Warwickshire Safeguarding

SAFEGUARDING ADULT REVIEW
OVERVIEW REPORT

in the case of

Alan

Acknowledgements

The coordination of this review has been assisted greatly by the SAR panel with their local, professional and organisational knowledge. It has also been assisted by the chronology authors in the work they undertook and analysis they provided of their agency.

The practitioners who attended the learning event are also thanked for their valuable contributions and discussion.

Lastly, we are grateful to Alan's family who despite the difficult circumstances have been able to assist the review.

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1. Alan – a family pen picture

1.1 The family would like to say that Alan was a loving, caring son, brother, and uncle. Alan had an infectious smile and laugh and made all that knew him melt.

1.2 Although Alan was difficult to understand when he was speaking, the family were able to understand him through his gestures and by understanding his own vocabulary. For a stranger to understand him it would take a lifetime for them to be able to effectively communicate with him.
Alan was loved by all that met him, and he was the centre of the family unit. The family's lives were centred around Alan and his happiness and wellbeing.

1.3 Alan required 24/7 care for all aspects of his life and would not be able to look after himself in any circumstance.

1.4 Alan loved his music and would always have Jim Reeves or Daniel O'Donnell playing in the background. Alan would always carry around his toys, this was from a young child, this continued into adulthood and was part of his autism.

1.5 Alan was unable to make complex decisions however, he could make choices regarding his meals and would get excited choosing what he wanted. He would get extremely excited if he was going to have steak or roast dinner or a steak pie, these were his favourite!
Prior to 2012, Alan enjoyed a full and active life, he would go on family holidays abroad, go to parties and family BBQ's. Sadly, Alan's mental health deteriorated, these precious family times became more difficult for him.

2. Introduction

2.1 This Safeguarding Adults Review (SAR) focuses on the case of Alan.

2.2 Alan was born 3 months prematurely at home and due to a lack of oxygen he suffered from brain damage causing him to have physical and mental health issues. Alan had learning disabilities, was on the autistic spectrum and suffered from Bipolar disorder. Alan lived at home from birth up until he was admitted to hospital as an inpatient, in October 2018, having been sectioned under the Mental Health Act.

2.3 Alan was discharged from the hospital in August 2019, when he was housed in a Housing Association tenancy, achieved through the local authority, in his new home in Warwickshire. Alan was cared for by a local care provider. He was provided with 2 to 1 care 24 hours a day with 1 waking night and 1 sleeping night carer. Towards the end of Alan's life the level of care at night was increased due to Alan's behaviour becoming more challenging.

2.4 On the 14th December 2019, he was admitted to Warwick Hospital via the Emergency Department (ED), having been found unconscious whilst sleeping on a sofa. Alan passed away on the 22nd December 2019. Alan was 44 years old at the time of his death.

2.5 Section 44 of the Care Act 2014 places a statutory duty on local Safeguarding Adults Boards (SABs) to arrange SARs.

- When an adult, with needs for care and support, (whether or not the local authority was meeting any of those needs) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

2.6 In January 2020, Alan's case was considered by the Warwickshire Safeguarding Review subcommittee and it was agreed that the circumstances of the case should be made subject of a Safeguarding Adult Review.

3. Methodology and terms of reference

3.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively and additionally

- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adults partnership in Warwickshire to improve its services and prevent abuse and neglect in the future.

- Agree how this learning will be acted on, and what is expected to change as a result.

- Identify any issues for multi or single agency policies and procedures.

- Publish a summary report, which is available to the public.[1]

[1] Warwickshire Safeguarding Adults Board SAR Protocol and Guidance (accessed 21/10/20) - Warwickshire Safeguarding Adults Board SAR Protocol and Guidance

3.2 The Warwickshire Adults Review sub-group decided that a proportionate review would be undertaken. Each agency identified as being involved was requested to provide a report and chronology detailing their involvement. Practitioners who were involved in the case were invited to take part in two reflective discussion events. The discussion from these events is reflected throughout the report. These events were well attended, and professionals fully participated in the learning process.

3.3 The author contacted the family and discussed with them the purposes of a SAR and how it would be undertaken. The family expressed a desire to be involved and were able to supply the review with invaluable and insightful information on both Alan and his support needs.

3.4 Terms of reference for the review were agreed and these are at appendix A. The terms of reference identified the focus of the review as between 1st October 2018 until 14th December 2019 (date of admission to hospital)

The areas identified by the panel for consideration were:

- How well was the need to engage the family in the decision making, as detailed in the Court of Protection Order, understood by agencies supporting Alan?

- To understand how historic information is taken into consideration and shared between agencies on prescribed treatment pathways.

- What level of understanding did all services have on how the views of the family surrounding Alan's best interests were taken into consideration?

- To understand how the family's views on Alan's best interests were taken into consideration regarding medication changes as detailed in the Court of Protection Order by agencies.

- How effective was management and oversight maintained of Alan's care plans? How was Alan supported effectively and how were the medical needs identified in the care plan communicated proportionately between agencies and the family?

- To understand practitioner's knowledge of pain management. Alan's family were reported to be able to identify when Alan was in pain. Did all services seek the views of the family on establishing the level of pain Alan may have been experiencing?

- To understand the multi-agency response to the escalation of the family's concerns.

- To identify and highlight for learning purposes any areas which are considered to be good practice.

3.5 The agencies identified as having relevant involvement in the case, who provided a chronology and individual management review (IMR) and took part in the discussion, were: -

Coventry and Warwickshire Partnership Trust
George Eliot Hospital NHS Trust
The Care Provider
South Warwickshire CCG
South Warwickshire Foundation Trust
Stratford District Council
Warwickshire Adult Social Care
Warwickshire Police
West Midlands Ambulance Service
Housing Association
Warwickshire Legal Services

4. Background

4.1 At the time of his death Alan was 44 years of age. Alan was born prematurely and as a result of a lack of oxygen he suffered brain damage. Alan is described by his family as having severe learning disabilities, was on the autistic spectrum and suffered from Bipolar disorder.

4.2 From the time of his birth until October 2018, Alan was cared for at home by his parents and family. Alan and the family were well known to the GP. From 2011, Adult Social Care (ASC) supported Alan and the family with assessments and support plans.

4.3 From September 2013, Alan received support from Coventry and Warwickshire Partnership Trust (CWPT) Learning Disability Team and Crisis Intervention Team.

4.4 In January 2018, ASC records indicate that the family were finding it increasingly more difficult to cope. In February 2018, the Intensive Support Team (NHS) were involved. The Local Authority had agreed to 100 hours per week direct payment to provide Alan with 2:1 support. This was delivered by Alan's sister and brother in law supporting Alan's parents with care. In August 2018, it was concluded that Alan was not eligible for Continuing Health Care (CHC) and that his care would be jointly funded by ASC and the CCG.

4.5 A factor of this case is the relationship between Alan's family and some of the agencies and professionals involved. There are many areas where the family and agencies do not agree both on factual and recorded matters but also how Alan was responding to care. This review will seek to reflect both perspectives and indicate where this is supported by other sources.

5. Family perspective

5.1 The family strongly feel that Alan was failed by all agencies during the course of his life. The only exception they would give was the support that Adult Social Care, in particular the team leader, was able to give them when they were trying to secure a tenancy for Alan.

5.2 The family cared for Alan all of his life and provided for all his needs. When it became necessary for Alan to be sectioned the family describe themselves as being at the end of their tether. The family feel they had reached out on numerous occasions to support agencies but feel they had been provided with little support apart from 100 hours direct payment support per week, which was provided by Alan's sister and brother in law.

5.3 The family had applied for and been declined Continuing Health Care (CHC). They had asked for support from the Mental Health Crisis Team but were informed that they were unable to assist with Alan.

5.4 When Alan was an inpatient at hospital, the family were unhappy with the care which was provided to Alan and felt that this was not the right setting for him. They did feel that they were included in the care but felt that this was as a matter of necessity as the hospital trust was unable to provide the level of care that he needed.

5.5 When Alan was being transitioned to his own tenancy and support from the care provider, the family felt that the arrangements were rushed. The family had been informed that agency care would only be used as a matter of exception, when circumstances presented which could not be avoided but they state that agency care was used more frequently, in particular at night. The family would question the level of training and experience that some of the agency staff had.

5.6 The family felt that from the outset the care provider did not want their involvement in Alan's care and sought to limit their contact. The family were under the impression that they had in place a Court of Protection order giving them deputyship over Alan's personal welfare. The family would cite a number of areas where, as persons holding deputyship or as family, they were not

routinely involved in decisions regarding Alan's care and medication, or where they were involved their voice was not heard.

5.7 When the family did become aware of changes in medication, they often voiced their concerns and felt that these and their experience of caring for Alan was not taken into account. They also state that additional locks were fitted at Alan's address without reference to Deprivation of Liberty (DoLs) implications or the nominated responsible person (Alan's sister) named in the Court of Protection Order.

5.8 Towards the time of Alan's death the family feel that his medication was being increased and that he was being over medicated. They strongly feel that in the 24 hours before his death Alan was given Codeine that was not properly recorded within the care notes and medical records.

6. Summary of Facts

6.1 At the beginning of October 2018, Alan's sister contacted Adult Social Care (ASC) stating that the family needed support in the form of respite, and they were finding it difficult to cope. The sister informed ASC that any support would be best delivered at the family home address as Alan would find it difficult to cope elsewhere. The concern was passed to the Learning Disability Team for their urgent attention.

6.2 On 4th October 2018, both police and ambulance attended Alan's family address having been called by the family. Alan was said to be being aggressive, the family had attempted to call the mental health crisis team but had been unable to get a response. The GP also attended, and Alan was prescribed Diazepam to assist in calming him.

6.3 The GP followed up this visit in following days as Alan was suffering from his feet swelling. Alan was waiting for an inpatient bed but the nearest was said to be 200 miles away. The GP records show that if an inpatient bed could not be sourced then an acute medical admission may be required.

6.4 On 10th October 2018, Alan was conveyed to the hospital emergency department. Alan was at the time suffering from cellulitis[2] to his right leg, chest infection and a possible psychotic episode. An in-patient bed was sought for Alan, but a local bed could not be sourced. The hospital records show that a Deprivation of Liberty (DoLS) Safeguards authorisation was applied for and a

[2] Cellulitis - is a potentially serious infection of the deeper layers of skin

mental capacity assessment carried out. Alan and the family were seen by the Learning Disability Acute Liaison Nurse (LDALN)[3].

6.5 Discussion with the family showed that there were plans at that time for Alan to be admitted to an inpatient mental health unit in Darlington, the family were concerned as this was a considerable distance away and this would leave Alan isolated but if the need continued were happy to agree to this, although they would have preferred a more local provision.

6.6 Alan was assessed by mental health services and after discussion with the family, five days later, was discharged home to await a bed in a mental health unit which was available more locally.

6.7 The hospital recorded that during his stay in hospital Alan's family provided a significant amount of his care. They were involved in decision making regarding his treatment plan and in their words '*offering invaluable support to SWFT both with his care and insight into Alan's condition and needs'.* The family provided the hospital with 'their shifts' to support the 2:1 carers that the hospital provided to Alan.

6.8 On being discharged from hospital Alan's GP received a discharge letter from the hospital. Following contact from Alan's mother the GP attended the home address on two occasions to give advice and reassurance.

6.9 On 24th October 2018, Alan was detained under section 2[4] Mental Health Act 1994 and admitted to hospital following what is recorded as a deterioration of his mental health over the previous six weeks, community acquired pneumonia and cellulitis. Alan was allocated a social worker from the Learning Disability Team.

6.10 On admittance there was a multi- disciplinary meeting (MDT) which discussed Alan's medication and his reluctance to accept this from staff. The family were consulted and gave their assistance. It was also noted that Alan presented as being unsteady on his feet due to benzodiazepine[5] being prescribed.

6.11 The family raised concerns regarding Alan's physical health and the link between this and the deterioration of his mental health.

6.12 In early November 2018, there was a post admission meeting at the hospital which involved Alan's family, hospital staff, Learning Disability Team, ASC and a

[3] LDALN – A joint funded post between CWPT and South Warwickshire Foundation NHS Trust (SWFT) to offer support to staff and liaise between the acute and Community Learning Disability Service.
[4] Section 2 Mental Health Act 1983 (admission for assessment) - Section 2 Mental Health Act 1983 (accessed 21/10/20)
[5] Benzodiazepines are a type of sedative that may sometimes be used as a short-term treatment during a particularly severe period of anxiety

professional advocate. During the meeting the family expressed that they were not happy with several aspects of Alan's care, including overlooking his swollen leg, medication administration and staff attitudes. The family felt that the hospital was not able to meet Alan's needs and asked whether he could be moved to residential care. This is the only occasion where an advocate was involved with Alan, as thereafter his family acted on his behalf.

6.13 In November 2018, at a care and treatment meeting attended by the family, Alan was assessed and further detained under the Mental Health Act but now under section 3[6]. It was also highlighted that since admission Alan's medication had been reduced by half.

6.14 In mid-January there was an MDT meeting at the hospital, which the family attended and are recorded as feeling care had improved. It was confirmed that Alan had been formally assessed as lacking the mental capacity to make informed decisions regarding his discharge destination. There are conflicting agency records whether the family agreed with a view that it was in Alan's best interests not to be discharged home and specialist supported/residential accommodation should be found. Various options were discussed with the family and it was agreed that residential care would be the best option. The Speech and Language Team (SALT) had created a speech book, which was considered positive by all.

6.15 At the beginning of March 2019, Alan's family had visited two potential residential providers. The family selected a local care provider. At a review meeting a best interest decision was made that Alan should be discharged to the care provider. A plan was also finalised to manage gifts being given to Alan by the family. This issue was to be a source of tension between the care provider and Alan's family.

6.16 In April 2019, the family raised concerns with the hospital that they felt there had been errors in Alan's medication. This coincided with Alan suffering a condition where he tended to lean to one side. Alan also attended accident and emergency with a fractured toe around this time.

6.17 In April 2019, an application for housing was received by Stratford District Council completed by staff from ASC. The housing team then engaged with ASC to provide a pathway for housing for Alan. There was regular contact between the family and housing, but housing felt limited in what they could share, due to Alan's inability to consent and an order from the Court of

[6] Section 3 Mental Health Act 1983 (admission for treatment) - Section 3 Mental Health Act 1983 (accessed 21/10/20)

Protection not being in place. The family feel they were very well supported on this aspect by ASC.

6.18 The housing department felt under considerable pressure to progress the rehousing of Alan. Throughout the exchanges the authority sought clarification on the legal status of the MDT being able to secure a tenancy on Alan's behalf. As, at this time, there was no order from the Court of Protection or Power of Attorney in place, the housing authority was unable, despite best efforts, to progress the application.

6.19 On 9th May 2019, ASC carried out a formal review into Alan's support and care.

6.20 Around this time the family further expressed concerns over Alan leaning and the assessment of this condition. Alan had been referred to physiotherapy and neurology, there was a review of Alan's medication and Risperidone was reduced and codeine was introduced.

6.21 In June 2019, a mental health tribunal was held at the hospital and it was decided that Alan was to remain under section 3, Mental Health Act.

6.22 Towards the end of June 2019, a suitable property was identified for Alan. There had been considerable dialogue between ASC and the housing authority to secure the tenancy and work with the organisation who held and managed the authority's housing stock. As Alan's situation required priority the housing authority and ASC were able to overcome Alan's inability to secure his own tenancy and no court order being place at this stage. This was undertaken as a matter of exception due to Alan's homelessness status and the priority of his situation.

6.23 At the beginning of July 2019, ASC created a formal care support plan in readiness of Alan's discharge. The plan recorded Alan's 24-hour supervision and monitoring due to his lack of awareness of his needs, and risks to himself. It detailed that *'Alan requires 2:1 support with managing his personal hygiene, his toilet needs, ensuring he is dressed appropriately, making use of his home safely, managing and maintaining his nutrition, accessing and being part of his community, maintaining a habitable home, and maintaining his family relationships*.'

6.24 On 19th August 2019, Alan was discharged from the Hospital under section 17[7] MHA (leave of absence) to his new bungalow. This had been preceded by transition and planning meetings, which included members of the family, staff from the care provider, hospital staff, Learning Disability Team, CCG and Occupational Therapy. A communication protocol was put in place detailing how the care provider would communicate with the family and a plan to

[7] Section 17 MHA 1983 (leave of absence from hospital) - Section 17 MHA 1983 (accessed 22/10/20)

eradicate the use of presents from the family as rewards. It is apparent that the GP surgery was not informed of Alan moving from the hospital to his own accommodation.

6.25 The care provider state that Alan to initially settled well into his new home, although the family had some early concerns. This is supported by the Learning Disability nurse, who commented that Alan settled well and seemed happy. Within days Alan's mother visited the bungalow unannounced. She was described as being angry and was concerned that agency staff were being used to provide Alan's care. It is clear from the care provider's records that daily contact was maintained with the family, with contact up to three or four times a day. The use of agency staff was an area of continued concern for the family.

6.26 On 20th August 2019, Warwickshire Legal Services were instructed by the ASC social worker to apply to the Court of Protection for a deprivation of liberty authorisation for Alan. The application included a request to authorise Warwickshire County Council to enter into a tenancy agreement on Alan's behalf. This was submitted on 28th August 2019 and granted by the Court on 6th September 2019. This order also conferred the role of Relevant Person's Representative (RPR)[8] on Alan's sister.

6.27 Alan's parents had also made two applications to the Court of Protection, the first being for deputyship for matters of finance and property on 11th July 2019 and the second being for permission to apply for health and welfare deputyship on 22nd July 2019.

6.28 The application for deputyship for health and welfare was considered by the Court on 29th August 2019 and initial orders were made granting Alan's parents' permission to proceed with their application for deputyship. Copies of the application and supporting paperwork, together with the Court's initial order, were served on ASC as required but it is not clear what happened to it. It is also clear that other agencies received copies of this order.

6.29 It would appear that neither of the applications for deputyship resulted in a final order. The finance and property application was dismissed on the basis that Alan had no property. The health and welfare application did not lead to an order for deputyship being made by the Court. What is clear is that all agencies involved in the care of Alan, except ACS, were under the impression that the order giving the family deputyship for matters of health and welfare had been granted. It is of note, that in any case, no agency with

[8] Relevant Person Representative (RPR) – the role of a RPR is to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the deprivation of liberty safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

knowledge of the application for health and welfare made any representation to resist it.

6.30 At the beginning of September 2019, there was a post discharge meeting at the Hospital. This was attended by Alan's family; the records show that all parties at the meeting stated that the placement and support from the care provider was going well. Alan was formally discharged from the hospital and from the section 3 MHA order. The GP was not informed by the hospital of the discharge and only became aware when there was a later request for a change in medication for Alan.

6.31 In mid-September there was a meeting with the family. At the meeting the family raised concerns they had over costs being incurred by Alan. There was also discussion regarding the family giving gifts to Alan, which was a source of tension between the family and the care provider. As a result of the discussion that the family assumed the responsibility for shopping for Alan.

6.32 It is important to note that up until this point the care provider and indeed other agencies, such as ASC, had received mainly positive feedback on the quality of care being provided to Alan by the care provider.

6.34 In September and October 2019, the care provider recorded incidents involving Alan, the first was Alan's reluctance to return from a pub visit resulting in aggression towards staff and the second followed a visit from Alan's sister and Alan anticipating a present and being aggressive towards staff.

6.35 In October 2019, there continued to be tension between the family and the care provider, the care provider felt that it was difficult to establish a routine due to the frequency of the family visits.

6.36 Towards the end of October 2019, there was a discussion between Alan's sister and the care provider regarding concerns that the family had about the use of the heating in Alan's bungalow and over the variety of activities that Alan was being offered. The social worker visited Alan and recorded that he appeared happy and well. Alan had suffered an ear infection for which he had been prescribed antibiotics.

6.37 In November 2019, ASC requested the need for an MDT as Alan's placement was at risk of breaking down due to a breakdown in relationship between the Alan's family and the care provider. This request was made on three occasions to all relevant parties, but the CCG were reticent to become involved in the tension between the family and care provider.

6.38 There also appears to have been an escalation in Alan's challenging behaviour with 6 incidents recorded by the care provider in late November and early December. A full MDT was scheduled for 19th December 2019.

6.39 On 1st November 2019, there was a Care and Treatment Review[9], this was attended by the clinical commissioning practitioner, commissioner, the care provider staff and an expert by experience.

6.40 During November 2019, Alan was seen by the GP for a painful ear and a lump on his foot. The family continued to have concerns over Alan's welfare and the support that was being afforded to him by the care provider staff.

6.41 On 23rd November 2019, the care provider recorded that there was a change to Alan's previously settled sleep pattern.

6.42 At the end of November 2019, the GP received a letter from the Learning Disability Team requesting an increase in Risperidone from 1 mg twice daily to the same dose three times daily. This coincided with the care provider noting that Alan's behaviour had become more violent with him 'hitting and lashing out' at staff. They passed their concerns to ASC who discussed a plan to use PRN[10] as prescribed and maintain vigilance over Alan's physical health.

6.43 At the beginning of December 2019, Alan's mother again voiced concern regarding the son's increase in medication and requested a discussion with the consultant psychiatrist. Alan's mother stated that the medication was making Alan unsteady on his feet.

6.44 On 3rd December 2019, Alan was at a function with carers when he became unsettled and refused to leave when asked. Alan was distracted with a present from under the Christmas tree with good effect. When he arrived home Alan refused to go to bed and became destructive. An incident report was completed which notes that locks may have to be fitted to the lounge door, but this would have to be subject of an MDT.

6.45 On 5th December 2019, Alan was out with care staff at an activity when his behaviour was described by staff as dangerous and displaying destructive behaviour. Alan was said to be striking out at staff. At one point Alan fell through a fire door. The incident report refers to considering level 2 Non-

[9] A **Care & Treatment Review** (CTR) is a meeting about an adult who has a learning disability and/or autism and who is either at-risk of being admitted to, or is currently detained in, an in-patient (psychiatric) service.

[10] PRN - The PRN prescription stands for '**pro re nata**,' which means that the administration of medication is not scheduled. Instead, the prescription is taken as needed.

Abusive Psychological and Physical Intervention (NAPPI)[11] but again recognises the need for an MDT to discuss this.

6.46 On 6th December 2019 the care provider staff recorded a further incident with Alan between 7.50 pm and 3.30 am the following morning. The incident centred around Alan not wanting to go to bed. It is reported that Alan used destructive behaviour to property and struck out at staff. During the course of his behaviour Alan fell 'gently' against a chair. Medication in the form of PRN Diazepam was administered.

6.47 The care provider staff also contacted the Crisis Team seeking advice after a sudden change in Alan's presentation (four days). The plan was to increase the night-time regular dose of Risperidone (i.e. 1 mg morning, 1mg afternoon and 2 mg at night). On 7th December 2019, the consultant psychiatrist increased the Risperidone on the 6 p.m. dose from 1 to 2 ml. The following day the night-time care staff for Alan was changed to two waking members of staff.

6.48 It is apparent around this time locks were fitted to the lounge and bathroom doors in Alan's flat. There was no MDT best interest discussion regarding this decision. The care provider state that the family agreed to this, but the family would strongly dispute this. The family state that locks on doors were mentioned during a phone call early in December but the family stated they were against this and as they felt it would not be a good idea for Alan.

6.49 Copies of the care provider waking night records would indicate that there were incidents of challenging behaviour on 9th and 11th December 2019. These records would indicate that staff locked the lounge door on these occasions to prevent Alan gaining access. In the early hours of 11th, the record indicates that Alan was banging on the lounge door until 6.45 a.m. Neither of these incidents were subject of incident reports by the care provider.

6.50 It was apparent that at this time Alan was not sleeping well and had started to spend nights in a chair or sofa. On 10th December 2019, the GP visited Alan after staff reported that he had redness to his leg and a cough. Alan was prescribed antibiotics.

6.51 On 12th December 2019, Alan was seen at home by the consultant psychiatrist, learning disability nurse, and the care provider staff. Alan's mother was also present. The care provider reported that there had been some improvement since the increase in Risperidone. Alan was prescribed regular doses of diazepam (4 mg at night – total daily dose 10 mg). Alan's mother expressed concern over the use of diazepam as it had previously made Alan unsteady on

[11] NAPPI - Non Abusive Psychological and Physical Intervention (accessed 09/12/20) - NAPPI

his feet. In an email, later the same day, Alan's sister asked for additional pain relief to be considered for Alan and also expressed a concern regarding the use of diazepam.

6.50 On 12th December 2019, a further incident report was completed by the care provider describing Alan as being highly anxious and agitated between 8.00pm and 10 pm. He repeatedly asked for his mother to come around, staff attempted to reassure Alan. Alan was striking out at staff and they had to employ NAPPI blocking tactics, eventually staff, on advice from the on call manager locked themselves in the lounge. Alan remained outside and could be heard striking the door. Alan was said to calm down before night-time staff arrived.

6.51 When the agency night staff arrived it was established that neither of the staff had previously worked with Alan. The care provider states that there was a full handover between the late turn staff and the agency night staff. This included being given access to Alan's communication passport, his Medication Administration Record (MAR) and a detailed history of recent interventions and incidents involving Alan.

6.52 When it became known to the on-call care provider manager, that agency staff with no prior knowledge of Alan had been sent, they made themselves available for contact by phone. Calls were made to this manager on 5 occasions for advice and the manager attended the bungalow at 3.52 am. An advanced nurse practitioner (ANP), who knew Alan was called and attended at 4.50 am. Alan was assessed for additional pain relief in the form of Codeine and prescribed 30-60 mg four times a day. Once the ANP left Alan is described as 'demonstrating signs of mania' and PRN 2 mg Diazepam and Codeine for pain relief was administered. At 6.15 am Alan fell asleep in a chair.

6.53 On the morning of 13th December 2019, the care provider called the GP as Alan was asleep and they wanted advice on giving him his medication. At this point the GP was not aware of the medication changes as prescribed by the consultant psychiatrist the previous day. There is currently a project which will introduce an Integrated Care Record and this will make key information, such as changes in medication, visible across all NHS services as they are entered.[12]

6.54 On the night of the 13th December 2019 and into the hours of the early morning 14th December 2019, Alan is said to have a very settled night, which was incident free. He was administered 4 mg Diazepam at 7.00 pm in accordance with the short course prescription. This was to manage his bipolar

[12] Coventry and Warwickshire Integrated Care Record - www.happyhealthylives.uk/our-priorities/digital-transformation/integrated-care-record/

relapse. He was monitored throughout the night by staff and was heard snoring and described as breathing normally.

6.55 On 14th December 2019, at 7.39 a.m. an ambulance was called to Alan's address as Alan had been found unresponsive by the carers on a sofa where he had been sleeping.

6.56 The records form the ambulance call state that the carers were instructed to move Alan to the floor, they responded that Alan was already on the floor. On attendance the ambulance crew noted that Alan was breathing noisily and a partially occluded (blocked) where vomit was evident. There was evidence of a dried substance around Alan's mouth.

6.57 It was recorded on his initial notes that there was a query regarding a Codeine overdose. As part of Alan's initial treatment, he was administered two separate doses of a medication used to counteract Opiate overdose (Naloxone).

6.57 Alan was admitted to the intensive care unit, the hospital notes on admission describe Alan as being very unwell and it was suggested that his condition could have been due to a prolonged lack of oxygen. Alan passed away on 22nd December 2019. Alan's family raised concerns regarding the levels of medication Alan had been given and the hospital informed the family that the Coroner would be notified. A notification to the Coroner was subsequently made.

7. Analysis of involvement

7.1 How well was the need to engage the family in the decision making, as detailed in the Court of Protection Order, understood by agencies supporting the adult?

7.1.1 When Alan was initially discharged from hospital, he was under a section 3, MHA order and was later discharged under section 17 MHA, which allows for a leave of absence from a hospital. Alan was formally discharged from the Hospital and section 3 MHA on 3rd September 2019.

7.1.2 The deprivation of liberty order applied for by and granted to Warwickshire County Council on 6th September 2019 confirmed that under the MCA, Alan lacked capacity to (i) Litigate the proceedings (ii) Make decisions about where he should live (iii) Make decisions as to his care (iv) Enter into a tenancy. The order authorised a deprivation of liberty as described in Alan's care plan (June 2019) and the Council's DOLS application. It also appointed Alan's sister as his Relevant Person's Representative. The order further authorised the Council to enter into a tenancy agreement for the address secured for Alan as his place of residence. If urgent or planned more restrictive measures were to be put in place a further application should be made to the Court.

7.1.3 The accompanying DOLS application set out that the responsible authorities for the care placement were South Warwickshire CCG and Warwickshire County Council. The application recognised that during the day Alan would have access to all areas of his home but during the night the kitchen door would be locked for safety reasons.

7.1.4 Just prior to this application being made the family had made an application to the Court of Protection for deputyship in relation to property and finance and more significantly health and welfare. The family were under the impression, when they received official court paperwork, that orders had been granted giving them deputyship. This paperwork was in fact a notification that their application and the initial court orders relating to the case should be served on the GP, Head of Social Care and the Head of the CCG. This would allow these agencies to make any representations to the Court, should they wish to oppose an order for deputyship being made. Professionals who have seen this paperwork as part of this review agree that it would be easy for families or indeed professionals, receiving this to reach the conclusion that this was the deputyship order itself, rather than the preliminary stage in the court process. .

7.1.5 The paperwork did reach agencies and as a result the family and all agencies, except ASC, involved with Alan's care believed that the family had deputyship over Alan's health and welfare. As far as ASC were concerned at this point the legal position was not clear. The legal case was, as the process had not been completed the order was not effective. It is of note that no agencies, to the knowledge of this review, sought to oppose the family's application. However, it should also be noted that the grant of deputyship would not have been a foregone conclusion. The Courts generally take the view that an application for a welfare deputy will not normally be necessary because most care and treatment decisions can be made by those involved in providing care, so long as they are acting in the person's best interests. The Court will only appoint a personal welfare deputy in the most difficult cases. Examples might include where there is a history of disputes within the family, or where the person is at high risk of abuse or when there is a need for someone to make a series of linked welfare decisions over time. In cases where there are disputes between the incapacitated person's family and the agencies involved, these would usually be decided individually by the Court, rather than by making a deputyship order. Whatever the individual agency understanding was, there was significant confusion, which required clarification.

7.1.6 Had a deputyship order been in place then Alan's parents would have 'stood in Alan's shoes' for all health and welfare decisions relating to his care and treatment. They would have been in a position to give or refuse consent to all such decisions.

7.1.7 Even without this or other legal authority, such as a Lasting Power of Attorney, his family should have been consulted by decision makers on Alan's best interests when decisions were being taken. Alan's sister also had a specific

responsibility for the DOLS application to monitor the care plan and request a review by the Court if she felt that it was no longer meeting Alan's best interests.

7.1.8 At the end of November 2019, the GP was contacted by the LDT and a request was made to increase Alan's Risperidone, this was agreed. The family were informed of this intention and voiced their concerns. It is not evident that there were constructive discussions with those involved in Alan's care, including his family regarding his best interests. Had the CoP order for health and welfare been in place, the GP and LDT would have been acting against the deputyship.

7.1.9 The BMA Guidance on best interest decision making for those who lack capacity[13] advises that where there is a deputyship, the order should be seen and the provisions of the order understood. Had this been requested it would have been noted that the deputyship order had not been granted.

7.1.10 Where there is a dispute on best interests, there should be attempts to reach a consensus, if this is not possible the family should have been advised as to what options were available to them.

7.1.11 Restrictive measures were put in place without appropriate best interest discussion involving those involved in Alan's care. A deterioration in Alan's mental health and behaviour resulted in the care provider fitting locks to the lounge and bathroom doors. The care provider state that the bathroom lock was a replacement standard bathroom lock to allow privacy as opposed to restrict access, although photographs held by the family would suggest that this is not the case. The incident report on 12th December 2019, indicates that staff prevented Alan's entry to the lounge to protect themselves. This action was not the subject of any best interest discussion. The care provider contend that this was agreed with the family, but the family would dispute this and there are no records to substantiate that there was a best interest discussion and agreement. Any such a discussion at this time is not recalled by other professionals. In particular Alan's sister should have been party to any discussion or decision in this area as a person holding the status of a RPR as granted by the Court of Protection.

7.1.12 Overall there was a confusion that existed with all agencies as to what CoP order was in place and therefore what level of authority the family had in decision making in various aspects of Alan's life. That aside the family were not involved in some best interest decision making and the provisions of the Mental Capacity Act were not always considered and used.

[13] BMA, 2019 Best interests decision-making for adults who lack capacity A toolkit for doctors working in England and Wales (accessed 09/12/20) - BMA - Best interests toolkit

7.2 Was historic information taken into consideration and shared between agencies on prescribed treatment pathways?

7.2.1 The family had cared for Alan all his life. Their experience and knowledge of Alan, the person, was invaluable in understanding Alan's needs. This was recognised by the hospital in October 2018, when Alan was detained under the section 2 order. The hospital noted that the family provided a significant amount of care, offering invaluable support and insight into Alan's condition and needs.

7.2.2 The hospital recorded that there was regular liaison with the family, who were very involved with Alan's care. The LDALN liaised between the both Trusts, providing the inpatient care and the Trust who was to be providing the post discharge care. The family were recorded as being 'exhausted and struggling to cope' however they still maintained a 24-hour rota system to support Alan's care.

7.2.3 Due regard was given to family views regarding their concerns of Alan being discharged to a residential bed some distance away and as a result Alan was discharged to his family home. Within one-week Alan was re-admitted to hospital under a section 2 order. This hospital is where Alan spent the next 10 months.

7.2.4 Although it was very much the family wish that Alan was not discharged to a distant hospital on the first occasion, it does raise the question whether the family would have consented had there been a suitable provision more locally. The search for a local provision did continue until one was sourced later in the month. The records and the history would suggest that the family were still struggling to cope and the discharge into their care had every likelihood of not being sustainable.

7.2.5 Aside of the family, the service who knew Alan and his history best was the GP practice, having treated his complex needs for several years. The GP practice did demonstrate good practice by attempting to have the same GP seeing Alan on each occasion and as a matter of practice conducting annual learning disability assessments. The GP practice was not notified of changes in Alan's medication regime in September and December 2019.

7.2.6 Whilst an inpatient at hospital historical and current information around Alan's communication difficulties were gained and a communication book was developed by the Speech and Language Team receiving valuable input from Alan's family, which enabled staff to have a greater understanding of Alan's needs and presentations.

7.2.7 ASC had been involved with Alan since 2011, and therefore would have accumulated a substantial history of Alan and a relationship with his family. From the records and information provided it is not clear that this information was routinely used to inform future support.

7.3 How did services make best interest decisions for Alan and how were the views of the family, surrounding his best interests taken into consideration?

7.3.1 There is a clear picture that the care provider and the family were in conflict regarding what care and support was in Alan's best interests, to the extent that the placement was said to be at a point of breakdown. There is evidence that the family were initially happy with the quality of care provided to Alan, but this did not last. The care provider raised the likelihood of a breakdown of service with the Care Quality Commission and the Clinical Commissioning Group. Some of this conflict and tension emanated from what the care provider considered to be the family being too involved with Alan's care. At the hospitals where Alan had previously been treated the level family involvement was recognised as being unusual but invaluable. Although it is recognised that on occasions some of the family could appear aggressive in their approach and communication.

7.3.2 The ongoing family involvement was anticipated on the transition to the care provider service. The care provider state that they hoped to overcome any challenge or criticism by demonstrating they could provide good quality care for Alan. There were a number of areas that bought the family into conflict with the care provider. One of these was the areas of continued tension was Alan receiving gifts from the family. This was never effectively resolved. It is of interest to note that on an occasion where Alan was displaying challenging behaviour to carers, whilst out, he was distracted and calmed using a gift. It poses the question as to whether the approach was always consistent.

7.3.3 The family believed they held deputyship under the Court of Protection order for Alan's personal welfare. There did not appear to be a joint understanding of what in terms of care and therefore personal welfare was in Alan's best interests. The care provider state that the family wanted to micromanage the placement, which was contradictory to Alan's best interests. The care provider cite a number of conditions that the family exerted on the care for Alan, some of which breached policies and procedures. There was a constant dialogue between the family and the care provider but resolution was not found.

7.3.4 The family had very strong views on how Alan's care should be given, in all aspects. These views were based in lived experience gained over Alan's life. The family deeply cared for Alan and undoubtedly wanted the very best for him. At times the family's frustration and concerns were not expressed in the most appropriate way, but that said they were framed around what they believed was in Alan's best interests. ASC reflected and made attempts to view matters from the family's perspective and this, they would say, improved their working relationship with the family, in particular the work undertaken to secure the tenancy for Alan.

7.3.5 There were certain areas which the family highlighted which the care provider did not think was appropriate, an example of this is the use of a wheelchair by Alan. The provider and other agencies saw the wheelchair as a means of

restraint as Alan was mobile and did not require it. The family saw the wheelchair as the best way to ensure Alan was safe. The care provider relied on the Mental Capacity Act in their rationale for not using the wheelchair, but it is not clear that they followed the Act in reaching this decision. This was also the case when other measures such as locks were considered. The care provider was not alone in this respect. ASC applied to the Court and gained an order covering Alan's tenancy, care and support and deprivation but after this little evidence was found of the Mental Capacity Act being used to make other best interest decisions for him.

7.3.6 During reflection in the practitioner's event it was discussed whether suitable consideration was given as to whether too much emphasis was given to the family and whether their views were challenged enough regarding their views on best interests. This is a very difficult area and agencies stated they wanted to maintain a working relationship and due to this they were probably, at times, not as challenging as they should have been. This is one area where holding a best interest meeting would have provided a forum to air views and explore options leading to agreement and consensus or at the very least acknowledging and recording different views and agreeing next steps.

The wider use of advocates could also have been considered. The criteria for an Independent Mental Capacity Advocate (IMCA) to be involved was not met so there was no legal requirement to involve one. IMCAs can however be asked to provide advocacy outside of this statutory requirement one example being in safeguarding. The West Midlands Adult Safeguarding Policy and Procedures states ' *where there is a disagreement, relating to the individual, between the local authority and the suitable person whose role it would be to facilitate the individual's involvement, and the local authority and the suitable person agree that the involvement of an independent advocate would be beneficial to the individual.'* While this was not a safeguarding matter, the principle applies that even where family know the person well and are acting in good faith, an advocate brings independence and a focus on only acting for the individual. It is recognised that this would have been a very sensitive matter for Alan's family. An Independent Mental Health Advocate (IMHA) was used at an early stage whilst Alan was in hospital, but the family were not happy with the advocates role and it did not continue.

7.3.7 Although there was very regular contact between the care provider and the family, this communication did not address what the core issues were, really understanding the family and what the course of action was in Alan's best interests and what to do if common ground could not be found.

7.3.8 The care provider would state that they initially accepted Alan as a client, acknowledging that the relationship with the family would be difficult. They felt that if they showed Alan, the family and others involved in Alan's care that they

were able to offer quality care to make a positive impact for Alan then the relationship would improve as a consequence.

7.3.9 It is clear this was a very difficult situation for agencies and the family, with Alan at the centre of an ongoing situation. Certainly, by the start of the of the care provider's involvement, the difficulties were apparent, and the hospital had experience of how the relationship could be managed. At this point consideration should have been given to the regularity and structure of the MDT. It may have been worth considering how these meetings would be chaired, using the framework of the MCA and the necessity for accurate and agreed records being maintained with consistent and full membership. This would have provided a good foundation for transparency, with a view to improving relationships or a basis for escalating matters to the Court of Protection.

7.3.10 A mediation meeting was set for 19th December, which was later redefined as the Care and Treatment Review. Due to Alan's death this meeting did not take place but due to the critical stage of the relationship between the care provider and the family, it would have been preferable to expedite this meeting. There was a likelihood that these differences were not going to be resolved and in order to get clarity on the best interest decisions, an escalation could have been considered with a return to the Court of Protection for determination.

7.4 Were the family's views on Alan's best interests taken into consideration regarding medication changes as detailed in the Court of Protection Order by agencies?

7.4.1 As stated, the position of the CoP order is now clearer, and it is apparent that there were no provisions in the only effective order which designated any decision-making authority by the family on Alan's medication or his health and welfare. On the basis that the agencies had a mis-placed belief that an order was effective, it would have to be said they did not ask for and follow decisions made by those they believed were Alan's Deputies. At times they acted against their stated views. This suggests that they did not understand the role of a Deputy. Whether the order was in place or not the family should have been consulted, their views on best interest sought and rationale given for any best interest decision including not following their views.

7.4.2 Alan's medicine regime presented a more critical element of Alan's best interests. From the outset the family raised concerns regarding Alan's medicines (Hospital - November 2018).

7.4.3 In April 2019, the family raised concerns with the in-patient hospital that they felt there had been errors in Alan's medication. This coincided with Alan presenting as leaning noticeably to one side. After a review, Alan's Risperidone was reduced and codeine was introduced.

7.4.4 At the end of November 2019, the GP received a request from the LDT to increase the level of Risperidone. Alan's family was informed of this increase but on being informed they expressed concerns over the increase in medication.

7.4.5 On 6th December 2019 (Friday), the crisis team was contacted by the care provider following a sudden change in Alan's presentation, although it is recorded that this had existed for four days. The plan was to increase the night-time dose of Risperidone, this was despite the care provider staff recording that medication was making Alan unsteady on his feet. The following day the consultant psychiatrist increased the 6 p.m. dose of Risperidone form 1ml to 2 ml. Again, Alan's family would say that they were not consulted on this decision.

7.4.6 On 12th December 2019, there was a meeting between Alan's mother, the learning disability nurse, psychiatrist, and care provider staff, recorded by the care provider as an MDT. ASC and the CCG, as agencies responsible to Alan's care were not invited to this meeting. It was reported that the increase in Risperidone had seen an improvement in Alan. Alan was also prescribed diazepam to a total daily dose of 10 mg (Night-time dose of 4 mg and daily 3 x 2 mg). Again, it is recorded that Alan's mother voiced concerns regarding the use of diazepam. It was accepted at the learning event that this meeting could not have constituted a MDT and important agencies involved in Alan's care were not present.

7.4.7 Regarding this meeting Alan's mother states that she was 100% against the increase of diazepam as it increased the risk to Alan by making him unsteady and prone to falls. Alan's mother would say that her views were ignored.

7.4.8 After the meeting the care provider was contacted by Alan's sister, requesting that the increase in medication was reviewed but this request was denied on the basis that the consultant was the decision maker. If professionals believed that a valid deputy was in place, then they should have regarded them as the decision maker.

7.4.10 The British Medical Association guidance for doctors on best interest decision making on those who lack capacity acknowledges *'Best interests meetings are not required by the Mental Capacity Act 2005 (MCA) but are a good way of making important healthcare decisions for adults who lack capacity, and to demonstrate that a best interests decision has been properly considered.'*

7.4.11 The same guidance states that '*A detailed record should be kept of all best interests meetings, summarising the information exchanged and clearly documenting the decisions reached. It is good practice for notes to be shared with everyone who was at the meeting, allowing them to check for accuracy before they are finalised.'* The MCA Code of Practice also requires that a detailed record should be kept of all best interest decisions made and how they were reached.[14] The review has not been able to access any such records.

[14] Mental Capacity Act Code of Practice s.5.15

7.5 How effective was management and oversight maintained of the adult's care plans? How was Alan supported effectively and how were the medical needs identified in the care plan communicated proportionately between agencies and the family?

7.5.1 Records would indicate care and discharge plans were coordinated; planning was timely, and the family was involved in these discussions. The family would dispute this and claim that the discharge from the in-patient hospital was rushed. The Hospital Trust cites the family being involved in the development of various documents to improve the quality of Alan's care including an information sheet on medication for new staff, a personal safety plan and a communication passport. They were also invited to and attended on of the pre discharge training sessions.

7.5.2 A thorough and detailed care plan was completed by adult social care in June 2019. It accompanied the application for the Court of Protection order and was referenced within the order. The plan detailed aspects of managing Alan's behaviour and links to triggers such as physical pain and frustrations over his communication. The plan clearly indicated the necessity for Alan to be cared for by staff that were familiar and known to him.

7.5.3 The plan states that Alan would be unable to articulate pain and would demonstrate this by his behaviour, such as hitting out. The plan deals with the transition from hospital to the care provider and states that if the care plan cannot be delivered by the care provider, a referral can be made to the Intensive Support Team. The plan shows that the family including Alan's sister and brother in law, who had previously been carers by direct payment had been consulted when completing the plan.

7.5.4 It is of note that on the evening of the 12th December 2019, when Alan was described, by the care provider, as displaying some of his more challenging behaviour, he was being cared for overnight by agency staff who did not have prior knowledge of him or his needs. Also, that Alan appeared to be suffering from Cellulitis, which could account for increasingly challenging behaviour.

7.5.5 There were instances where the family identified medical needs on behalf of Alan but did not feel that their views were being considered. On 9th December 2019, Alan's mother and sister were informed that Alan's leg was inflamed, they both stated that this pain would have had an impact on Alan's mental health and that he would require pain relief until the antibiotics took effect.

7.6 To understand practitioner's knowledge of pain management. Alan's family were reported to be able to identify when Alan was in pain. Did all services seek the views of the family on establishing the level of pain Alan may have been experiencing?

7.6.1 The in-patient hospital trust identify that the knowledge Alan's family had regarding his pain management was invaluable. They acknowledge that there were occasions when the family disputed the professional's knowledge of the most appropriate pain management.

7.6.2 The Trust also acknowledged that sudden deteriorations in Alan's mental and physical health often led to a short-term management plan to settle Alan's behaviour. It was this which tended to cause conflict with Alan's family as their focus was pain management rather than the symptoms of Alan's mental health episode.

7.6.3 The family strongly believed that Alan's physical health had a direct bearing on how his mental health fluctuated. This was also articulated in the care plan. This was the case in December 2019, when Alan was suffering with a flare up of cellulitis and the family wanted the care provider to consider pain relief whilst the antibiotics were to take effect but they felt this was initially dismissed by the care provider.

7.6.4 The care provider were fully briefed as part of the transition from the in-patient hospital on how Alan masked pain and staff were said to be very clear on the correlation between mental and physical health. The care provider state that the family were fully consulted about every professional intervention. The family would say this was not always the case, as with a decision made to increase Alan's Risperidone at the end of November and on 9th December 2019.

7.6.5 The family have concerns regarding the medication that was administered to Alan on the days preceding his death. This review has not undertaken a forensic pharmaceutical informed enquiry into the administration of medicines but it is clear that on the night of 13th, early hours of 14th December 2019, Alan was administered Codeine, the dosage of which, did not feature on the Medicines Administration Record (MAR). The care provider would contend that this would not present a risk as the medications would be recorded on the waking night record and levels would be established by twice daily medicines audit.

7.6.6 Despite these checks and balances the failure to record administered medicines is not good practice and in contravention of National Institute of Clinical Excellence (NICE) guidance on Managing Medicines for Adults receiving Social Care in the Community[15] states 'Care workers should use a medicines administration record to record any medicines support that they give to a person. This should ideally be a printed record provided by the supplying pharmacist, dispensing doctor or social care provider'. This failure to record the medicine administration also caused the family to be misinformed of Alan's medication post his death, which added to the anxiety

[15] National Institute of Clinical Excellence, 2017 (accessed 15/12/20) - NICE Guidance Managing medicines for adults receiving social care in the community

they were suffering at the time. This failure to record the administration of Codeine on the MAR is also contrary to the care provider's policy on Medication, which states '*The MAR chart should never be left blank as this could be seen as an error and disciplinary action could follow. PRN medication should be left blank on the MAR chart unless it is administered. If PRN is administered the back of the MAR must be completed. All PRN administration must be authorised by an authorised person and an e-mail notification sent.'*

7.7 To understand the multi-agency response to the escalation of the family's concerns.

7.7.1 During both admissions to the acute and residential hospitals Alan's family had been significantly involved in Alan's care. Whilst this was acknowledged as invaluable it was also noted as not being the norm. On the move to the care provider there seemed to be an expectation that the family support would be reduced, and this was supported by care agreements. The care provider felt that the frequency of family visits was disruptive to Alan's routine and particularly the family giving gifts to Alan. The care provider felt they would be able to overcome this differing view by providing quality care to Alan.

7.7.2 There is evidence that the care provider attempted to work with the family, they were provided with twice daily (at least), weekly and monthly updates. When the family challenged decisions the care provider would state that they attempted to provide full and justified rationale. The care provider identified areas where the family could have a role in Alan's daily life such as shopping and meal selection.

7.7.3 Despite this the tension between the family and the care provider continued to the extent that in November 2019, there was a recognition by ASC that the placement was at risk of breaking down. The care provider communicated their concerns to both the CCG and CQC. ASC attempted to convene the MDT on three occasions in November but were unable to secure the attendance of the CCG. It would have been prudent for all agencies to have prioritised this meeting and attempted some formal mediation between the family and the care provider at an earlier stage. This aspect, on reflection, is accepted by those commissioning the care for Alan.

7.7.4 If this was not successful there needed to be a determination in what was in Alan's best interests and how resolution could be achieved. If a resolution could not be achieved there may have been a requirement to seek decisions from the Court of Protection.

7.7.5 Taking into account the trajectory of the relationship and likely outcome there was no evidence of discussion or planning for this eventuality or what the plan might have been should it continue.

7.8 To identify and highlight for learning purposes any areas which are considered to be good practice.

7.8.1 The social work team manager and housing department demonstrated tenacity and a desire to 'do the right thing' in a difficult landscape involving Alan's ability to sign the tenancy and achieved a solution.

7.8.2 The Learning Disability Acute Liaison Nurse (LDALN) provided a good link between services.

7.8.3 The ITU staff in December 2019, when Alan was admitted, dealt with the family sensitively in difficult circumstances for them and were thanked by the family for their help.

7.8.4 CWPT attempted to keep the family fully informed and updated and to keep Alan central to all decision making.

7.8.5 The adult social work records are described as being good. The social worker and manager worked hard to view situations from the family perspective and due to this were able to form a working relationship, which assisted in being able to secure the tenancy for Alan.

7.8.6 The GP practice worked hard to ensure consistency of service to Alan, undertaking an annual review for patients with learning disability. The practice was proactive in seeking out information when Alan's situation changed.

7.8.7 The care provider worked hard to update the family with at least twice daily updates, weekly and monthly updates.

8. What are the learning points from this case?

8.1.1 There was a lack of suitable local provision to meet Alan's needs when he needed admission under the Mental Health Act. This necessitated him being sent back home before being accommodated as a hospital in-patient. The nearest identified setting was in the North East of England and if this provision was used it would have isolated Alan from his family.

8.1.2 The Mental Capacity Act was not actively and systematically used as it should have been. This applies to the misunderstandings around the deputyship order and to various best interest decisions which were not made in line with the Act.

8.1.3 It was important for Alan to be provided services, where possible, from professionals who were known to him and who were familiar with his needs. This was demonstrated well by the GP practice who made it a priority for the same GP to be involved. This was also recorded within his care plan. Whilst receiving support from the care company it was necessary to use night-time

agency staff, whilst circumstances may make this unavoidable, it should always be mitigated by supporting with known staff and clear person specific information.

8.1.4 Housing providers do not deal with applications involving the Mental Capacity as a norm and it would assist them and other agencies to streamline pathways to have a joint protocol between relevant stakeholders to build a solid joint understanding of process.

8.1.5 Advocacy (IMHA) was not used effectively in this case and the involvement of an advocate to represent Alan as a qualifying person under the mental Health Act, whilst being cared for under sections 2 and 3 of the Act may have assisted the relationships, joint understanding and provided independent support to Alan. Part of this discussion should have included the suitability of the family acting as advocates.

8.1.6 This case has highlighted the importance of historical information when making decisions on a person's care, particularly when they lack mental capacity. Also, that families have really in-depth knowledge and insight into the individual which should inform best interest decision making around patient care.

8.1.7 When the deputyship application was served on the agencies, it should have been directed to the practitioners involved who in turn should have ensured that they understood the effect of the paperwork, and made a clear decision on whether they wished to be joined as a party in the Court proceedings. Had the court appointed deputies then their role as best interest decision-makers would need to have been clear.

8.1.8 When making decisions for people who lack capacity, the process and principles of the MCA must be followed. Where there were disagreements between carers and the family on best interest decision regarding Alan's care this should have been fully explored in effective MDT meetings using the framework of the MCA. Where this type of dispute occurs and particularly where it can be foreseen it may be necessary to ensure good structure, consistency and recording of MDTs. There should be a clear plan in place should resolution not be achieved, and this should include escalation to the Court of Protection to resolve any disputes if necessary.

8.1.9 Care plans should be fully understood by all those involved in a person's care, where they cannot be adhered to, this should be referred back to the MDT for appropriate discussion and action.

8.1.10 Deprivation of Liberty Safeguards should be fully understood by all those involved in the care of a person who lacks mental capacity. Any change to a

care plan which amounts to a further deprivation of liberty should be transparently discussed by the MDT, so it is in the persons' best interests and the less restrictive option, is properly recorded and authorised by the Court.

8.1.11 Where it is necessary for care providers to use agency staff it is incumbent on the provider to ensure that the necessary level of training in line with their own standards and policies is given.

8.1.12 That key information on discharge from hospital and clinical information should be communicated to the GP in a timely fashion.

8.1.13 Carers need to ensure a patient's medication regime is accurately recorded on the MAR and that information is accurately conveyed to those who require the information such as emergency staff on admittance to hospital.

9. Recommendations

1. The Warwickshire Safeguarding Partnership should be assured that where a person lacks mental capacity and there is a court application being progressed that: -

(i) the agencies involved with the subject of the application understand the application process, and the provisions of any orders. Also that any orders are recorded, and other relevant organisations are made aware of them.

(ii) that agencies have suitable processes for the receipt, dissemination, understanding and recording of Court of Protection Applications and Orders.

2. The Warwickshire Safeguarding Partnership should share the learning of this review with the Court of Protection to establish if measures are required to ensure that families applying for and obtaining orders understand the process and the paperwork they receive.

3. The Warwickshire Safeguarding Partnership should be assured that all organisations involved in the care of persons lacking mental capacity understand and adhere to the deprivation of liberty safeguards and best interest decision making as required by the Mental Capacity Act.

4. The Warwickshire Safeguarding Partnership should be assured that all care providers involved in the administration of medicines adhere to NICE guidance in particular with regard to short course and PRN medication.

5. The Warwickshire Safeguarding Partnership should provide training and/or guidance to allow staff to manage effectively disputes with families over best interest decisions. This should include practical advice and guidance to support practitioners.

6. The Warwickshire Safeguarding Partnership should develop guidance for best interest meetings to support professionals from all organisations.

7. The Warwickshire Safeguarding Partnership should work with relevant stakeholders to develop pathway for persons who lack mental capacity and are homeless to be able to achieve a tenancy.

Appendix A – Terms of Reference

SAR – Warwickshire Safeguarding Partnership – Alan
BACKGROUND

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult
the adult has died, and
the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

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

CIRCUMSTANCES

The subject of this review is Alan.
Alan was born 3 months prematurely at home and due to a lack of oxygen he suffered from brain damage causing Alan to have physical and mental health issues. Alan had learning disabilities, was on the autistic spectrum and suffered from Bipolar disorder. Alan lived at home from birth up until he was admitted to Hospital on the 24th October 2018, after being sectioned under the mental health act.
Alan was discharged from hospital on the 19th August 2019, when he was housed by the local authority in his new home in Warwickshire. Alan was looked after by a local care provider where he was provided with 2 to 1 care 24 hours a day with 1 waking night and 1 sleeping night carer.
On the 14th December 2014, he was admitted to Warwick Hospital via the Emergency Department (ED). The notes state that he had been in his chair for 12 hours overnight. Alan passed away at 04.00 on the 22nd December 2019.

SUBJECT

Name	Date of birth	Date of death
Alan	1975	22/12/19

SCOPE
Time period:

From 1st October 2018 until 14th December 2019 (date of admission to hospital) Agencies are asked to consider and include any information which falls outside of these parameters which is or could potentially be relevant to this safeguarding review.

METHODOLOGY

This review will be conducted by using an appreciative inquiry methodology assisted by individual management reports (IMRs) and chronologies provided by agencies involved. This approach will be enhanced by a facilitated practitioner event.
Due to current Covid 19 restrictions it is anticipated that all meetings and practitioner events will be held in a virtual format.

CHRONOLOGIES TO BE REQUESTED FROM:

1. **Coventry and Warwickshire Partnership Trust**
2. **George Eliot Hospital NHS Trust**
3. **The Care Provider**
4. **South Warwickshire CCG**
5. **South Warwickshire Foundation Trust**
6. **Stratford District Council**
7. **Warwickshire Adult Social Care**
8. **Warwickshire Police**
9. **West Midlands Ambulance Service**

TERMS OF REFERENCE

Areas of consideration

1) How well was the need to engage the family in the decision making, as detailed in the Court of Protection Order, understood by agencies supporting the adult?
2) To understand how historic information is taken into consideration and shared between agencies on prescribed treatment pathways.
3) What level of understanding did all services have on how the views of the family surrounding Alan's best interests taken into consideration?
4) To understand how the family's views on Alan's best interests were taken into consideration regarding medication changes as detailed in the Court of Protection Order by agencies.
5) How effective was management and oversight maintained of the adult's care plans? How was Alan supported effectively and how were the medical needs identified in the care plan communicated proportionately between agencies and the family?
6) To understand practitioner's knowledge of pain management. Alan's family were reported to be able to identify when Alan was in pain. Did all services seek the views of the family on establishing the level of pain Alan may have been experiencing?
7) To understand the multi-agency response to the escalation of the family's concerns.
8) To identify and highlight for learning purposes any areas which are considered to be good practice.

If an issue is identified authors are asked to comment whether there has already been organisational remedial action or whether the issue still exists.

CHRONOLOGY

A key incident chronology is requested from each organisation and a template will be sent for completion.

SIGNIFICANT PERSONS

Relevant family members, and any other important personal network will be informed what the Safeguarding Adult Review is for, how it will work, what the parameters are and how they can engage in the review.

PRACTITIONER EVENT

To be facilitated by Report Author. To generate learning arising from the themes present in the Chronology.

Appendix B – The Author

The author is Independent of this case and any of the agencies involved. He is the chair of the Cambridgeshire and Peterborough Safeguarding Adults Review sub-group.

He is a retired police officer and senior investigating officer. He has since been involved in working with local authorities, the health and third sector and the Church of England in a safeguarding capacity.

He has authored Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.