Bury Safeguarding Partnership
Working together to safeguard adults and children in Bury

Bury Safeguarding Adults Board

Safeguarding Adults Review in respect of Robert

Author: Anna Berry

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Glossary:

Abbreviation	Definition
SAB	Safeguarding Adult Board
BISP	Bury Integrated Safeguarding Partnership
SAR	Safeguarding Adult Review
GP	General Practitioner
PLE	Practitioner Learning Event
S42	Section 42 (of The Care Act)
DoLS	Deprivation of Liberty Safeguards
MCA	Mental Capacity Act
MHA	Mental Health Act
OT	Occupational Therapy
CMHT	Community Mental Health Team
LMHT	Liaison Mental Health Team
KF	Key Finding

1. Foreword

1.1. Independent Chair

Not applicable.

2. Introduction

2.1. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when certain criteria are met. These are:

- When an adult has died and the SAB knows or suspects that there may be abuse or neglect, or has not died but may have experienced serious abuse or neglect, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

2.2. Safeguarding Adults Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership and accountability.

2.3. The aims of the Safeguarding Adults Review are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

2.4. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

2.5. The review process to meet these aims and objectives has followed a clear path. The methodology chosen for this review is a Learning Together approach. This included a "panel" group to agree terms of reference and a focus on themes, patterns and factors together with a "practitioner" group and family discussions. The Independent Reviewer has conducted research by analysing the information provided and by interviewing representatives of

agencies; culminating in a SAR report for presentation to the Bury Integrated Safeguarding Partnership (BISP).

3. Overview of the case and circumstances leading to the review

3.1. Robert was a 60-year-old man with learning disability and a diagnosis of schizophrenia. He resided in a care home in Bury and was subject to a DoLS authorisation as he was assessed to lack mental capacity to make decisions about where he resided.

3.2. The review will consider three key periods of time leading up to his death:

- The 12-month period of time prior to a significant period of hospitalisation.
- The period of time Robert spent in hospital and the discharge arrangements.
- The 3- 4 week period after discharge from hospital leading to the incident of his death.

3.3. Robert left the care home in May 2022 as part of his ordinary pattern and daily routine but failed to return. This prompted a missing person report and Robert was later found in a field by Greater Manchester Police (GMP). Following this incident, he became medically unwell resulting in admission to the Royal Oldham Hospital, where he required Intensive Care treatment for rhabdomyolysis and acute kidney injury. The Royal Oldham Hospital is one of the hospital sites provided by Northern Care Alliance NHS Foundation Trust.

3.4. Robert was discharged from hospital 38 days later and the review will consider the way that agencies worked together to plan and provide for his care and support needs upon, and following discharge. This line of enquiry was agreed by the SAR subgroup and subsequent SAR panel as providing an important context to decision making post hospital discharge.

3.5. Robert left the care home approximately 4 weeks after hospital discharge to go to the cinema. His body was later found in the River Irwell.

3.6. The services involved in his care in the timeframe of this review were:

- Greater Manchester Police (GMP)
- NCA- Northern Care Alliance NHS Foundation Trust (Diabetes and Endocrinology Service, ED of Fairfield Hospital, ED/ICU/ Acute Ward of Royal Oldham Hospital
- PCFT- Pennine Care Foundation Trust, Liaison Mental health Team (LMHT)
- PCFT- Pennine care Foundation Trust, Community Mental health Team (CMHT)
- PCFT- Pennine Care Foundation Trust, Learning Disability Team (LDT)
- The Brandles Care Home
- Bury Council Adult Social Care
- Woodbank GP practice

3.7. A referral was made by NHS Greater Manchester Bury on 1st August 2022 for consideration of the Safeguarding Adult Review Criteria.

3.8. The SAR Subgroup acknowledged that there were areas of improvement identified for the planning and coordination of multi-agency care. This was also a finding of the S42 Safeguarding enquiry.

4. Key Themes identified for this review

Robert's care and support needs, care planning and risk assessment.

- What were his identified care and support needs prior to the hospital admission in May 2022, whilst in hospital and the differences to those identified needs following discharge in June 2022.
- What risk assessments were undertaken and in conjunction with whom? How did these assessments inform DK's care planning?

Hospital Discharge Processes.

- How are all partner agencies involved in the hospital discharge planning process in order to ensure the person is in receipt of safe and appropriate care following discharge.

Mental Capacity Act.

- Consideration of single and multi-agency involvement to demonstrate how the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) were utilised within the timeframe agreed within this review.

5. About Robert

5.1. Robert was a 60-year-old man who resided in a care home. He had diagnoses of schizophrenia, Learning Disability (LD), Addison's Disease and a pituitary adenoma and was under the care of relevant clinical specialities for each.

5.2. Robert's sister contributed to this review to provide insight into his life, personality and the impact of life events on his overall wellbeing. The review has also gained a rich level of insight of Robert from agency discussions and records.

5.3. Robert was one of six siblings and has 2 sisters, 2 brothers and a half-brother. Like his siblings, he was brought up in care from an early age and therefore relationships with his brothers and sisters have been difficult over the years in so much as the geographical distance between them. Robert's sister reported that he had suffered an extremely traumatic childhood.

5.4. His sister was removed/ adopted at birth and therefore she built her relationship with Robert from adulthood and reported a close relationship where he would listen to her, and she was able to help and advise him on occasions. They spoke regularly but due to the distance between them and their individual circumstances, it was a challenge to see more of each other. However, visits to Scotland to stay with his sister were facilitated on several occasions which Robert would very much enjoy and this was reflected in his care plan.

5.5. Robert also maintained contact with his two brothers but arrangements to see each other more regularly were challenging and halted to some extent by the COVID 19 restrictions. Although his biological mother survives him, there has been no contact between them as far as agency records and family discussions reflect.

5.6. Roberts's sister reports that he appeared to be very happy at The Brandles and this was a settled environment for him after events and placements over the preceding years that had been quite difficult. She reported that he enjoyed particular activities and routines such as walking, going to the cinema and listening to Elvis.

5.7. This is reflected by several professionals and a common point made throughout this review is that Robert enjoyed his daily outings such as trips into Bury and Prestwich, going to the local cafe for a "brew and a pie" and sometimes visiting his friend who had a cat. He particularly loved Elvis Presley and was very knowledgeable about his life and career and liked to collect

memorabilia. These points are particularly relevant to the themes of this review, professionals highlight the importance of facilitating the things that Robert enjoyed doing.

6. Engagement with Family

6.1. Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a Safeguarding Adult Review. A focus on their understanding about how their family member was supported on a daily basis and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.

6.2. The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively[i].

6.3. In particular Robert's sister was able to provide information about him, and his experiences which have helped to identify the learning for future practice.

7. Parallel processes

7.1. For reference, background, and context it is helpful to consider the relevant statutory process and their conclusions.

7.2. **Inquest and cause of death**

7.2.1. The coronial inquest into Robert's death is pending and this review will be shared for the process. For reference, Inquests are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries[ii]

7.3. **CQC**

7.3.1. In respect of The Brandles it is relevant to note that the circumstances of Robert's death led to two processes; firstly an inspection of the service and secondly a CQC investigation, both of which will be defined below.

7.3.2. The CQC Inspection of The Brandles was carried out in November 2022.

7.3.3. The Care Quality Commission (CQC) is England's independent health and social care regulator. Its goal is to make sure that health and social care services offer individuals safe, effective, compassionate, and high-quality care, and it continually encourages providers to improve their services. The fundamental standards of CQC are built on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

7.3.4. The CQC conducts frequent inspections at care homes, which include discussions with employees, evaluating care, and examining documents. The goal is to gain a thorough understanding of the level of services delivered. The CQC bases its decision on two critical frameworks: the Key Lines of Enquiry (KLOEs) and the Quality Standards.

7.3.5. The KLOE are:

- Are they safe?

- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

7.3.6. Following a review of their findings, the CQC will assign a grade to the care provider based on its key line of enquiries. The Brandles was inspected on 1st November 2022 and each of the KLOE were assessed as "good" and therefore the overall rating was found to be "good"[iii].

7.3.7. The CQC inspection described the Brandles as "a residential care home providing personal care and accommodation for up to 7 people with mental health difficulties and people who have a learning disability".

7.3.8. Additionally, and specifically to the circumstances of Robert's death, CQC are conducting an investigation. From 1st April 2015, the CQC has had the lead responsibility for investigating and where appropriate prosecuting breaches of fundamental care standards contained within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[iv]. This means that CQC can prosecute registered persons (registered providers or registered managers) for a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; *the requirement to provide safe care and treatment resulting in avoidable harm to a service user, or where a service user has been exposed to a significant risk of avoidable harm*.

7.3.9. The investigation is ongoing CQC formed part of the panel for the review and have therefore been cited on the process throughout.

8. Key learning episodes:

8.1.1. Within the information provided for this review there is evidence of over 100 episodes of contact between services in the timeframe of this review. This includes phone calls, visits, meetings, appointments (not exhaustive) between acute hospital services, community mental health, learning difficulty services, care home, advocacy, GP (not exhaustive).

8.1.2. Consideration of the care and support that Robert received in this timeframe provides an important context to his journey through services.

8.1.3. Some of the key episodes have been consolidated below in three key areas which will assist with analysis against the themes of this review:

- Pre- hospital admission
- Hospital admission and discharge
- After discharge

Date	Episode
Pre hospital admission 2021/2022	
From 2016 to 2021	Adult Social Care record several safeguarding referrals due to different issues with friends and other residents. COVID 19 lockdown restrictions noted to be challenging
July 2021	CMHT record multiple communications, meetings and liaison between the reviewing officer, the advocate and Robert to agree a new placement due to continued issues in previous placement relating to the management of his behaviours and interactions with other residents. Advice was sought from the DoLS team, and a review of Robert's mental capacity undertaken and the best interests process was initiated.
13/07/2021	Review undertaken by diabetes and endocrinology department. MRI arranged due to macroadenoma. It was noted Robert previously refused an MRI scan.
30/07/2021	A Mental Capacity assessment was completed, Robert was assessed as lacking capacity to make the decision whether to move to a new placement. A Best Interests decision was made to move Robert to The Brandles. The Brandles were advised to make a DoLS application.
10/08/2021	Discussion took place between CMHT and Robert's advocate, it was noted that a DoLS authorisation had been sent to Bury council.
26/08/2021	An OT assessment took place to consider road safety with reference to the use of a bicycle
26/08/2021	The DoLS authorisation was approved and CMHT discussed this with the Best Interests assessor
November 2021 to March 2022	CMHT record that there were multiple communications with the Brandles care home due to an increase in agitated behaviour. Robert's smoking noted to be a trigger at different times and a physical health review was arranged
November 2021 to March 2022	The Brandles record multiple communications with the CMHT Reviewing officer (as above entry) to discuss Robert's increase in agitation, interactions with other residents, frequency of smoking discussed several times and difficulties with COVID measures recorded. Physical wellbeing flagged a few times and a physical health review arranged. There is also regular communication with the advocate. The care plan and risk assessment is considered regularly in the context of the DoLs and Robert's daily activities, there is a plan in place for daily excursions (this included that Robert must have a meal and drink beforehand, it should be recorded the time he leaves, the time he returns, and any action to be taken if he is late back).
01/12/2021	Robert attended the Emergency Department (ED) after a fall, where he sustained a fracture to his left wrist. This was to be followed up in fracture clinic and Robert was discharged.
11/02/2022	Review with Robert's LD Consultant as placement raised concern about his behaviour.
30/03/2022	The Brandles raise concern with CMHT about Robert's interactions with other residents in terms of compatibility of residents
05/04/2022	CMHT reviewing officer discussed possibility of a new placement with the procurement team.
06/04/2022	Discussion with the Brandles about DoLS in terms of concerns about his behaviours.

07/04/2022	Robert was reviewed by a CMHT reviewing officer at The Brandles and excessive smoking was discussed with a consideration of how the DoLS could be utilised to restrict the level of smoking. Personal hygiene was discussed and strategies to improve that included in his plan.
13/04/2022	Robert was reviewed by CMHT reviewing officer. Weight loss was noted in the review therefore a medical review was arranged
26/04/2022	Discussion between CMHT and The Brandles, an improvement in self-care noted at this point.
28/04/2022	Discussion between CMHT and The Brandles- overall improvement in interactions recorded with less episodes of confrontation between residents.
09/05/2022	There was a physical confrontation between Robert and another resident. A safeguarding concern was raised
13/05/2022	A CMHT duty officer was informed that Robert had been missing overnight and had been returned to the care home by Police at 7AM
13/05/2022	Adult social care notified by The Brandles that Robert had not returned and had been reported to police as missing. Records reflect that Robert was found by police in a field the following morning. The Brandles had notified Police, CQC, Advocacy, DoLS team, CMHT and GP.
Points: - Multiple communications between CMHT reviewing officer (commissioner) and The Brandles (care provider) and a continual review of behaviours, wellbeing and emerging issues- this is good practice. - Placement suitability under regular review (compatibility of residents) - Appropriate DoLs authorisation process followed	
Period of hospital admission 16th May 2022 to 24th June 2022	
16/05/2022	Following the incident where Robert became unwell and did not return home, he was admitted to hospital via ED after collapsing, noted to be dehydrated and confused. Robert was transferred to ICU and recorded to have rhabdomyolysis. Medical history records Robert had prior diagnoses of schizophrenia, pituitary adenoma, addisons disease, learning disability. Robert's journey included ED, ICU and transfer to a ward before discharge. It was noted once on the ward that he required supervision by staff and he was agitated and wandering, the definition of the supervision is not documented. DoLs authorisation was initiated but had not completed during this admission. MCA assessment is explored on several occasions when Robert expressed that he wanted to go home and it is recorded on two occasions that he was deemed to have capacity but on other occasions that he lacked capacity, it is not recorded how this decision was determined or why a DoLS authorisation had been submitted. It is noted that the Learning Disability Team were not consulted for advice on this. It is also noted that the LD team were aware of the admission when Robert was intubated and ventilated, the fact of his admission was communicated to the community mental health team. The Brandles provided Robert's "LD passport" for the hospital on admission.
09/06/2022	Robert was seen by Community LD Consultant Psychiatrist whilst he was on the ICU of the Royal Oldham Hospital.
18/05/2022 to 23/06/2022	CMHT Reviewing officer records multiple calls to the hospital team, the community LD team and The Brandles to liaise about Robert's progress in hospital. Noted that Robert was agitated and there were difficulties with verbal communication. There were discussions about discharge and physio and OT assessments were completed. CMHT document prior to

	discharge that the Brandles would like to understand more about the impact of Robert's ill health and update the care plan prior to discharge.
01/06/2022	The Liaison Mental Health Team made contact with the ICU team to discuss Robert and his medication requirements, this contact and liaison was repeated 4 times prior to the days leading up to discharge. It was noted that Robert had wanted to go home and became agitated at times, medication changes were discussed between the two teams (liaison mental health, medical and the LD Consultant in respect of his medication)
21/06/2022-22/06/2022	It is noted by the LMHT that they attended the ward to review Robert as he was medically ready for discharge. The LMHT advised the ward staff that his community team and care home should be involved in discharge arrangements. The care home had expressed some concern about mobility as his room was upstairs, they also requested that his care plan be updated to reflect the hospital admission and discharge.
23/06/2022	The Liaison Mental health Team attended the ward to contribute to the discharge, the care home manager was present and due to her concerns about mobility it was agreed that an OT assessment would be undertaken before discharge.
23/06/2022	It is documented by the acute hospital that Robert was medically optimised and there was no requirement to review his care plan (this was in contrast to the view of the care home) but after agreement from LMHT. It was the decision of the hospital to discharge Robert home in the evening.
17/05/2022 to 14/06/2022	NCA experienced a major IT outage during these dates meaning that full access to all information was limited.
16/05/2022 to 23/06/2022	The Brandles record daily contact with the hospital, regular contact with the CMHT Reviewing officer and the advocate. The Brandles expressed concern about the discharge arrangements as they wanted to start the review of his care plan prior to discharge to enable any questions about his physical health to be clarified. It is noted that although they had attended the hospital to express this concern, Robert was sent home in a taxi and the Brandles were not expecting this to happen. This was discussed with the CMHT reviewing officer the following morning who arranged additional 1-1 support due to concerns about Robert's mobility. This arrangement was put into place but after a few days Robert expressed that he did not want any additional support. The care plan and risk assessment were updated the following day after discharge.
Points: - Resident "passport" was provided to hospital which was good practice and communicated Robert's care plan, needs, communication methods and all other relevant information including DoLS. - Good liaison between CMHT and LMHT - Positive practice for Psychiatry assessment to be completed in hospital - Capacity assessments not recorded clearly, indicate a lack of knowledge and understanding. - DoLS application initially made but not followed through. - Noted- IT outage was a national incident and impacted on information being available. - Formal discharge planning meeting did not take place- agencies all had different understanding of the process	
Post discharge:	

24/06/2022 to 17/07/2022	Care plan and risk assessment was reviewed by CMHT with the Brandles on 24/06/2022 which was the day after his discharge. Additional support for 3 hours per day was arranged, this was in view of the discharge from hospital the previous evening and was due to general anxiety about Roberts physical health following the hospital admission. This was to be reviewed after 4 weeks. **Risk assessment included review of the following domains:** • **Deterioration in mental health**- (none noted but review was to be arranged with his consultant) • **Risk of deterioration in physical health**- post discharge physical health review was arranged with GP for 8th July. Weekly weights were to be completed and daily food and fluid intake to be monitored. • **Self-neglect** – this domain was included with reference to the support he needed to complete daily tasks • **Harm to others**- behaviour related to smoking had been noted prior to the hospital admission, it was noted that when Robert ran out of cigarettes his behaviour could be challenging to other residents. It was agreed that his access to cigarettes would be restricted, and this restriction was communicated to the local authority supervisory body and included on his care plan and risk assessment document. This was for further review on July 27th. • **Exploitation and vulnerability**- this domain was included due to past safeguarding risks. **Post discharge actions taken from care plan and risk assessment:** • A physical health check with the GP was arranged and carried out on 8th July, Robert was accompanied by care home staff. The hospital discharge summary was noted, there were no concerns noted and repeat blood test were arranged for 3 weeks' time. • A mental health review was arranged and carried out on 12th July by Roberts LD/ Mental Health Consultant who had reviewed him whilst in hospital. He was accompanied by care home manager and the recent hospital admission was discussed in the context of general and overall health needs. The action from this consultation was that a referral was made to the Multi-Disciplinary Team Community Learning Disability service (MDTC) for a holistic **"health care needs assessment".** • The MDTC accepted the referral on 13th July and scheduled the discussion and triage meeting for 20th July (unfortunately Robert had died 2 days previously). • Roberts 1-1 support was utilised for the first 2 weeks, however in the 2 weeks prior to his death Robert did not want to be accompanied on his outings. This was communicated to the CMHT, a review of the 1-1 support was scheduled during the week of his death.
18/07/2022	Wanted to attend the cinema to watch the Elvis film, discussed with CMHT and agreed. Noted that it was very hot, Robert had something to eat (breakfast and lunch) and was given a drink to take and clothing was discussed. Robert was found deceased later that day.

Points:

- Positive practice to review Care plan and risk assessment.
- Regular contact between CMHT and Care Home and discussion about requested outings.
- Good engagement with and between Primary care and LD/ Mental Health
- Plan for holistic health care needs assessment was positive
- There was an opportunity to consider restrictions when Robert said he did not want 1-1 support

8.2. Broad Summary of findings

- A disconnect of multi-agency working across acute and community teams.
- Inconsistent application of legal literacy
- A disconnect between acute and community with reference to transfer of care
- An absence of person-centred care planning in the transfer between one location to another

9. Overarching Learning

9.1. The review has identified learning following consideration of the following areas of practice that were identified during review process, highlighted within the agency reports and discussed at the practitioner event.

Areas of learning:
Legal literacy- understanding the mental capacity act and Deprivation of Liberty Safeguards and application to care planning and risk assessment.
Transfer of care and multi-agency working
Voice and Lived Experience

10. Analysis of findings

10.1. **Legal Literacy – understanding the Mental Capacity Act and Deprivation of Liberty Safeguards**

10.1.1. Robert moved into The Brandles care home 11 months prior to his death. The Brandles is a residential care home providing personal care and accommodation for up to 7 people with mental health difficulties and people who have a learning disability. Robert moved into a new care home after his previous placement became unsuitable for several different reasons including compatibility of residents and an increase in challenging behaviours that the previous home was not able to manage.

10.1.2. It is helpful to review the living arrangements and the details of Robert's care package in order to consider the DoLs which will be explored in due course. The care plan was regularly reviewed by the Reviewing Officer of the CMHT. The accountability for the commissioning of Robert's care package was held by this team.

10.1.3. To clarify, the commissioning and reviewing role within the CMHT was carried out in in line with the Section 75 agreement between Local Authority and PCFT. S75 is a partnership of equal control whereby one partner can act as a "host" to manage the delegated functions, including statutory functions of both partners who remain equally responsible and accountable for those functions being carried out in a suitable manner).[v]

10.1.4. Robert's care plan articulated his diagnoses and summary of needs. It recorded a "stable" mental state but reflected ongoing concerns about episodes of behaviour that were often difficult to manage. Of interest, there is wider work ongoing in Greater Manchester to consider the cause of behaviours and minimise distress in contrast to current ways of working which tend to focus on "managing behaviour". To note, this was frequently related to his level of smoking, for example if he ran out of cigarettes, he would become agitated; this is a theme seen throughout and discussed on a regular basis.

10.1.5. Also recorded in the care plan were his physical health needs, his annual physical health check with his GP, other medical appointments and his six-monthly review with the psychiatrist. Robert is recorded as being happy and settled at The Brandles and noted is a high degree of communication and liaison between the care home and the reviewing officer which is good practice.

10.1.6. The plan reflects the degree of support and assistance Robert required with his medication, general daily self-care and management of finances. He did have an appointee to help him manage his finances.

10.1.7. The care plan also included a risk assessment which reflected a number of factors and indicators including, deterioration of mental health and physical health, poor personal care, harm to others (based on behaviours), and vulnerability to exploitation (based on past safeguarding issues). It is reflected in the care plan that the Brandles made a DoLS application which was authorised shortly after Robert moved and this was because he lacked capacity to make decisions about his care and treatment with particular reference to where he lived.

10.1.8. Mentioned above is the fact that Robert was living at The Brandles care home with a DoLS authorised; the translation and application of that into his daily care plan will be considered.

10.1.9. To begin with we will consider the Mental Capacity Act (MCA), and in addition we will look at the Deprivation of Liberty Safeguards (DoLS). The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways.

- By empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process.
- By allowing people to plan ahead for a time in the future when they might lack the capacity.

10.1.10. The key important messages of the MCA are as follows:

- The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.
- The MCA is designed to protect and restore power to those vulnerable people who lack capacity.
- The MCA also supports those who have capacity and choose to plan for their future.
- All professionals have a duty to comply with the Code of Practice. It also provides support and guidance for less formal carers.

- The Act's five statutory principles are the benchmark and must underpin all acts carried out and decisions taken in relation to the Act.
- Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity.
- The MCA is designed to empower those in health and social care to assess capacity themselves.
- Understanding and using the MCA supports practice – for example, application of the Deprivation of Liberty Safeguards

10.1.11. There are different contributory factors that may affect someone's capacity, or ability to make decisions and it can be seen that three of these can be applied in Robert's case. These are:

- Stroke or brain injury
- Mental health issues
- Dementia
- Learning disability
- Confusion, drowsiness or unconsciousness because of an illness of the treatment for it
- substance misuse.

10.1.12. Before moving onto DoLS, we will consider the 5 statutory principles of the MCA:

- **Principle 1:** A presumption of capacity- every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

- **Principle 2:** Individuals being supported to make their own decisions- A person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

- **Principle 3:** People have the right not to be treated as lacking capacity merely because they make a decision that others deem 'unwise'. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

- **Principle 4**: Best interests- anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

- **Principle 5:** Less restrictive option- someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

10.1.13. It is important for health and social care staff who support some client groups (for example, those with mental health problems, particularly those with severe and enduring mental ill health, or older people) to have an understanding of the Mental Capacity Act as well as how it interfaces with the Mental Health Act 1983 (as amended by the 2007 Act). This will also include the need to have an awareness of the Deprivation of Liberty Safeguards. Health and social care staff who support people should have an understanding that there are requirements to follow the MCA even when a person is detained under the Mental Health Act,

and an understanding of which legal framework should be used at the relevant time, to deprive a person of their liberty. For ease of reference, Robert was not detained under the MHA during the timeframe of this review.

10.1.14. The Deprivation of Liberty Safeguards (DoLS), which apply only in England and Wales, are an amendment to the Mental Capacity Act 2005. We have established that the MCA provides a statutory framework to support individuals to make decisions or to make decisions/act on behalf of people who lack the capacity to make decisions for themselves. These can be small decisions such as what clothes to wear or major decisions such as where to live. It is recognised that there are times when the measures put in place will restrict a person's movements, albeit in their best interests and proportionate to the risk of harm, to a point where they may become deprived of their liberty.

10.1.15. Since the introduction of DoLs, the Supreme Court made a legal ruling in its judgement of the case of P v Cheshire West and Chester Council and "another" which introduced the "acid test". The MCA Acid Test is a legal ruling that helps determine if someone is being deprived of their liberty. The Acid Test looks at whether the person lacks capacity to make a decision about where they are living and what their care and treatment needs are. The Acid Test also states that an individual is deprived of their liberty if they lack the capacity to consent to their care/treatment arrangements, are under continuous supervision and control, and are not free to leave[vi].

10.1.16. The issues of "not free to leave" is a very important consideration in Robert's case which we will consider in due course. "Not free to leave" does not mean the person can never leave the premises in which they reside. In each of the cases before the Supreme Court, the individual left their place of abode frequently. What it means is that any "leaving" is controlled by others (including short periods with the intention of returning). To demonstrate this, there are many people who will spend hours every day away from their living arrangements - they may attend day centres, out to activities/ appointments, out to a pub or for a meal, or to visit family members. But if they have to return to their placement at the end of their time away, that means they are not free to leave, and this constitutes a deprivation of their liberty.

10.1.17. There are six assessments which must take place before a standard authorisation can be given by the supervisory body (the Local Authority). If a standard authorisation is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative (RPR) and will usually be a family member or friend; in Robert's case this was a paid RPR.

10.1.18. Now we have considered the MCA and DoLS, we can explore what this meant for Robert, and consider the process and findings of the DoLS authorisation process. The review has considered three key documents in order to understand Robert's circumstances and the process that was followed and documented when assessing his capacity. These are:

- Form 3- Best Interest Assessor (BIA) combined assessment (Age, mental capacity, no refusals, BI assessments and selection of representative)
- Form 4 (Mental capacity, mental health and eligibility assessments)
- Form 5- standard authorisation form

10.1.19. For information, Form 1 is the standard and urgent request (for new authorisations or changes in circumstances) and form 2 is the further authorisation request (on expiry of an authorisation). As above, forms 3 and 4 contain the six required assessments for a DoLs and Form 5 is the authorisation form.

10.1.20. Robert's move to The Brandles prompted a request for authorisation in July 2021. After assessments, the supervisory body (the local authority) authorised the DoLs to come into force on 1st September 2021 with an expiry date of 31st August 2022.

10.1.21. Form 3 articulates the assessment carried out by the DoLS best Interests assessor. The assessment includes appropriate communication and liaison with Robert, The Brandles, the paid RPR, the DoLs mental health assessor and the CPN/ Reviewing officer. Referenced is a review of specific documents such as Form 1, Form 4, care plans and risks assessments and Medication Administration Records (MARS).

10.1.22. The BI assessment concludes that Robert *"lacked capacity to decide whether or not he should be accommodated in the care home for the purpose of being given the proposed care and/or treatment, and the person is unable to make this decision because of an impairment of, or a disturbance in the functioning of, the mind or brain".* The findings of Form 4 (to be considered shortly) were considered alongside the functional assessment with a conclusion that Robert's inability to understand, retain or weigh up the relevant information which is as a result of the cognitive impairment constitutes a lack of capacity for the specific decision. This was recoded "*as a result of the Schizophrenia and learning disability which impacts upon Robert's level of cognitive functioning".* Additionally, it was recorded to be unlikely that Robert would regain the capacity to make this decision due to the nature of the impairment.

10.1.23. The mental health assessment also concluded that Robert lacked capacity (as per above) and cited schizophrenia, learning disability and pituitary adenoma as the impairment. The assessment summarised to say that *"he lacked insight into his illness, care needs, challenging behaviour, risks and consequences. Therefore, he was unable to understand most of the information relevant to the decision. He had an impairment in the processing of information".*

10.1.24. The assessments recorded in both forms (3 and 4) considered daily routine and the plans and risk assessments that went alongside this. Assessments included reference to Robert's level of smoking, daily trips to the shop to buy cigarettes and other social outings and appointments, for example to visit his friend, or attending his chiropody appointments. The care home processes for these arrangements is described in terms of where Robert would go, what time he was expected back and the actions the care home would take if Robert was late in returning. There were some elements of concern recorded which prompted different actions, for example Robert had previously had an accident on his bike and thus he was not to go out on his bike due to concerns about road safety whilst cycling, this prompted an OT assessment. It is noted that the main door to The Brandles was unlocked throughout the day and locked throughout the night.

10.1.25. The reviewer notes that there is often a preoccupation with "locked doors" when DoLS are in place. This translates as DoLS being defined by a "locked" door rather than the type of care and support that can be offered being mindful of the principle of least restrictive practice.

10.1.26. This is supported by Butcher (2023) who considers a successful care package to include the importance of frequent community access, continued structure and routine within the "real world". Facilitation of the things Robert enjoyed to do was an important part of his person-centred care package. What is important is to document whether community access is escorted or unescorted and to ensure that care plans and risk assessment are reflective of those assessments and decisions.

10.1.27. Both forms robustly described how case law was applied when reaching their conclusions, namely the European Court of Human Rights Strock v Germany (2005 ECHR 406) and the Supreme Court P v Cheshire West and Chester Council acid test.

10.1.28. The conclusions of both forms and subsequent authorisation (form 5) reflect and agree that Robert was restricted to where he lived (he was required to live at The Brandles) and lacked capacity to consent to remain there as confirmed by the required assessments. Form 5 (authorisation) summarises the restrictions that were in place to support Robert as follows:

- *The care home (Managing Authority) exercise complete and effective control over R's daily life, which is due to the level of supervision required to maintain his safety and well-being both day and night.*
- *R continues to require his care needs and ongoing monitoring of his physical and mental health to be met in a safe and protective environment. R is unable to anticipate or instigate any medical attention he may require and is dependent upon staff members to arrange any medical care he may require over a 24-hour period.*
- *R requires his medication, which is prescribed by his GP or Mental Health professionals to be administered by trained staff at the care home.*
- *R is prescribed Olanzapine 20mg once a day.*
- *Activities and care interventions are determined by the staff.*
- *R requires staff to prompt him to wash and change his clothes.*
- *Mealtimes and menu options are determined by staff.*
- *Whilst residing at The Brandles R is subject to environmental controls (temperature, decor, light) living arrangements.*

And

- *In relation to freedom to leave, R is not free to leave by himself. Although he goes out into the community, he will tell staff where he is going and if he does not return by a certain time staff would initially try to speak to him on his mobile telephone and go for a drive in the local area. If this was unsuccessful, and he failed to return, then the Police would be contacted. R is able to access all areas of the care home. He would be vulnerable to abuse and exploitation. The main door to the home is unlocked during the day and locked at night.*

10.1.29. The review would like to make the following points to provide context for the further analysis within this review:

- A DoLS authorisation is not a risk assessment; care planning and risk assessments must take place to reflect the restrictions.
- An authorisation only provides authority for the health or social care provider to deprive the person of their liberty. It does not require them to do so.
- The five principles of the Mental Capacity Act (MCA) still apply when there is a Deprivation of Liberty Safeguards (DoLS). The DoLS is rooted firmly within the MCA and all the key principles of the MCA fully apply. The DoLS will be about safeguarding the rights of people who are under high levels of care and supervision but lack the mental capacity to consent to those arrangements for their care. Robust care planning and risk assessment is essential.
- Care and treatment should always be provided in the least restrictive way possible. For example, in Robert's case, there was a concern about his safety when cycling and thus he was not able to use his bike until an OT road safety assessment had been completed and this decision reconsidered. In summary one may need to be kept away from places or situations where safety could be at risk so restrictions may be used to prevent a person from leaving a care home

10.1.30. The review has considered Robert's care plan, risk assessment and the degree of communication taking place between the Reviewing officer (CMHT), the care home and the LD consultant between July 2021 and 16th May 2022 (when he was admitted to hospital). Evidenced is a continual review of presentation, care planning and risk assessment that adapted when needed to changing behaviours. In particular Robert's interactions with other

residents was under continual review in terms of placement suitability and compatibility (for all residents). This had been a concern within the previous care home.

10.1.31. Robert went out of the Brandles unaccompanied to buy cigarettes from the shop, to go for a walk, attend his podiatry appointments and occasionally to visit friends or other social activities. Contained within his care plan/ risk assessment was a process to be followed if he did not return at the time that was specified, and there is evidence that this plan was followed on the occasion when Robert failed to return and subsequently became ill prior to hospitalisation.

10.1.32. The review concludes that the team around Robert including The Brandles as his daily care provider followed the correct process for DoLs authorisation and applied what was known about Robert to his care planning and risk assessment in accordance with the principles of the MCA.

10.1.33. In terms of the period of time that Robert spent in hospital it can be noted that a DoLs was not authorised. To note, DoLS applies to a specific institution such as care home or hospital and cannot currently be transferred- a new authorisation if required if a person moves between care settings. Of relevance is the Mental Capacity (Amendment) Act 2019 and the introduction of the Liberty Protection Safeguards (LPS) to replace DoLS. The Government announced a delay to the implementation and therefore changes are not yet in place.

10.1.34. Therefore to conclude, until the Liberty Protection Safeguards (LPS) are implemented, DoLS authorisations are not transferable and only apply only to the setting in which it was assessed. As such, hospital admissions from a care/nursing provider, need to be separately assessed and this was not effectively applied in Robert's case.

10.1.35. On admission to hospital is it documented that Robert was deemed to lack capacity regarding his care/treatment and needed to be accommodated in hospital to receive such care. For reference and to distinguish from the Cheshire West judgement, it is helpful to consider the Ferreira judgement which, in narrow terms means that there is not a deprivation of liberty for anyone receiving live saving treatment such as in ICU[vii]. This relates to the first and former stage of Roberts hospital admission when he was intubated and ventilated. Later and at different stages of his treatment, it was not clear how conclusions on capacity were reached, what information had been reviewed and with clarity on what decision this was referring to.

10.1.36. Also noted is that the hospital did in fact consider and make a DoLS application via their usual electronic system however, due to an IT outage the application was not submitted for a number of weeks and then it went to the wrong Local Authority. The IT outage was a National Critical Incident and contributed to some uncertainties about care provision in Robert's case. This means that during Robert's admission, the recording of information, communications, actions and conversations may not have always been readily available to anyone providing care to him.

10.1.37. Of note, the contingency planning during the outage increased visibility on the wards of speciality teams including the safeguarding and LD team, however differences in perception of mental capacity, the lack of DoLS authorisation and an absence of the LD team in the latter stages of his hospital admission can still be seen in Robert's case. Although the review finds that the LD team were initially contacted whilst Robert was in ICU which is good practice, the is an absence of consistent and proactive involvement throughout Robert's admission. Additionally, Robert was admitted to a hospital outside of his local area of residence which is likely to be the reason why the DoLS application was submitted to the wrong Local Authority and this was then very close to the time of discharge.

10.1.38. Mentioned above and acknowledged by the acute hospital Trust during panel discussions, was the absence of continued involvement of the LD liaison team who may have aided and assisted ward staff in multiple ways, it is difficult to conclude the reasons why staff were not prompted to seek specialist input from the team in this instance. This is especially relevant during the latter stages of Robert's admission when he started to become agitated, expressing that he didn't want to be in hospital and "wandering around".

10.1.39. Towards the end of the admission there is an MCA assessment recorded within the hospital records that concluded that Robert lacked capacity and that restrictions were required to keep him safe from falls as he was trying to leave the ward. However, this was not a formal decision specific assessment and did not prompt exploration of DoLS in view of the suggested "restriction". There are several more references to "capacity" and in particular on the two days after the above recording, there is reference to a further MCA assessment, carried out because Robert wanted to go home, and the conclusion was that Robert had capacity. There is an absence of oversight or exploration of the reasons for these two starkly different conclusions and/or what they may have meant in terms of a management plan.

10.1.40. Despite exploration of the records, and panel and practitioner discussions it is not possible to conclude on the extent that the IT outage affected oversight and there may have been an assumption that there was a DoLs due to the initial application being made. There may have also been an assumption that the LD Liaison team were consistently involved throughout the admission, when in fact they were not.

10.1.41. To conclude on this thematic area, the review finds that there was good practice in terms of applying the MCA and DoLS prior to hospitalisation and this translated into a daily care plan and risk assessment that adapted where needed. That care plan was compiled into a "passport" which was shared with the hospital on admission but there is a lack of evidence to the extent this was viewed or used during Robert's time in hospital.

10.1.42. The review also finds that when Robert failed to return from his outing from the Brandles (May), the agreed process was followed in terms of reporting him as missing. It can be seen that the oversight of his physical health was regular and there was not an obvious indication prior to this incident that Robert's physical health had deteriorated to the extent that his usual daily routine needed to be further restricted.

10.1.43. In summary and being mindful of the significant problems that the IT outage caused, the review concludes that there was insufficient application and oversight in hospital of the MCA, with different references to MCA assessments and varying outcomes, and a lack of follow up of the DoLs authorisation process. Considering the length of admission this may indicate a gap in knowledge and understanding of these principles. This is Key finding 1 and there will be a recommendation relating to this.

10.1.44. Consideration of actions post hospital discharge will be considered later in this report.

10.2. **Transfer of care and multi-agency working**

10.2.1. This review is particularly interested in the period of time that Robert spent in hospital and his transfer of care upon admission to hospital and then again on discharge. Robert spent 38 days in hospital, this consisted of a period of time in the Intensive Care Unit and subsequently on a ward.

10.2.2. Admission to hospital and discharge from hospital can both be considered as a transition of care. The Department for Health and Social Care (2022) state that *"multi-disciplinary teams*

should work across hospital and community settings – including with services provided by community health, adult social care and social care providers – to plan post-discharge care, long-term needs assessments and, where appropriate, end of life care".

10.2.3. Looking at the experience through Robert's eyes, this period of time may have been traumatic for him, he was extremely unwell and required a long period of intense hospitalisation to optimise his physical health after a medical crisis. Robert enjoyed the predictability of his life and adjusting to a new environment was difficult for him especially in the context of all we know about Robert including that "*he lacked insight into his illness, care needs, challenging behaviour, risks and consequences and had an impairment in the processing of information"*

10.2.4. Reconsidering the term "transitions", this involves people moving through boundaries of existing care provision and most certainly for Robert, he required the system working to look beyond usual organisational responsibilities, connect effectively with other services and collaborate to provide a seamless transfer process. Pathways to strengthen transition between hospital, community or care home will be considered.

10.2.3. Let us consider how Robert's different needs were assessed whilst in hospital. There is evidence of multiple phone calls and communications between the CMHT, Liaison Mental Health Team (LMHT), the Consultant Psychiatrist and The Brandles. In the days leading up to discharge it can be seen that that there were different conversations to ascertain if any needs had changed and physiotherapy and occupational therapy assessments were facilitated because of the questions asked regarding Robert's current mobility and daily functioning.

10.2.4. Also reported during the panel and practitioner discussions, and documented on the day leading up to discharge was a visit to the hospital by The Brandles where they expressed concern because they did not feel fully sighted on Robert's medical issues, the period of hospitalisation and the impact that this might have on his future care requirements. They were worried about mobility because Robert's room in the care home was on the second floor.

10.2.5. There is evidence of the different component parts of the system being involved in discussions via telephone or on the ward, different communications with each other are recorded but there is little evidence of a collective multi-agency discussion, and in particular The Brandles as the daily care provider had voiced concern that they did not feel fully informed.

10.2.6. Therefore, the review has considered principles of multi-agency working and how well this worked during Robert's admission to hospital and on discharge. In the widest sense it was essential that the separate speciality services, the hospital departments, and agencies working with Robert wrapped around him to support him. However, the review finds that there was not effective communication and multi-agency working to ensure a person-centred care approach. There was a disconnect between the specialities sitting within the acute service, and those in the community.

10.2.7. There were multiple strands to the care Robert received as follows;

- Medical care- in the emergency department, the intensive care unit and the ward
- Liaison mental health team input
- Continued CMHT oversight in collaboration with LMHT
- Psychiatry review (Community Consultant Psychiatrist)
- Physiotherapy and occupational Therapy
- Phone calls and visits from the care home provider

10.2.8. As noted, the review observes regular communication between different teams at different times during Robert's hospital admission- recognition of the importance of this was not absent. What cannot be seen is any one occasion where all those components came together to consider Robert's needs holistically, this resulting in silo working and different perceptions. This is evidenced in the agency reports and practitioner feedback, all of which offer slightly different perceptions of how care was delivered and the way the discharge was managed.

10.2.9. These differences are observed prior to discharge in the following ways; the hospital recorded that Robert was "*medically optimised, discharge was agreed by the wider MDT and agreement noted from the care home that Robert can be discharged that day".* In contrast The Brandles recorded that they would need to understand Robert's needs, ensure they can provide appropriate care and update his care plan before he returned home. The CMHT record concerns that they (reviewing officer) and the provider (the Brandles) hadn't been involved as expected with discharge planning. The LMHT record a hybrid of these views in that the care home would be happy for Robert to be discharged once the care plan was reviewed to reflect the views of the medical team and the LMHT namely that; he was that he was back to his "*baseline"* and *"medically fit both physical and mental health, acute problems resolved with no new after care needs".* Considering all perspectives, it is difficult to ascertain how Robert's "baseline" was measured and the review has not found evidence that his "passport" was used as a reference point.

10.2.10. Overall, during Robert's time in hospital, it is difficult to ascertain how decisions about care and treatment were made. There is an assumption that they were made in his best interests but no evidence of how best interests decisions were reached and no reference to an advocate. To note, emergency care would be delivered in a person's best interests, however as Robert stabilised and became medically optimised, the decision making is not clear.

10.2.11. There is a difference of interpretation because the plans, decisions and conclusions were not reached together. It can be seen here that even with the benefit of hindsight and for the purpose of this review, there is confusion and lack of clarity on discharge. This provides some insight into the amount of "multi-way" conversations that were taking place, with Robert not at the centre and parts of the MDT not integral to full discussions.

10.2.12. To note, on the day of his discharge the LMHT had attended the ward as well as The Brandles owner and registered manager, each coming away with the understandings described above, but what is certain is that the care home were not expecting Robert to be discharged immediately that day and had wanted to explore safe discharge with the CMHT in their capacity as commissioners/ reviewer of his care package.

10.2.13. As well as the differences of interpretation of the discharge arrangements, the PLE and panel all expressed different views about whether a "discharge planning meeting" had taken place. The reviewer would suggest that if there are different perceptions then a formal meeting did not take place, instead various conversations between teams occurred on the ward which is not the same thing. The review finds that if a discharge meeting had taken place, then all agencies and services would have the same version and conclusion of the multi-agency discussion and there would not be any difference of perception or continued anxieties.

10.2.14. In considering who knew Robert best, this would be the CMHT and the care provider who had worked closely and very adaptably together on a daily basis for the preceding ten months. It is important to acknowledge that upon discharge they were accountable respectively for the commissioning and delivery of care and had expressed the view that they did not feel entirely confident that they understood the impact of Robert's experience in hospital which may have been traumatic for him, or the effects of his medical conditions on his

daily functioning. They wanted the opportunity to understand this and review his care plan before discharge. Due to how the discharge took place, the review of his care plan and risk assessment was completed the following morning by the care home and CMHT reviewing officer which is noted as good practice, albeit it may have been better practice for this to be done at a discharge planning meeting, prior to discharge.

10.2.15. On the day of discharge, conversations in the main were between the LMHT and the hospital staff. It is documented by the LMHT that the medical staff *"confirmed that they were not concerned about his medical presentation, he had been extremely unwell prior to admission but received the appropriate medical treatment and was now recovered with no expectation that his medical condition would decline or require any community treatment other than the normal contact with the GP. He is medically fit both physical and mental health, acute problems resolved with no new after care needs".*

10.2.16. LMHT acknowledge that there was some uncertainty about how to agree discharge with community services and they contacted the adult social care emergency duty team (EDT) and record that it was acceptable to discharge Robert in view of the conclusion of the medical staff; with a review of his care plan to be updated after discharge. After discussion at panel this is clarified to mean that the CMHT would review his care plan after he was discharged.

10.2.17. It is recorded that LMHT asked the care home if they were saying that they could no longer meet his needs and they were clear that this was not the case, rather that they would like to consider his care plan PRIOR to discharge and not after. The reviewer has formed an impression that it was thought that The Brandles were being difficult about the discharge, however they have voiced that they were frustrated as they were not integral to the discussions and were not given opportunity to proactively plan for Robert's discharge because it happened so quickly.

10.2.18. The review observes that discharge happened very swiftly when medical staff concluded Robert was medically optimised and pre-emptive multi agency planning in the days and weeks leading up to this point may have facilitated a more inclusive and controlled planned discharge.

10.2.19. It is also recorded by the LMHT and hospital that Robert wanted to return home and thus he needed to be discharged as there was *"no legal framework in place"* to keep him on the ward against his will. To note this was on the last day of his hospital admission and Robert had stated on many occasions during his admission that he wanted to go home. Again, consideration of capacity, best interests and DoLS could have been explored prior to and on this occasion.

10.2.20. It would be remiss to omit the views of the panel and practitioners that a safer mode of transport could have been agreed, albeit there was no adverse incident resulting from the transport, it was not an ideal way for Robert to have been discharged from a 38 day inpatient stay. The review would like to note that point for the benefit of the hospital Trust.

10.2.21. It is helpful to refer to the National Discharge and Community Support Guidance (2022)[viii] which makes clear the principle that "*people do not have a right to remain in a hospital bed if they do not need acute care"* but does highlight the need for multi-disciplinary teams comprising professionals from all relevant services to work together in a timely way to facilitate discharge. The review observes a "locking of horns" related to these two elements of the guidance and acknowledges the capacity pressures that the hospital experienced at that time and constantly since.

10.2.22. Although the reviewer acknowledged the challenges of the National Discharge and Community Support Guidance, for someone such as Robert with care and support needs, the strength of getting specialities and care providers in a room together should not be underestimated.

10.2.23. Therefore, transfer pathways and a methodology or criteria for agencies to come together and consider all their information may have assisted with the following aspects:

- Person centred care planning
- Assessment of capacity in hospital
- Facilitation of DoLS authorisation in hospital
- A discharge planning meeting to ensure all the right people had been consulted.
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10.2.24. In Robert's case the general consensus was that mental health services were ordinarily the lead agency, because they were responsible for the commissioning and review of his care package however this was somewhat flawed because at the point when Robert was ready to be discharged home, there was not a seamless transition from "medical care" to "mental health care".

10.2.25. In terms of how clinical plans were communicated, there was an expectation that the care home would pick up where they left off which may require "translation" of specialist clinical information into a care plan. Therefore, the review concludes that the care home were not integral to planning and were not listened to when they sought additional information and assurances.

10.2.26. There are nationally recognised pathways that are designed to aid the seamless transfer of care, this includes the "Red Bag Pathway" which is designed to support care homes, ambulance services and the local hospital meet the requirements of NICE (2015)[ix]. In summary this pathway uses a "red bag" is to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with resident. The standardised paperwork will ensure that everyone involved in the care for the resident will have necessary information about the resident's general health, e.g. baseline information, current concern, social information and any medications, on discharge the care home will receive a discharge summary with the medications in the red bag. This, together with a multi-agency discharge process would have avoided any element of uncertainty and strengthened the way care was planned and delivered in hospital and on discharge.

10.2.27. The review has discovered that the "Red bag Scheme" was introduced in Bury in 2018 to older adult care homes via a collaboration between the acute trust, NWAS, older adult care homes and the (then) CCG. Despite measures of success the scheme was halted during the COVID-19 time period and its future is under consideration. Supported living providers and specialist mental health care homes such as The Brandles were not included in the implementation.

10.2.28. However, the care home did share an LD "passport" which went to hospital with Robert, it is noted by the acute trust that this was received but the extent to which this was viewed or used by the hospital is not evidenced. For information, Robert was admitted to a hospital in a neighbouring borough (the Royal Oldham Hospital), albeit the LD passport is a recognised mechanism for sharing information across Greater Manchester and not just in Bury.

10.2.29. Therefore, whilst we know that Bury introduced the "Red Bag Scheme", and that the care home used similar principles of this to develop and share Robert's LD "passport", there is limited evidence that it was utilised during his time in hospital. To clarify, the passport was shared in paper format and was contained within the hospital records. It is standard recognised practice for LD passports to be used and thus it is noted as good practice that a "passport" was developed and shared in this instance.

10.2.30. Considering the period after discharge, reassuringly the care plan was reassessed and reviewed by the CMHT reviewing officer on 24/06/2022 which was the day after Robert was discharged from hospital. The care plan is described as a person-centred review and explores a summary of needs. The Brandles are recorded in this review as having concerns about his recent hospital admission, physical health generally and whether his needs had changed since being in hospital. They were concerned about his safety in terms of any changing mobility requirements, there was an interim plan for some 1-1 support for Robert. To clarify, the 1-1 support was not a requirement of his hospital discharge, nor was it indicated in the hospital discharge, however this was agreed due to the recent discharge from a lengthy hospital admission.

10.2.31. After a few days Robert expressed that he did not want additional support. It would have been difficult to assess risk relating to this because it was additional support that was not necessarily required. Smoking again was noted to be a challenge in terms of the extent to which he wanted to smoke was physically harmful, additionally his finances would not allow him to buy more cigarettes, therefore there were restrictions put into place in respect of limiting the number of cigarettes that Robert could have access to per day.

10.2.32. The care plan references the need to have a physical health review. He was noted to be settled and happy at The Brandles and he did not express any desire to move. There is little evidence that there was any clinical advice that Robert's illness was likely to have any impact on his daily functioning and there is reference to Robert being back to his "baseline" and medically optimised, his care plan and risk assessment was reviewed and there was no fundamental change to his daily routine albeit a recognition that it would be in his best interests to reduce his smoking. Robert was seen by his GP for a physical health review and reviewed by his LD/ Mental Health consultant and resulting from these assessments, a referral was made to the MDT Community Learning Disability Team (MDTC) for a "health care needs assessment" which was pending at the time of his death.

10.2.33. The MDTC is made up of learning disability nurses, occupational therapists, speech and language therapists and psychologists. The referral for Robert was made on 12th July and accepted the following day. The MDT triage meeting to consider the assessment was scheduled 2 days after his death.

10.2.34. The care home reflected on their plans and processes when Robert went out, he did not like to use/ take a mobile phone and had been supplied with a specific watch which would light up at different times to prompt Robert about the time and it was noted that this worked well for him. He would also be given a pack with some additional money and contact details in the event that he needed to contact the care home. On the day of his death there was consultation between the care home and the CMHT about the arrangements for Robert going to the cinema with some practical mitigations put into place in view of the hot weather. This included ensuring Robert had a good breakfast and lunch, was hydrated, wore weather appropriate clothing and took fluids with him.

10.2.35. The review has considered the extent to which Robert's restrictions may have been increased after discharge. For example, a retrospective view prompts one to consider if there

should have been additional restrictions to prevent Robert leaving the care home unsupervised. The care plan before and after hospitalisation reflects checks and balances that were in place for daily outings and the medical information from the hospital admission which stated that "he *is medically fit both physical and mental health, acute problems resolved with no new after care needs".*

10.2.36. With reference to the above question, it is evidenced in the care plan and risk assessment document that that a physical health review was arranged, the DoLS team has been consulted with (regarding additional restrictions related to smoking) and daily excursions were discussed with the reviewing officer within the CMHT. In view of Robert's quick deterioration in May, it could have been pertinent to formally reassess his restrictions, it is acknowledged that there were a number of proportionate actions taken after discharge to review his care plan.

10.2.37. As part of the care plan and risk assessment review, steps were taken to facilitate a physical health review, mental health review and a care needs assessment referral. The review concludes that it would have also been a reasonable and logical action in the meantime to have undertaken a formal review of the restrictions placed on Robert, and if restrictions needed to be increased this could have been reviewed by the Local Authority. An opportunity to do this was at the point that he declined the 1-1 support and whilst waiting for his health care needs assessment. The rationale for this being that he did not have capacity to decline support that had been identified in his care plan to mitigate against potential risks such as those domains included in his risk assessment.

10.2.38. In terms of safeguarding activity, the review found that there was only one occasion where a safeguarding concern was raised (during the timeframe of this review), and this was in July 2022 at the time of Robert's death. The S42 enquiry found that there were gaps in relation to hospital discharge, lack of evidence of MDT approaches- analysis within this thematic area supports those findings.

10.2.39. To conclude on this thematic area;

- There was a person centred "passport" shared with the hospital on admission but there is limited evidence that this was used, and insufficient evidence that overall, agencies in Bury have adopted a formal transfer scheme effectively, this is Key Finding 2, this is not a new recommendation and there will be a recommendation relating to this.

- There was insufficiency in how clinical plans were communicated to the MDT in its widest sense, the care home provider and the reviewing officer were not integral to the discharge planning and arrangements. This relates to the inconsistency in transfer of care pathways thus creating a disconnect between the hospital and community teams. This is key finding 3 and there will be a recommendation related to this.

- The CMHT reviewing officer together with the care home, the Consultant Psychiatrist and in communication with the DoLs team reviewed Robert's care plan and risk assessment in the period of time after discharge. Even with the benefit of hindsight, it is difficult to evidence any significant change from his period of hospitalisation that should and could have evidenced/ indicated an increase in risk in terms of Robert's daily activities. The DoLS continued to be in place and restrictions applied as they were prior to Robert's hospital admission with regular liaison between community specialty teams and professionals. However, the post-discharge community anxieties about Robert's physical health and his reluctance to accept additional 1-1 support should have prompted a review of the restrictions placed on him until his overall physical health status could be reviewed, this is key finding 4.

10.3. **About Robert – his voice and lived experience.**

10.3.1. Although it is evidenced within the hospital chronology that a Learning Disability "passport" was received from the care home, regular liaison took place with the CMHT, there was the involvement of LMHT, and discussions about medication management, this review has been unable to confirm the extent to which hospital staff had an understanding of Robert as a person.

10.3.2. Irrespective of what information may have been shared/ communicated by community teams and care home on admission, each patient should be considered individually, and professionals should always remain alert to indicators that a person may live with a cognitive impairment. This may have prompted discussions about capacity assessments, what is in the person's best interests and DoLS authorisation as well as consideration of what reasonable adjustments may be required.

10.3.3. It is noted within the report that The Brandles used a "passport" which is designed to follow their residents wherever they may need to go, for example to hospital appointments, hospital admissions, for paramedics and other services. This document was shared on admission to hospital and contained information about Robert including his DoLs authorisation and his communication needs/methods but there is little evidence that this was reviewed by his clinical team or utilised in terms of how care for Robert should have been delivered in hospital; it is acknowledged that the IT outage at this time may have affected access to certain documents and this may have been one of them, albeit there was a paper copy of this document in the records. However, this should not have prevented a professional from seeking such a summary out for someone known to have learning disabilities and care and support needs.

10.3.4. The hospital reflected on the absence of involvement of their Learning Disability Acute Liaison Team during Robert's hospital admission. The role of the hospital Learning Disability Safeguarding Team is to make sure support is in place for any patient with a learning disability diagnosis during their hospital stay. Even in the event that the "passport" hadn't been seen/ reviewed or used, it was documented within the records that Robert had a learning disability and thus there was no reason why the hospital Learning Disability Acute Liaison Team should not have been contacted or involved.

10.3.5. Their involvement would have ensured a much more person-centred approach, for example to ensure that reasonable adjustments within the care planning are in place and to provide advice and support to the staff.

10.3.6. Reasonable adjustments are a legal requirement under the Equality Act (2010) to make sure health services are accessible to all disabled people. We are not able to ascertain Robert's views and experience of his time in hospital, but we do know that he required clear, uncomplicated information and help managing matters of consent with reference to the Mental Capacity Act. We do know from his DoLS documentation that the authorisation was granted for a 12-month period because it was "*unlikely that he will regain capacity and there is a continued requirement for 24 hour care and support*". Therefore, his change of circumstances on admission to hospital should have prompted regular consideration and assessment of Robert's decision specific mental capacity, what care/treatment is in his best interests and DoLS application as well as reasonable adjustments in hospital.

10.3.7. This review has considered the systems within NCA to identify and support individuals with a cognitive impairment, appropriate care planning, communication with appropriate internal/external partners in order to safeguard patients. It is noted that NCA have been proactive in commissioning an MIAA Audit with specific reference to the LD Liaison system[x].

This resulted in an action plan to include the LD/Autism guidance, a review of the way the LD liaison team interface with clinical areas, and mandated Oliver McGowan training both of which are in the implementation stage. For reference, the Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff[xi].

10.3.8. It is helpful to consider that even for a person without Robert's needs, the extent of his illness and time on intensive care would be traumatic and we do not have an insight into how that was perceived or experienced by Robert.

10.3.9. We do not know the extent to which Robert understood why he was in hospital, who all the different people in hospital where and whether that was explained to him in a way he could understand. Robert liked his routine and was happy at The Brandles, he expressed several times that he did not want to be in hospital and therefore one can deduce that this was a very confusing and scary time for him, not only has he been extremely medically unwell, but he may not have understood what was happening to him on a daily basis.

10.3.10. Robert's care plan in the community included a range of information such as communication needs, mobility, personal care, medication, nutrition and social activities. The care plan was a good example of person-centred planning and was adapted when needed and reviewed regularly including on the day after he was discharged from hospital.

10.3.11. To conclude on this thematic area, a multi-agency transfer pathway was not applied effectively in Robert's case. This was further compounded by the inconsistent involvement of the hospital LD Liaison team who may have been able to strengthen approaches and oversight. This resulted in barriers to developing a person-centred approach which could have been overcome had the right component parts come together to share what they knew of Robert. This is captured in Key finding 2.

10.3.12. Lastly, let us consider Roberts movements on his final day. On the day of his death Robert went on an eagerly awaited excursion to the cinema to see the Elvis film. He dressed in his usual attire consisting of trainers, jeans, Elvis t-shirt, and he took a jumper with him which he often wore tied around his waist. Robert mostly liked to wear his Elvis hooded jumper and bomber jacket but did not do so on that day due to the heat.

10.3.13. The excursion had been discussed between The Brandles and the CMHT and certain actions taken in view of the heat wave. Already mentioned earlier in this report are his movements that morning; he followed his usual routine, had breakfast and lunch, was encouraged to keep hydrated and was discouraged from wearing some of his usual clothes. He was provided with a drink and money, and he set off for the bus stop which is 0.2 miles from The Brandles. Robert took the 12.37 bus in order to make the 13.00 cinema showing of the film. To note, he was looking forward to and very pleased about going to see the film.

10.3.14. For whatever reason when Robert reached the town centre/ cinema he did not go inside and can be seen on CCTV footage walking away from the area. Sadly, he was found just over 2 hours later in the river. The reviewer has not found any information during the course of this process to indicate a reason or explanation for Robert walking away from the cinema and towards the river that day.

11. Key findings

Key finding 1- In Robert's case there is insufficient evidence that all partner agencies are legally literate in the application of the MCA and DoLs. **This is not a new finding in Bury and there will be a recommendation related to this.**

Key Finding 2- there is insufficient evidence that there is an effectively embedded hospital transfer pathway thus impacting on person centred care planning and delivery. **This is not a new finding in Bury and there will be a recommendation relating to this.**

Key finding 3- The review finds that multiagency working and processes to facilitate safe transfer between hospital and community are inconsistently applied with a lack of understanding across the agencies. **There will be a recommendation relating to this.**

Key finding 4- On discharge the community services (commissioner and provider) felt anxious about Robert's physical health and wellbeing and on that basis arranged additional support in his new care plan. When Robert expressed that he did not want the 1-1 support, this should have prompted a review of the restrictions placed on Robert until such time that his physical health status could be fully reviewed and clearly understood. **This finding will be captured in the recommendation made against key finding 1**

12. Summary

12.1. The review has considered the way services planned and delivered care for Robert leading up to, during and after a period of significant ill health and hospitalisation. Despite increasing medical issues, Robert had experienced a happy and settled period of time at The Brandles where, although he was subject to a DoLS, the team around him worked together well to facilitate access to the things he enjoyed and promoted his quality of life.

12.2. Unfortunately, Robert became extremely unwell and required a period of hospitalisation at a time when capacity and demand for acute hospital services was significantly challenged, compounded by an unfortunate national IT outage which impacted on access to the fullness of information that staff would ordinarily be able to access. Staff did not always respond to this with the right level of professional curiosity to plan Robert's care in a person-centred way. As a consequence of that, the way that agencies worked together to plan for discharge could have been strengthened.

12.3. Considering that Robert lived within a care home setting, had known care and support needs and had a DoLS authorisation in place in the home, there was a lack of oversight to legal literacy on admission through to discharge. This indicates that hospital practitioners may not always be prompted to or know how to apply legal powers to safeguard people. This may have been strengthened if the LD Liaison team had been consulted throughout his whole admission and it is noted that significant progress has been made with reference to LD and Autism in the acute setting.

12.4. Throughout the period of time in hospital Robert did not remain central to care planning and his voice and lived experience was not consistently considered or applied to practice. The review finds that there is a lack of assurance in the application of multi-agency pathways to aid continuity of care in the transfer between community and acute settings. It should be noted in this case that Robert was discharged from hospital 4 weeks before his death.

12.5. It is noted that the multi-agency discharge planning process needs to be strengthened, although Robert was considered to be medically optimised, there was a disconnect in methods of multiagency working for someone with care and support needs. This challenged the process of post discharge care planning and risk assessment.

12.6. The review finds that although Robert's care plan and risk assessments were reviewed the day after his discharge from hospital, there was an opportunity to review Roberts restrictions in the time period from hospital discharge to his death.

13. Conclusion

13.1. This SAR Overview Report is the BISPs response to the death of Robert, to share learning that will improve the way agencies work individually and together.

13.2. It is not possible without hindsight bias to comment on whether there could have been a different outcome, and it is outside the scope of this review to make any inferences about the direct incident of Robert's death. The information considered in this review does not offer insight into why Robert decided to walk away from the cinema on the day of his death.

13.3. With this in mind, albeit not directly associated with the day of his death, the review shines a light onto wider learning, and specifically how agencies worked together prior to his death. Therefore, consideration of the findings, and recommendations outlined below may strengthen an individual's journey through services in future.

- Application of a transfer of care pathway to aid person centred care planning.
- Strengthening of legal literacy on application of the MCA
- A stronger multi-disciplinary approach when circumstances changed (admission to and discharge from hospital).
- An opportunity to holistically review Robert's community care plan prior to his discharge from hospital.

13.4. The review has considered the degree to which this case highlights systemic issues in how the multi-disciplinary teamwork with daily care providers to ensure quality oversight. The conclusion reached is that this case reflects wider challenges regarding system working and the knowledge and experience of staff responsible for meeting people's needs- this is not a new finding.

13.5. The case also raises the question of who we mean when we refer to a "multi-disciplinary team", the daily care provider (in this case the care home) must be central to that and not separate to it.

13.6. It is hopeful that the outcomes from this review will recognise thematic areas of learning from previous reviews. The findings and recommendations should be monitored for compliance, implementation and assurance by the BISP.

14. Recommendations

14.1. Recommendations made in this review should be applied as learning for the system where deeper and continual assurance is required. It is the responsibility of the BISP to use the findings and recommendations to develop an action plan to support improvements to systems and practice.

14.2. Arising from the analysis in this review the following recommendations are made to the BISP-

Recommendations:	
Legal Literacy (KF1 & KF4)	**Repeated recommendation**- It is recommended that the BISP adopts an MCA competency framework approach that can standardise practice and training and allow different professionals working at different levels in agencies to consistently apply the statutory requirements of the MCA and understanding of human rights, with special regard to restrictions and/or deprivation of a person's liberty. In addition: - The framework should acknowledge the requirement to have necessary and proportionate risk assessments and care plans in place. - Its effectiveness should be regularly reviewed to provide an oversight of whether practice is working. - The care home sector should be included in this work
Person centred care and multi-agency transfer pathways (KF2& KF3)	**Repeated recommendation-** It is recommended that the BISP revisit the effectiveness of all current processes (including the "red bag scheme" and LD passports) and seeks assurance from commissioners and providers of services about the degree to which transfer pathways are embedded into practice; and to seek reassurance that person-centred care is accurately understood, and that understanding is embedded in practice across partner agencies. With reference to transfer processes: The BISP are asked to consider approaches to multi-agency working to include practice guidance for the workforce to enhance: - A timely and seamless transfer of care across all settings. - Assurance of collaboration and inclusion of the wider/ independent care sector. - A jointly agreed understanding of criteria for when a formal transfer of care meeting is required when a person has care and support needs. - Assurance of its effectiveness. Lastly, BISP are asked to share this learning across Greater Manchester areas in recognition that this case highlights the issue of people moving across geographical boundaries.

[i] Department of Health and Social Care (2020) Care and Support Statutory Guidance: Issued under the Care Act 2014. London: The Stationery Office (section 14.165)
[ii] Coroners | The Crown Prosecution Service (cps.gov.uk)
[iii] The Brandles - Care Quality Commission (cqc.org.uk)
[iv] 20150510_hsca_2008_regulated_activities_regs_2104_current.pdf (cqc.org.uk)
[v] National Health Service Act 2006 (legislation.gov.uk)
[vi] DH_Consolidated_Guidance.pdf (publishing.service.gov.uk)
[vii] Ferreira V HM senior Coroner for Inner South London (2017) EWCA CIV31
[viii] Hospital Discharge and Community Support Guidance (publishing.service.gov.uk)
[ix] Overview | Transition between inpatient hospital settings and community or care home settings for adults with social care needs | Guidance | NICE
[x] www.miaa.nhs.uk
[xixi] The Oliver McGowan Mandatory Training on Learning Disability and Autism | Health Education England (hee.nhs.uk)