	Mr. BB would have received more consistent care and attention but would have been denied the chance to continue living at home. It was felt at a number of points that removing Mr. BB under MCA and then DoLS assessment would not necessarily be supported by the current evidence and best interests assessment. (However it has been noted that no formal best interests assessment is recorded) This, it was felt, would be "likely to support care at home".
Mental Capacity Act, 2005 Independent Mental Capacity Advocate. An IMCA represents and supports the person who lacks capacity and makes sure the decision is in their	There were safeguarding issues and therefore Mr. BB did not have to be unbefriended to qualify for an IMCA. It is unclear whether this option was explained thoroughly to Mr. and Mrs. BB.	May have assisted in setting out the competing needs and views and enabling a balanced decision. It may have been impossible to persuade Mr.

best interests.		and Mrs. BB to try this resource.
Court of Protection declaration in the best interests of the individual Where there is serious disagreement about a decision (eg for a person to reside in a care home) and it cannot be settled in any other way. A means of securing a legal decision through the Court as to the best interests of the person.	This was a situation where the disagreement was not settled and it was causing significant risk. In the absence of other ways of resolving this conflict this option should have been considered.	An independent view on balancing the factors in this case would have been achieved. For this to be an option Mr. BB capacity and the level of risk would need to have been assessed more robustly than was the case.
Mental Health Act 1983, S17a Community Treatment Order On discharge following a MHA section this is a formal agreement to comply with medication and, where this does not happen, that the person may be returned to hospital.	This is a contract which requires participation by all parties.	This level of participation/agreement was absent. It is unlikely that a CTO would have assisted. Clinicians would still have been left with the dilemma as to, in view of the level of risk (because of noncompliance) whether return to hospital would be in Mr. BB's best interests. This needs to be seen in the context that Mr. BB was at one stage discharged from the Home Treatment team's care because of non cooperation.

Appendix 3

Report from Mrs BB.
References to specific hospitals and teams have been removed for confidentiality and the photographs referred to by Mrs BB have not been included.

I have been back and forth to France a great deal lately. Although I know nothing about the French system of caring for the elderly, it struck me that at no time did I see what I call "the wheelchair dead," i.e. heavily drugged elderly people being pushed about like corpses. My impressions may mean that the French incarcerate their elderly-unseen, in prison-like homes! I saw, however, many extremely old people slowly walking about; they did not appear to be excessively sedated, and this in a country where there are pharmacies at every turn.

Turning to the UK, there is one thing in the last few years I recall with pleasure and that is my and my husband's stalwart opposition to excessive sedation. My own views were influenced by the extensive research of Professor Lishman whose life time of painstaking research into post haemorrhage conditions, and in the service of the mind should be revered. Professor Lishman urged great caution with sedation which otherwise could provoke a fatal second haemorrhage.

My and my husband's views meant that my late husband was never "the wheelchair dead," not until excessive unnecessary sedation at the end of 2010. His gentle charm shone on nearly all occasions. He remained humorous and articulate until the hour of his last breath. Fortunately, he was taken off sedation at W hospital when he belatedly arrived there from X hospital in his last days so his personality was briefly restored before he passed.

This was not the personality of an advanced case of dementia as described by a former CPN. I was puzzled by the description as my husband did not seem to me to be an advanced state of dementia even though he had had a subarachnoid haemorrhage. I discussed the comment with my senior nurse sister (family) who has, in fact, years of experience. She said that serious dementia is a very different story and gave me examples that were very remote from my husband. Therefore it appeared that the CPN was incorrectly increasing the muscle of Y hospital to the detriment of my late husband's security in his home. I condemn comments by psychiatric professionals becoming writ in stone which are not verified by unanimous consensus including that of the next of kin. I could never agree to my husband being classified as an advanced case of dementia. An example of a good state of mind would have been the night before he was wrongly incarcerated at X hospital on December 22, 2011. On that night, the 21st December, he was holding a lively conversation on a single topic for one hour. Such was the misreporting and incorrect analysis, however, that even when my husband arrived at the W hospital, he was under a X hospital guard. For what reason had he been sectioned? We had not been informed. (It was some months since the sadistic carer appeared to have provoked a street incident. And, in the circumstances, that alone might not have precipitated a section.) We had no privacy at W hospital even in the last hours. We talked regardless; we knew there had been a great mistake. (My husband's recovery from a haemorrhage had been remarkable if not total therefore some dementia like symptoms remained. My sister said it was mild dementia.)

I maintain that the MHT had no right to send a troop of people to interrogate my husband on April 9th 2009. At this time, there was no local disturbance whatsoever and certainly no paranoia for some years. It was a cruel, noisy intrusion which triggered a haemorrhage on the very same day. I condemn their lack of trust and belief in my good reports. At the time, my husband was well dressed, clean, well nourished and articulate. We were dismissed as imbeciles who did not know what was good for us, and this continued to be the case up to the passing of my husband.

Following haemorrhage and hospitalisation the very next day, there was a steady recovery to the extent he could visit a local café. Later in the year, there was another unannounced call from Y hospital. They were presented with a man standing on his two feet making himself a cup of tea. My husband answered two of three basic neurological questions correctly. One of the questions, anyone might not have known. I think it was the day's date. Instead of applauding this remarkable recovery- on his feet, making tea, gently talking sense- they dragged him to an ambulance. From an ethical point of view, I deplored this intrusion as much if not more than previously. Excessive medication set my husband back again. Discharge became subject to protection plans which were another intrusion and hence began the long opposition to excessive medication. (The word "protection" suggests altruistic idealism and protection of the vulnerable. The reality is otherwise. The word is a euphemism for bullying power and a tendency to deny the positive elements that create happiness in a person's life.)

And all this excessive medication (i.e. a wish to prescribe considerably more than 25mg of amisulpride a day) despite the fact that all psychiatric tests at W hospital and Z hospital whenever there was testing, ECG etc. were good and normal. There was no psychosis. A social worker from Y hospital said to me they must have been psychiatrists from Z hospital. If that was so and not another glib remark, why was my husband incarcerated in their hospital? Reports from W hospital and Z hospital had been clear on the psychiatric front. Even at X hospital a social worker had said there was no psychosis.

I am referring to all tests since the haemorrhage in 2009.**There needs to be transparent print out of test results given to all patients or/and their next of kin so that there can be no blurring of the issues. A basic, neurological 3 part question should not be reason to arrest someone even if there had been no correct answers. The questions should be listed in the report so anyone could judge whether or not they bore validity.** There would also be evidence of wrongful arrest. Something went wrong when all the psychiatric tests were said to be excellent at W hospital, results I had no reason to object to. (I am referring to mental tests not routine neurological tests) and he was even cleared of psychosis by X hospital but at the same time X hospital pursued his incarceration. How can this be in a supposedly civilised country? Elderly is not synonymous with imbecility. If the asylums are mixing the two concepts, they should be dramatically restructured and half emptied. In this country, however, it is a fact that elderly appears to signal a set -up of coercion. It is a fact, some, if not all, consultants lie. It is a fact, some, if not all junior doctors, ignore their patient's enquiry. It is a fact that some if not all police advise incorrectly to promote tough measures regardless of innocence and incredulity. Just how close one can be to an instance of conscious (or possibly unconscious) evil in the guise of Law is a harrowing thought.

The "protection plan" was a bureaucratic system my husband endured with mostly patient resignation because it helped me to some extent. In my opinion, such plans should be abolished as they are dictatorial and intellectually unrefined. I mean this in

a profound sense. Such set-ups should form no part of a free, humane society. There were serious riots in this country last summer mostly amongst the very young. In my opinion, this is happening in no small part because the elderly are not nurtured to retain a meaningful presence. When the elderly are heavily sedated, their good influence on the young decreases to zero. Even a less than ideal influence is better than no influence as the young need roots of comparison. This should happen naturally. It does not require a Generation Plan. My grand children have memories of their grandfather which are other than the wheelchair dead.

On the 22 December 2011, we endured the final unannounced intrusion. On this day, we- my husband and I- had decided to go to A& E, W hospital in a taxi for an ECG check-up.

Since there was an ambulance outside, we could have been there in minutes. It is a fact the young consultant was too busy writing the sectioning to listen to me. He was sectioning a man who was as steady and stable as a year before. My appeals for physical check-ups were ignored .The CPN tried to convey my wishes to the consultant at X hospital, and even the admin. at the MHT rang X hospital to get physical check-ups underway at X hospital. All to no avail. It is a fact even the blood pressure test was delayed till the 25th December. Furthermore, it is a fact half the building was unheated at X hospital (the part where he slept) and there was delay in getting to W hospital till just before the New Year. These are the facts of the last few days. I had to wrap my husband in overcoats to keep warm. No-one had initiative to move beds to the warmer areas.

It is a fact that young (and older) "professionals" seemed to be unaware of basic matters such as heart, lungs, and hypothermia in the elderly. It is also a fact that young (and older) " professionals" seemed to be unaware of time passing and the aptness of place.

My comments refer to caring for the elderly who may or may not have recovered from other ailments. I maintain that my husband had been cured of past ailments by a combination of past care, world history, family and his own intelligence.

His cure was brutally tampered with. The A to Z of the system had been and has been murder as illustrated in the before and after photos of December 22nd to December 24th 2011.

Ps Please only circulate to the panel the first two photos not the last photo I sent.
I would be pleased if you would delete the last photo from your system and let me know.
If you need it for any reason, at any time, I can forward it again to you.