Norfolk Safeguarding Adults Board

Safeguarding Adult Review

MRS BB

OVERVIEW REPORT

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Independent Overview Report Author

31 October 2016

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1. INTRODUCTION

1.1 This Safeguarding Adults Review (SAR) was established to review the circumstances leading up to the death of Mrs BB who was 84 years of age. Her body was found in a ditch on the morning of 21st January 2015, about a mile from her home, and not far from the residential home where her husband was living.

1.2 The decision to establish a SAR was made by the Chair of the Norfolk Safeguarding Adults Board in September 2015, following the completion of the Police investigation.

1.3 The Overview Report is lengthy because of the number and complexity of the issues which were identified during the Review. Therefore, the report starts with an Executive Summary which provides a brief narrative of the key events, a summary of the findings, and the recommendations to address the learning. These are described in detail in the main body of the report, together with details of how the review was conducted.

2. Overview of the Circumstances of the Case

2.1 Mrs BB had been diagnosed as having dementia, probably due to Alzheimers in October 2012, and lived alone from February 2013 after her husband was admitted into residential care nearby. Mrs BB had 4 children who provided fluctuating levels of support. She received twice daily home care visits but quite frequently was not at home because she made frequent trips to town or to visit her husband. There were concerns about Mrs BB's safety when she went out, with reports of her becoming lost, disorientated, anxious, and approaching strangers for help or lifts. During the 2 months prior to her death, these risks increased, because the frequency, and pattern, of her trips out became more erratic.

2.2 Following a Mental Capacity Act assessment in late November 2014, a Best Interests Decision was made with the family to look for a residential placement, in the South of England near one of her daughters, preferably for Mr and Mrs BB to be placed together. In the interim, 2 hours additional support was commenced to take her to have lunch with her husband. However, Mrs BB often continued to make her way there on her own. Therefore, in mid December, an alternative home care agency was commissioned to provide 9 hours support each day to keep her safe when out, and engage her in social activities. Initially this was provided between 09.00 to 18.00 but quickly changed to 08.00 to 17.00 because Mrs BB had sometimes gone out when the carer arrived.

2.3 From 18th January 2015, Mrs BB's behaviour became increasingly agitated, and police assistance was required when she made an evening visit to her husband's care home. On 20th January 2015, the carer arranged an urgent late afternoon GP appointment because of a further escalation of her agitated and erratic behaviour. This hampered the GP's ability to carry out a full examination. The GP decided that Mrs BB should be taken to A&E where she would be in a place of safety, and further investigations could be carried out. However, the carer did not pick up the need for Mrs BB to be in a place of safety that evening so she was not left alone.

2.4 On leaving the surgery Mrs BB continued to be agitated, and refused to go to hospital. After discussion with his manager, the carer returned Mrs BB home, and contacted one of the daughters who was unable to visit that evening to assist in taking to her hospital. The manager, who was unaware of the GP's view about the need for a place of safety, and believed that the A&E plan was about further tests, instructed the carer to ensure Mrs BB was settled, and he would visit the next morning to collect a urine sample and proceed to hospital if the carer could not get her there that evening.

2.5 When the carer visited in the morning, Mrs BB was missing. It appears that Mrs BB had left her home at some point the previous evening.

PART 1

3. THE SAFEGUARDING ADULT REVIEW ARRANGEMENTS

The Decision to Establish the Review

3.1 Under Section 44 of the Care Act 2014, the Local Safeguarding Adult Board (SAB) must carry out a Safeguarding Adult Review (SAR) where:

"An adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board's area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult"

3.2 A safeguarding referral made by the GP immediately after Mrs BB's death, was considered by the Safeguarding Adults Review Advisory Panel on 1st April 2015 when it was agreed that further action would need to be deferred until the completion of the investigation which had been commenced by the Police. This ran for some months during which information was gathered from the family and statements obtained from a number of professionals involved. The outcome was that there was insufficient evidence to support any criminal proceedings.

3.3 The decision to establish a SAR was made by the Chair of the Norfolk Safeguarding Adults Board in September 2015, and agencies were informed on 5th October. An Independent Overview Report Author was appointed to lead the Review who met with the SAR Group on 4th December when the methodology was agreed, and a target date set for completion by July 2016.

Purpose of the SAR

3.4 The purpose of the SAR, as set out in national guidance relating to the Care Act 2014 is to:-

- determine what agencies and individuals involved might have done differently to prevent the harm or death;
- review the effectiveness of multi-agency safeguarding arrangements and procedures;
- identify the learning, including examples of good practice, and apply these to improve practice and partnership working to prevent similar harm occurring again in future cases.

Review Methodology

3.5 This SAR has used what is known as a "systems" approach. The benefit of this is that in addition to reaching conclusions about agency actions in Mrs BB's case, it provides "a window on the system" [1] for looking at the reliability and effectiveness of the multi-agency arrangements for safeguarding adults, and how these can be improved.

3.6 It does this by using the analysis of the factors which contributed to the actions and decisions taken in Mrs BB's case, as the vehicle to identify underlying patterns and issues in the way services are organised and delivered, which either support good professional practice, or create the conditions in which less effective practice, and / or poor outcomes are more likely. In arriving at its findings, the Review methodology draws on the perspectives of professionals involved, local performance information, and evidence from national research.

3.7 Key features of the "Systems" approach include:-

- maintaining a focus on the situation, and experiences, of Mrs BB and her family;
- recognising the complex circumstances in which professionals work together to safeguard adults;
- seeking to understand practice from the viewpoint of the professionals and organisations involved, and avoiding the risk of hindsight bias when exploring the rationale, and factors, which led individuals and organisations to act as they did;
- transparency in the way information is collected and analysed;

3.8 The "Systems" methodology applies a six part typology to support the analysis:-

- What has been learnt about the tools used by professionals?
- Are there particular issues around how professionals respond to incidents?
- Are any elements of management systems a routine cause for concern in any particular ways?
- Are there common errors of human reasoning and judgement evident that are not being picked up through current organisational arrangements?
- What patterns are discernible in how professionals interact with adults with dementia and their families, and do these introduce risk into our systems?
- Were any patterns identified about ways of working over a longer period with adults with dementia?

[1] Charles Vincent 2004)

Key lines of enquiry

3.9 In addition to the above questions, the following specific key lines of enquiry were agreed in scoping the Review:-

Service Response and Information Sharing

1. How timely and effectively do professionals regularly share and update information, assess risk, and provide support to service users experiencing dementia and whose behaviour causes concern (e.g. appears to be lost, found wandering, not answering door)?

2. Are professionals, including service providers, clear about what information they should share, with whom, and when, in situations where they have concerns about the safety and welfare of service users?

Multi-Agency Case Co-ordination

3. How effective are professionals in identifying emerging crisis situations affecting service users with dementia. How well co-ordinated is multi-agency action in situations which require an immediate response.

Care Pathways for Service Users Over 65

4. What are the care pathways, and how well do they work, when a service user over 65, with dementia, is in crisis? Are these affected by the time / day when the situation presents, and does this result in any differential in professionals' response and actions?

Role of Home Care Providers

5. Is there a shared understanding of what can reasonably be expected of home care agencies to assist service users in crisis situations, which take account of the agency's remit, capacity, and skills? How effectively do the processes operate for escalating concerns within, and between, organisations, to achieve a timely response.

Mental Capacity

6. How effective are professionals in identifying situations where a person may lack mental capacity? Is there shared understanding across agencies as to who is best placed to carry out MCA assessments, and how?

Continuity of Service

7. How resilient are agencies' arrangements for ensuring continuity of support to a service user when the case holding professional is unavailable for some time, either due to annual leave or extended sickness?

Time period covered by the SAR

3.10 The time period to be covered by the Review was from 1st February 2012 to 21st January 2015. This enabled the Review to take into account:-

- professionals' involvement in respect of the assessment of Mrs BB's emerging memory problems in 2012;

- the circumstances, and impact, of Mrs BB's husband's admission into residential care in February 2013;

- assessments and support provided from November 2013 in response to referrals from the family;

Review Team Membership and Role

3.11 The Review Team comprised 11 senior representatives from the main organisations involved, but who were not involved in the case.

Assistant Director (Integrated Care) Norfolk County Council
Quality Assurance Manager, Adult Social Care, Norfolk County Council
Consultant Geriatrician - Norfolk and Norwich University Hospital
Assistant Director of Nursing – Norfolk & Suffolk NHS Foundation Trust
General Practitioner
Detective Sergeant - Norfolk Police
Quality Manager – Home Care Agency 1
Senior Nurse Adult Safeguarding - North Norfolk Clinical Commissioning Group
Safeguarding Adults Practitioner - North Norfolk Clinical Commissioning Group.
Safeguarding Business Manager, Norfolk Safeguarding Adults Board
Solicitor – Norfolk Safeguarding Adults Board

Independent Overview Report Author

3.12 The Review Team was chaired by Chris Brabbs, the Independent Overview Report Author, who is a former Director of Social Services with extensive experience of conducting safeguarding adults reviews, and children's serious case reviews. He had no previous involvement or connection with Norfolk.

Contribution of professionals involved in the case

3.13 The following 20 practitioners and managers were selected to be members of the "Case Group" because they either had significant involvement with Mrs BB, or who were well placed to explain how relevant services work.

General Practitioners x 2
Service Manager, SCCE, Norfolk CC
Team Manager, Adult Social Care, NCC
Practice Consultant - Adult Social Care, NCC
Social Worker, Adult Social Care, NCC
Former Assistant Practitioner, Adult Social Care, NCC
EDT Manager, Norfolk CC
Manager – Home Care Agency
Residential Care Home Manager
Senior Care Assistant – Residential Home
Former Care Co-ordinator - Home Care Agency 1
Home Carers x 3 – Home Care Agency 1
Carer – Home Care Agency 2
Police Community Support Officers x 2
Police Officer
Manager – Assistive Technology Service

Meetings

3.14 There were 7 meetings of the Review Team, and 2 joint events involving both the Review Team and the Case Group to check the facts and test out the emerging findings. There was generally good attendance, but operational demands on GPs affected their availability to attend some of the meetings. Each member of the Case Group was involved in an individual semi-structured discussion with the Overview Report Author and a member of the Review Team.

Involvement of family members

3.15 Information about the Review was sent to Mrs BB's husband, son and 3 daughters with an invitation to contribute if they wished. A response was received from Mr BB and 2 daughters, B and D, who provided helpful information and perspectives in discussions with the Overview Report Author at an early stage of the review. It was agreed that feedback on the findings would be provided prior to the inquest.

Arrangements for publication of SAR findings

3.16 It was agreed that the Overview Report would be published in September 2016, and will therefore be in the public arena before the Coroner's Inquest.

PART 2

4. SUMMARY OF KEY EVENTS AND AGENCY INVOLVEMENT

February to September 2012: Response to Emerging Memory Problems

4.1 In February 2012, Mrs BB attended surgery with her daughter B, expressing her worry that she was developing dementia, and feeling isolated because she had no friends. GP1 completed a memory assessment in which Mrs BB achieved a good score, and she attended for follow up blood tests.

4.2 When Mrs BB was next seen by GP2 on 06.07.12, with another daughter C, the GP was informed that her memory was gradually deteriorating, and she felt stressed caring for her husband. A six-item cognitive impairment test was undertaken and arrangements made for blood tests to be carried out as part of further investigations.

4.3 Mrs BB was seen twice by GPs during August 2012 when issues were explored around her increasing memory problems and low mood which was said to be due to the stress of caring for her husband. She was prescribed the anti-depressant drug, Citalopram. Following this, with the agreement of 2 daughters, B & C, a referral was made to the Older Age Community Mental Health Team on 06.09.12 for a specialist memory assessment. A note was made on the records that Mrs BB had "unspecified dementia". [2]

Assessments of Mr and Mrs BB / Hospital Admission of Mr BB

4.4 In the meantime, OT1 had carried out an assessment on 28.08.12 of the difficulties being experienced by Mr BB because of his limited mobility following a number of falls which

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[2] *Read Codes are a coded thesaurus of clinical terms and have been used in the NHS since 1985. There are two versions: version 2 (v2) and version 3 (CTV3 or v3), they provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems across primary and secondary care e.g. General Practice surgeries and pathology reporting of results.*

had resulted in admission to hospital. Mr BB was receiving home care twice daily to assist with personal care and transfers. Shortly after Mr BB was re-admitted to NNUH on 06.09.12 after a further fall. He was subsequently discharged to a specialist community rehabilitation unit. This contributed to C contacting Social Care on 12.10.12, to explore whether some form of "Housing with Care" might be the best option taking account of Mrs BB's "mental state".

Memory Service Assessment of Mrs BB

4.5 A Primary Mental Health Practitioner (PMHP 1) carried out a home assessment on 16.10.12 which concluded that Mrs BB had a cognitive impairment. She was disorientated in time, and her ability to recall recent information was significantly impaired. Although she had some insight into her memory deficits, she did not appear to recognise how this impacted on her ability to complete everyday tasks safely. The outcome was that she would be tried out with medication. The result of the assessment was confirmed in a letter to the GP on 24.10.12 which also requested that an ECG be carried out.

Response to Referrals from the Family: November 2012 - January 2013

4.6 C rang NCC Customer Service on 06.11.12 to request a community care assessment in view of the dementia diagnosis, the imminent medication trial, and Mr BB no longer living at home. C referred to Mrs BB's fluctuating capacity, her struggle in maintaining her previous routines, and that she had previously wandered into town in the early hours of the morning leaving her front door open. The referral was passed to the Locality Social Care Team for allocation.[3]

4.7 12 days later on 18.11.12, Mrs BB's son (A) rang the GP surgery wanting to discuss Mrs BB's care but GP3 was unable to return the call because A's contact details were no longer on the patient notes.

4.8 On 30.11.12, Mrs BB was admitted to NNUH with a radial fracture of the wrist which required surgery following a fall. She was unable to recall the details, and the family explained about her worsening memory loss. She was discharged on 11.12.12 with a 6 week re-ablement package of home care provided by Norfolk First Support (NFS). [4][5]

4.9 On 13.12.12, A rang the NCC Customer Service Centre to raise concerns about Mrs BB's medication, and she had been outside in the cold. A then rang the GP surgery requesting a home visit as advised by NCC, and explained that Mrs BB was now a danger to herself because of severe memory loss, and wandering outside at night. GP3 visited Mrs BB at home the next day on 14.12.12 when A was present, and noted that her UTIs were frequent, she was experiencing low mood, was occasionally restless, and had wandered once while in hospital. GP3 recommenced the Citalopram, and contacted the Memory Team who confirmed that a visit to commence the dementia medication had been organised with the family for later in January.

4.10 On 03.01.13, a Social Care assessment was carried out by SW1 at the rehabilitation unit when both Mr and Mrs BB were present. This was focused mainly on Mr BB's needs, as Mrs BB declined an assessment in her own right.

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[3] *Separate social care assessments were now proceeding in parallel in respect of the 2 referrals made by G – one by SW1 from The Rehabilitation Unit (referral 12.10.12), and SW2 from the Southern Locality Team (referral 06.11.12).*

[4] *Norfolk First Support* provides intensive support for up to six weeks after service users return home from hospital and seek to help people regain confidence and skills to remain independent

4.11 Home Care Agency 1 picked up the home care service from NFS on 21.01.13, and commenced 2 x 15 minute calls a day – between 12.00 and 12.30 to assist with meal preparation, and between 18.00 and 19.00 for a medication prompt. This support was noted by the Memory Team Nurse (MTN1) who visited 2 days later to provide the initial 8 week supply of the dementia medication, Donepezil. Her next visit to review the trial was planned for 04.03.13.

4.12 On 23.01.13, SW2 carried out the assessment requested by C in early November, and concluded that the current package of home care was working well. Mrs BB agreed to consider attending a day centre once a week but was not interested in Housing with Care, or any respite care options.

4.13 On 05.04.13 MTN1 rang the Home Care Agency 1 office to see if they could offer any information on how best to catch Mrs BB at home as she had made 2 abortive visits in March to carry out a review - 1 notified by a letter sent direct to Mrs BB, and the other unannounced. Home Care Agency 1 explained that they were experiencing the same difficulty. Although MTN1 recorded the intention to send another appointment, there is no record that this was done.

4.14 Shortly after on 11.04.13, A advised NCC that he was now the main carer and contact person, because Mrs BB and C had fallen out. He had stopped the medication because he perceived that this was causing Mrs BB to become more aggressive. Once stopped, Mrs BB was said to be calmer and more sociable.

4.15 On 17.05.13, a trial visit to a local day centre was cut short because Mrs BB appeared disorientated having had no recollection of the arrangement to visit. The arrangement for a further visit was not kept, and A later explained that Mrs BB did not wish to attend as people did not talk to each other.

4.16 On 22.05.13, GP1 made a home visit at Mrs BB's request as she was becoming more stressed and missed her husband. GP1 prescribed Citalopram, referred her to a Specialist Nurse in the Frail Elderly Team, and left a message with the Memory Team requesting an update.

4.17 A week later on 29.05.13, GP3 had a telephone consultation with Mrs BB who had a UTI, and still feeling low but would be starting the recently delivered Citalopram. GP3 recorded the comment that Mrs BB was "to come in" [6] in 2 weeks time after bloods had been taken. [7] The surgery also left a message for an update from the Memory Team when MTN1 returned from annual leave.,

4.18 On 10.06.13, following internal discussion involving the Consultant in Old Age Psychiatry, the Memory Team made the decision to cease involvement due to Mrs BB's non-concordance with the medication trial, and that they had been unable to make contact with Mrs BB or her family, and sent a letter to the GP confirming this on 21.06.13.

4.19 GP3 next saw Mrs BB with A on 17.07.13 when he prescribed Simvastatin (a statin) following a diagnosis of pre-diabetes, and planned a medication review in 6 months time. This plan was noted by the Practice Nurse 2 weeks later on 29.07.13 when she reviewed the blood tests with Mrs BB and B, and provided advice on how her diet could be

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[6] *The GP records used the shorthand TCI*

[7] *These were subsequently taken on 07.06.13, and GP3 requested a further test and a letter was sent to Mrs BB on 13.06.13 to make another appointment. These were subsequently taken on 05.07.13.*

improved. The nurse recorded that this was a "difficult situation as Mrs BB has dementia, and at the moment living alone with some family back-up".[8]

Developments Leading to Arrangement of a Social Care Assessment October – December 2013

4.20 Over an 8 week period from the start of October, the Police were involved on the following 4 occasions – three times in response to calls made by Mrs BB, and one by Mr BB on her behalf.

- 01.10.13 during the night when her kitchen was flooding due to her ceiling leaking, and all appropriate emergency services were mobilised.

- 05.11.13 followed Mr BB's call that Mrs BB could not turn the water tap off. A police officer visited and found her safe but upset.

- 23.11.13 when Mrs BB rang to say she had heard someone at the door at 2am. The Police rang EDT who arranged a SWIFT visit who noted that Mrs BB had short term memory loss, and was very anxious living on her own. After speaking to A who described how Mrs BB's Alzheimer's was getting worse, and he was feeling exhausted because of his role as a carer, EDT sent a referral to the Social Care Centre of Expertise (SCCE) for the situation to be followed up. [9]

- 25.11.13 Mrs BB twice rang 999 to report a dripping tap but then put the phone down. Arrangements were made via the NCC Customer Service Centre for the Home Carers to check the situation later that day.

4.21 When SCCE rang A on 25.11.13 to follow up the EDT referral, he requested an assessment saying that Mrs BB had been telephoning him, and the Police, several times a day because she believed she had intruders, and he was finding it "draining" as he had a full time job. A stated that Mrs BB was independent in relation to her personal care, but refused to take her medication. He also shared that Mrs BB had nearly got run over about 4 weeks ago. In describing her as "very confused, upset and emotional", A said that Mrs BB had a previous history of mental illness which had included a year on a psychiatric ward. [10] A explained that he and his sister C had been thinking that Mrs BB should move into residential care, but at that moment, Mrs BB would refuse this.

4.22 The SCCE Practice Consultant (PC1) passed the case through to the Locality Team for an assessment of Mrs BB, a carer's assessment for A, and consideration of the possible need for an increased package of care and assistive technology to help reduce the risks. The Locality Practice Consultant decided that case should be allocated to an Assistant Practitioner 1 (AP1), and Business Support arranged an appointment via A for 11.12.13.

4.23 On 04.12.13, when attending for a flu jab, Mrs BB and C were informed that a blood test had been missed at the start of the year. C agreed to try and arrange for B to bring her when she would be visiting at Christmas. Mrs BB subsequently missed 2 appointments

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8 *The GP notes do not refer to any discussion of the memory issues, or low mood - the supply of Citalopram would have run out by the end of June.* .

9 *SCCE is the social work team which handles referrals passed through by the Council's Customer Service Centre.*

10 *Corroboration of this episode of mental illness, which involved an in-patent stay, was confirmed by D during the Author's discussion with D to gain her contribution to the Review.*

for these after reminder letters had been sent. A further letter was sent asking her to contact the surgery regarding a non urgent matter.

Developments following Cancellation of the Assessment Visit by the Family December 2013 – March 2014

4.24 On 10.12.13 A cancelled AP1's assessment visit scheduled for the following day because repairs were being carried out on Mrs BB's bungalow following the flood.

4.25 On 03.01.14 AP1 was informed that a neighbour had rung to express concerns about Mrs BB looking distracted, and having "glazed eyes" when he had spoken to her at Sainsburys. Mrs BB had said she was "not ok" and had been to the GP surgery. The neighbour first took her to the surgery, but then home when Mrs BB did not want to wait for the appointment. He then made another GP appointment for later that afternoon but got no response when he called for her. In response to this, AP1 contacted the GP surgery to check on her whereabouts, and then rang Mrs BB who said she gets "low" but was otherwise "ok". AP1 left a voicemail for A to contact him to re-arrange the assessment visit.

4.26 On 30.01.14, AP1 commenced a planned 6 week period of sick leave to undergo a minor operation – returning to work in mid March. [11]

Further Police Involvement – June 2014

4.27 On 11.06.14, 2 Police Community Support Officers (PCSO 1 and PCSO 2) came across Mrs BB around 16.30 appearing lost and confused, and they returned her home where she appeared more orientated. PCSO 1 rang A and established that he, and the Home Care Agency 1 carers, would be visiting later. A explained that Mrs BB had onset dementia, and that the GP and Social Care were aware, and she had paid carers. PCSO 1 updated the contact details for A and Home Care Agency 1 on the CAD system. [12]

Response to Referrals & Incidents: July – August 2014

4.28 On 15.07.14, B spoke with AP1 to request an assessment with a view to Mrs BB being admitted to join Mr BB in his residential care home initially, and then for them to move to a home near her in the south of England. B shared her perception that Mrs BB was not managing at home, could not turn the TV on some days, and was not eating and drinking properly despite carers calling twice daily. AP1 promised to look at the whole situation and get back to her. There is no record of any follow up, until B rang again a month later on 19.08.14 to chase up the assessment saying that Mrs BB was getting "progressively worse".

4.29 In the meantime, on 08.08.14, a review by AP2 of Mr BB's situation concluded that he continued to require residential care, and noted his wish to move into a residential care home near to B, preferable with Mrs BB. AP2 recorded that she would liaise with the allocated worker for Mrs BB (AP1) to explore this possibility but there is no record that this liaison took place.

4.30 On 27.08.14, AP1 carried out the assessment with A present, and recorded that Mrs BB walked to visit her husband daily, but there were concerns around her safety as she was getting lost, and asking strangers to give her a lift- on one occasion being charged £10. A had tried to devise a route for her but she could not retain the information. Mrs BB had

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[11] *There is no record of any further Social Care work on the case until July 2014.*

[12] *The Police Computer Aided Despatch System*

indicated that she was very lonely and wished to join her husband in a residential setting, but the family's attempts to organise a placement near B were proving unsuccessful. AP1 recorded the plan as *"services to continue, but with more support intended".*

4.31 10 days later, on 06.09.14, the police received a request for a welfare check from a member of the public who had returned Mrs BB home because she had said she was lost. The police noted that there had been a previous similar incident in June. PCSO 3 was despatched to visit but before she arrived, PCSO 2 phoned into control and said he knew Mrs BB, this was a regular occurrence, and that he had previously spoken to the social worker involved who had explained that they were waiting to get Mrs BB into a care home. This was then confirmed by A in a telephone call with PCSO 3 who remembered him sounding frustrated when stating that this was not happening quickly enough. A said that he would be visiting that evening.

4.32 On 19.09.14, AP1 wrote up his assessment which was then used to review the personal budget allocated to fund Mrs BB's care. [13] The revised calculation resulted in an increase in funding [14] which was authorised by the Practice Consultant (PC3). On 25.09.14, AP1 completed the Care and Support Plan, but although increased funding had been approved, no additional services were set up, nor a referral made to the Assistive Technology Team.

October - November 2014 - Further Incidents of Concern

4.33 Around the first half of November 2014, there were further reported incidents which were indicative of Mrs BB's deterioration in her memory:-

- On 3 occasions, the home carers discovered that Mrs BB had mislaid her keys, and on the second occasion, Mrs BB was locked in, and the carer had to climb in through the window as there was no key in the key safe.

- On 31.10.14 a neighbour contacted the Police to request a welfare check after a man brought Mrs BB home after finding her distressed in Sainsbury's because she thought she had lost her handbag. The neighbour explained that Mrs BB had often tried to get in her car, asking to be returned home even though she was already there. She also referred to an occasion when Mrs BB had said she has lost her umbrella when she was stood holding it. The Police received a corroborating call from the gentleman involved. A police officer subsequently spoke to Mrs BB and noted that "all was in order".

- On 14.11.14, AP1 was informed by the NCC Customer Service Centre that a member of the public had found Mrs BB 'wandering' in town and after establishing that Mrs BB wanted to visit her husband, had taken her to the home.

November 2014 - Response to Further Family Request for Residential Care

4.34 This last incident was referred to by B on 18.11.14 by B when she rang AP1 and said Mrs BB was "completely gone". B repeated her preference for her parents to be in a residential care home near her, and she had a list of homes who would take publicly funded people. AP1's response was that short term respite care could be provided, but

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13 *The personal budget questionnaire is entered into a software programme which produces a calculation based on the information about needs and risk factors. This is an indicative figure and managers have discretion to adjust this subject to the Council's scheme of delegation.*

14 *The increased budget would have been insufficient to fund residential care, but would have funded a substantial increase in the home-based level of support.*

that this could add to Mrs BB's confusion if there was then a further permanent move later. This was acknowledged by B.

4.35 During the conversation, B is said to have dismissed other options suggested by AP1 - assistive technology, a Personal Assistant to help Mrs BB to travel to the residential home, or the use of taxis. Sheltered housing was viewed as too expensive and would not stop Mrs BB from wandering. AP1 suggested that B contact the GP to review the medication and issues around her cognition. B explained that the family had taken her off some medication because Mrs BB had previously said "she would take the lot".

4.36 AP1 later discussed Mrs BB's deteriorating mental health with PC3 who explained her decision that as Mrs BB was currently only receiving a low level of home care, a move to residential care could not be considered at that stage, and that there were other measures of care which could be put in place to keep Mrs BB safe – primarily those already discussed with, but rejected by B.

4.37 Following this discussion, AP1 sent an email to PC3 which, whilst acknowledging that Mrs BB appeared not to meet the criteria for residential care, expressed his concern that a more robust care package might not fully meet her needs because of the safety concerns arising from the increased number of times she was getting lost and found wandering around town. He posed the question whether a reassessment and mental capacity assessment should be carried out. PC3 sent an email reply confirming that she would allocate a social worker to carry out a MCA, but re-iterated the decisions given earlier, and included the point that AP1 had been scheduled to visit Mrs BB on 11.12.13 due to the concerns around wandering, but the review and PBQ had not been completed until September 2014. Therefore, a more robust care package should have been in months ago as requested.

4.38 On 20.11.14, AP1 returned a call from the manager of the residential care home (RHM) where Mr BB was living. RHM shared her concerns that Mrs BB appeared to be experiencing increasing levels of confusion, and might be vulnerable as she often arrived with strangers who she had asked for a lift. RHM had seen Mrs BB standing in the road, flagging down strangers to transport her home. RHM also informed AP1 that although Mr BB was willing to move nearer B if that was what the family wanted, Mrs BB had said she did not want to go with him.

Mental Capacity Assessment - November 2014

4.39 On 25.11.14 Social Worker 3 (SW3) was asked to carry out the MCA assessment and to work alongside AP1 who would remain the allocated worker. SW3 had a detailed discussion with AP1 the next day to prepare. During this, AP1 shared his observation that A appeared to be quite negative towards Social Care due to previous issues over Mr BB's financial affairs. They discussed the options for increasing support, which might include a personal assistant, or day activities to give Mrs BB more purpose and activity to reduce some of the risks. It was agreed that AP1 would make a referral to the Assistive Technology Team, but that any equipment would need to be "tamper proof" as Mrs BB turned off the electric sockets, and disconnected the telephone at night. It was also noted that if Mr and Mrs BB were to be accommodated together it would be beneficial for them to have some time apart because of the tensions arising from Mrs BB blaming Mr BB for her situation because of his mismanagement of their finances.

4.40 On 27.11.14, SW3 visited Mrs BB and B to carry out the MCA. SW3 recorded that B raised the following concerns:-

- when Mrs BB leaves the house, she becomes disorientated and gets lost. She is also vulnerable through asking strangers for lifts.

- **e**vening and nights are the biggest concern, because she was wandering out of the home during the evenings, and once was out for a number of hours when it was dark. Mrs BB also disconnected the telephone at night.

- Mrs BB often spoke about being lonely, and given Mrs BB was leaving her home on several occasions during the day, it was questionable whether she felt settled in her home where she would be alone apart from the twice daily visits from her carers.

- Mrs BB was unable to rotate foods in the fridge, and at times ate foods which were off. Mrs BB liked soups but this was becoming difficult because she was unable to use a can opener.

4.41 Mrs BB appeared subdued and disengaged during most of the conversations with her, and either did not respond to questions or said she could not remember. B described how Mrs BB seemed to be thinking a lot and was often observed smiling to her as if she had thought of something funny. Mrs BB was pre-occupied in repeatedly checking the money in her purse during the hour's visit which B said had become a habit.

4.42 SW3 and B discussed the possible service options to address the risks. These included assistive technology with the provision of a tracking device (Buddi system), and pressure mats to alert the family if Mrs BB left the property, and to check if she was restless at night. They also discussed support to take Mrs BB to see Mr BB for lunch as this was her regular routine, and mention was also made of increasing the support to cover the evenings as this was the time of day when Mrs BB was at the greatest risk. Day centres were dismissed as an option by B as Mrs BB was not really into social groups. SW3 noted that B would ideally prefer Mr and Mrs BB to be placed near her where they would have greater support.

4.43 SW3 followed this visit up by ringing RHM on 01.12.14 which identified additional risks as Mrs BB was often arriving inappropriately dressed for the weather conditions, and on one occasion had arrived soaked as she had not been able to open her umbrella. RHM also highlighted the road safety risks with Mrs BB having been observed in the middle of the road. Mrs BB's pattern of visiting was very variable sometimes visiting every day but at different times, but then not visiting for several days. They agreed that this ad hoc pattern would make it difficult to set up services.

Implementation of Revised Care Plan - **December 2014**

4.44 Following the assessment, SW3 drew up a revised care plan and arranged an additional 2 hours support each day from Home Care Agency 1 to start on 08.12.14 to escort Mrs BB to and from the residential home at lunchtimes – describing this as the time of greatest risk. Her instructions to the agency was to report all missed calls to Social Care so that a clear account could be obtained of Mrs BB's routine, and her whereabouts. If Mrs BB did not want to visit, a meal should be provided, and they should take her out to social events or for a drive.

4.45 A referral to the Assistive Technology Team was made by AP1 on 01.12.14 for a Buddi tracking device. In a subsequent telephone call about the problem the team was experiencing in contacting A to arrange the visit, it was acknowledged that charging the system could be a problem as Mrs BB pulled out all the plugs and telephone at night.

4.46 On 04.12.14, when Mrs BB attended with C for a flu vaccination, they were reminded about the missed blood tests at the beginning of the year. C stated that she would see if B could bring Mrs BB during her visit before Christmas. [15]

Assistive Technology Assessment

4.47 On 11.12.14 the Assistive Technology assessment was carried out with A present. Although the family's concerns were discussed that Mrs BB may wander and get lost, and the Police had picked her up twice, the outcome was that no equipment was to be provided because the family were unable to monitor a Buddi device, and as Mrs BB lived alone, and had memory problems, it would not be appropriate to provide one. Social Care was not informed of this outcome.

Concerns raised by the Residential Care Home

4.48 On 15.12.14, a senior care staff member at the residential home (RHSC) rang SW3 to report concerns about Mrs BB's home conditions which she noticed recently after taking Mrs BB home. These included the bedroom lights not working, the toilet being blocked, some faeces in the sink, and soiled pads on the floor. SW3 agreed to RHSC's request to tidy the house because the latter had a good relationship with Mrs BB.

4.49 RHSC also reported that the additional home carer service was not always working because sometimes Mrs BB would still make her own way there and often arrived "freezing cold" due to the weather. Sometimes the carer arrived late to take her home, and Mrs BB was then tempted to walk back alone. SW3 recorded that a period of respite care might be needed to ensure Mrs BB's safety.

Updated Risk Assessment and "Best Interests" Decision

4.50 On 16.12.14 SW3 visited the residential home to seek Mr BB's views about the future, and had the opportunity to see Mr and Mrs BB together. They were agitated and frustrated with each other over Mrs BB's inability to use the television. Mr BB explained that Mrs BB was often cross with him, but he felt a move to a home near B would be the best option as he did not want to be apart from her for too long. SW3 took Mrs BB home and helped with the TV.

4.51 SW3 updated the risk section of the assessment form, and recorded that Mrs BB appeared unsettled and distressed, and that concerns hade been raised by all professionals and friends about her ability to remain at home safely. Specific risks listed were:-

- poor appetite, and snacking on chocolates, which has contributed to a significant loss of weight and dropping down a few clothes sizes;

- leaving the property numerous times during the day to either visit Mr BB or wander around the town, which is adding to her weight loss;

- the risk of getting lost – on occasions she has not known where her house is, and has asked strangers for a lift to the residential home;

[15] *There is no record that any appointment or reminder letters were sent out following this visit*

- safety when crossing the road as she appears to be disorientated;

- risk of hypothermia through leaving the home inappropriately dressed;

- Mrs BB's speaking about being frightened at night times and feeling lonely. She has very little contact apart from when she goes out into town which may be why she is leaving her home so frequently;

- risk of falling due to her weight loss and disorientation;

- personal hygiene is at risk because Mrs BB is struggling to manage her stoma bag safely and faeces have been seen around the home;

- risks arising from disconnecting the telephone at night which makes her non-contactable;

- disengagement with the carers, often not accepting their support.

4.52 SW3 recorded that the increased daily support was not preventing the above risks, and Mrs BB continued to leave her property even after carers had completed the escort task, and had been out at numerous times during the night time, and due to the colder weather and darker evenings, the risks posed to her had increased**.** Assistive technology had been looked into but there was a wait for the Buddi system due to Mrs BB turning off the electricity at night times. Therefore her whereabouts at night would not be known.

Best Interests Decision

4.53 SW3 recorded that it appeared to be in Mrs BB's best interests to be accommodated in a dementia home, ideally with Mr BB, close to B who could provide frequent support, which would include enabling her to continue her enjoyment of walking. SW3 recorded that such a move was likely to result in Mrs BB being deprived of her liberty, but that Mrs BB lacked the mental capacity in relation to her care needs and safety, and was likely to abscond from a residential home if it was not secure. In the interim, to keep Mrs BB safe while the residential placement was being arranged, day sits should be implemented to ensure her safety. Respite care was to be considered if the risks increased. SW3 recorded that Mrs BB was unable to comment on this plan, but when asked if she liked being at home, she had replied "no" very confidently.

Implementation of Increased Home Care Support

4.54 SW3 spoke to a co-ordinator at Home Care Agency 1 on 17.12.14 who did not think that day sits would be beneficial as the current carers were chasing after Mrs BB all day, and that spreading the calls across the day would be the best option. SW3 countered this by highlighting the problem that if Mrs BB was out when the carers called, she would not be supported and would therefore remain at risk of wandering. The agency stated that they would be unable to provide the day sits over the weekend.

4.55 SW3 then spoke with A2M, the manager of Home Care Agency 2, who agreed that they could cover the hours, and that an added advantage would be that this would add to the ongoing assessment through getting to know Mrs BB and her behaviours. SW3 immediately informed the Care Arranging Team so they could formally commission the care package of 9 hours a day between 09.00 and 18.00 to start the following day on 18.12.14.

4.56 A2M provided the service personally up to Christmas, and found that Mrs BB's memory was deteriorating, she was not taking her medication, and was placing herself at risk when she was out in the local community. He changed the start time to 08.00 when it was still dark, as Mrs BB had sometimes gone out before the he arrived.

4.57 On 19.12.14, A2M completed the standard initial assessment form and care plan, and gave a rating of "mild" in relation to the risks of:-

- unintentional risk to physical safety
- risk from others (abuse / exploitation)
- risk to others (anti-social behaviour)
- minor disabling or distressing problems with thinking, feeling or behaviour

A2M provided some immediate feedback to SW3 that Mrs BB was very active, but he was able to keep her safe.

4.58 Between 23.12.14 and 30.12.14, Mrs BB stayed with B.

4.59 Between 03.01.15 and 13.01.15, the service was provided by one of the agency's home carers (A2C). The daily reports provided a mixed picture of Mrs BB's mood and behaviour. These referred to Mrs BB sometimes being distressed and anxious. Often this was when she had decided that she wanted to visit Mr BB, but at other times she appeared to enjoy these visits. She was always calm however, and more engaged, when they had a drive out, and particularly enjoyed the visits to the area where she grew up. A recurring feature was Mrs BB making impulse decisions to go out for a walk several times a day. Whatever the recorded behaviour during the day, the daily record sheets frequently ended with the observation "No issues today".

The Search for a Residential Home Placement

4.60 On 05.01.15, SW3 contacted the commissioning team in B's local authority area who agreed to provide a list of residential homes, and get their placement officers to ring.

4.61 On 14.01.15, SW3 met with Mr BB to seek his views about the possible options - placement together either in a local home or near B, or for Mr BB to remain where he was and a separate local placement for Mrs BB. Mr BB's preference, if he was going to move anywhere, was to move near B so she could support him, and take him out, as he felt isolated since A did not visit anymore as they had fallen out. He also stated that Mrs BB was often rude to him. During this visit SW3 observed Mrs BB looking well, and happy, sitting with A2C waiting for lunch. A2C said that Mrs BB was keeping him busy.

4.62 Later, SW3 rang B who still preferred the option of a home near her, and that she would have nowhere to stay if Mrs BB was in permanent care in Norfolk. SW3 provided details of a residential home near B which may have vacancies, and also vacancies in Norfolk. B commented that Mrs BB was enjoying the care agency support, and the trips out. They exchanged further emails the following day on 15.01.15, SW3 discussing homes near to B, including one with vacancies. B confirmed she would be viewing one the next day and making appointments to view the others. SW3 offered to make contact with any home B liked to provide details of the couple's needs.

Increase in Mrs BB's Agitated Behaviour

4.63 Between 14.01.15 and 18.01.15, the records made each day by the home carer, A2C, indicated that Mrs BB was becoming more agitated and restless:-

- 14.01.15, Mrs BB was a "bit high" that morning and they walked twice to the residential home without going in, but then walked back for lunch. Immediately on returning home, Mrs BB wanted to go shopping, and then see Mr BB again.

- 15.01.15 A2C informed A2M that Mrs BB had been very high today and had been verbally aggressive towards Mr BB during her several visits to the care home and he had ended up in tears. She also swore at staff several times. Mrs BB settled down at home at 16.30 after another long walk. A2C recorded *"No issues today - used F word several times today"*.

- 16.01.15, Mrs BB had visited Mr BB 4 times. During one walk, Mrs BB became verbally aggressive towards A2C, and a female member of the public who saw this, and not knowing the situation, tried to intervene and lead Mrs BB away because she thought A2C was posing a risk to Mrs BB. A passing member of the residential care home explained the situation to the lady and A2C's role. Mrs BB was said to have settled at home at 16.00.

- 17.01.15 Mrs BB had been "harsh" towards her husband, but later enjoyed the drive out and was chatty. On return home, she was very calm and did not want to see Mr BB in the afternoon.

- 18.01.15, Mrs BB's use of the F word has got worse every day, both to him and Mr BB, but appeared to like the long drives and is calm during these.

Mrs BB's Evening Visit to the Residential Home 18.01.15

4.64 That evening, Mrs BB arrived at the residential home after 18.00. She was verbally and physically aggressive - hitting staff and screaming "f… off" at the top of her voice. After staff had tried to calm Mrs BB down without success, RCM was contacted at home who advised staff to call the Police for assistance, partly because of the potential risks to residents, but also Mrs BB knew the key code, and as she could move fast, she could potentially leave the home in a distressed state and not be safe.

4.65 The Police checked the crime intelligence system where Mrs BB was only known due to being a victim of theft in 2011. Police officer 2 (PO2) visited and found that Mrs BB was slightly aggressive and was having to be restrained by staff because she was trying to let herself out of the building. PO2 tried to engage with Mrs BB but this was difficult, and she continued to swear and told him to "F… off" several times. After getting her to calm down, PO2 contacted B who said that A and C were coming to collect Mrs BB. PO2 continued to talk to Mrs BB and formed the opinion that she was very confused and not in a fit mental state to be residing alone overnight.

4.66 When A and C arrived, A was initially quite abrupt towards PO2 and staff expressing his dislike that PO2 was there, However, A apologised when PO2 explained the circumstances. PO2 discussed the care arrangements with A, who said that would be taking her home to her house. A explained that Mrs BB had a day time carer but was alone overnight. A also explained that he was trying to get her into a care home but there were issues with Social Care and finances. PO2 reported back to the Control Room that the situation was under control, no assaults had occurred and staff had merely been following protocol.

4.67 On 19.01.15, A2C found a note left by the family about the previous evening's incident, and informed A2M who left a voicemail message for SW3. A2C recorded that day that Mrs BB was calm in the morning, and during a drive to Great Yarmouth. They visited Mr BB at 16.00 and returned home at 16.50.

4.68 On the same day, B updated SW3 by email that the home she had viewed was too far away, and did not feel Mrs BB would be happy there. B referred to the previous evening's incident when the Police were called. Mrs BB had left the house as soon as the carer had left, and did not lock the house. B's view was that the situation was very critical now so it would probably be best for Mrs BB to stay in Norfolk as this may make it quicker to "get things sorted". SW3 provided information about a home where Mrs BB could be placed quickly. B said that C was going to view another Norfolk care home the following day and would let SW3 know how they get on.

Sequence of Events – 20th January 2015

4.69 A2C recorded that on arrival, Mrs BB was standing on a small table at the open window – possibly attempting to climb out. A2C helped Mrs BB down, secured the window, and located the door keys. Mrs BB was restless, and after making an early visit to Mr BB at 09.15, she refused to go home and roamed the streets. Mrs BB had lunch with Mr BB and then went to a coffee shop for a second time who refused to serve her.

4.70 Around 12.30, A2C rang A2M to explain his concern that Mrs BB was more agitated and confused than normal. A2M could hear Mrs BB shouting in the background and he asked A2C to calm her down and call back. A2M rang SW3, but had to leave a voicemail to explain the situation and request her to call back. [16] Around 15.00, in a further telephone call with A2M, A2C described how Mrs BB was being verbally aggressive, and had left a shop without paying. A2M requested A2C to request a GP home visit to rule out the possibility of a urine infection.

4.71 Around 15.15, A2C rang the surgery to request a home visit and accepted the offer of a surgery appointment for 16.50 with GP2. He also booked an appointment for the following morning in case he was unable to get Mrs BB there that afternoon. A2C informed A2M of the appointment arrangements. A2C drove Mrs BB to the surgery having persuaded her to go to surgery by telling her that A was waiting for her there.

GP Consultation

Explanatory Note

In addition to the agency records, the Review has had access to the official police statements taken during their investigation, and noted that there are some significant variations between the accounts given by GP2 and A2C. It is not the role of the Review to seek to reconcile these differences, and therefore the Review Team decided that for completeness, the most appropriate way forward was to include a summary of both accounts. This is achieved by using the account set out in GP2's statement provided to the Police, [17] and the GP's clinical record for Mrs BB, but with further explanatory comments at those points in the story where A2C's account is different.

The analysis later in the report will include more information from GP2's statement on his assessment and rationale for his approach and decisions.

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[16] *In her police statement, SW3 states that she did not listen to her messages until the following morning 21.01.15 because she had been in a team meeting.*

[17] *GP2's signed statement provided to the Police dated 03.02.15.*

GP2's Account

4.72 As per GP2's statement, GP2 had access to the following entry made in Mrs BB's clinical notes note by the receptionist who booked the appointment:-

"Carer called this afternoon to ask if a GP could go out to visit the patient – explained that patient is "hyper" - keeps going out for long hikes for several hours at a time - goes to cafes in town and just walks out without paying – whilst carer with her uses 'F' word practically every other sentence. Carer very concerned for her welfare - agreed to bring her in to see a GP – booked with GP2 this afternoon".

4.73 A2C explained to GP2 that Mrs BB had been unusually agitated and aggressive, had been swearing frequently, and was confrontational. A2C also referred to the evening visit to the residential home. [18] Mrs BB was defensive with GP2 and denied any health concerns, urinary symptoms or pain. Mrs BB was angry at having been brought to surgery, having been led to believe by A2C that they were going for a drive.

4.74 Mrs BB allowed GP2 to check her temperature and her pulse rate was normal, but she did not allow the pulse oximeter to stay on her finger long enough to record the oxygen saturation. At this point, she stood up and started pacing in the corner. She told A2C to "f… off" and lightly punched him. A2C managed to calm her down slightly, but she was keen to leave the consulting room. A2C stood in her way to prevent this while they decided what to do. [19]

4.75 GP2 discussed with A2C that as Mrs BB was acutely confused and agitated, she was not safe to be at home alone, and therefore they agreed that A2C would take her to A&E at NNUH which was a place of safety where she could be assessed and treated appropriately. It was also agreed that A2C would inform A.

A2C's Account [20]

4.76 In his police statement, [21] A2C said that Mrs BB did not want to be in the consulting room and tried to leave on 3 or 4 occasions. GP2 made a quick medical assessment, and told A2C that Mrs BB may have a UTI, but that due to her aggressive nature, and GP2's opinion that it would be difficult to get a urine sample from her, Mrs BB should be taken to A&E to assess her. GP2 did not feel it was urgent enough to request an ambulance but that she could be taken there by carers or the family. [22] GP2 did not give a time by

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[18] *This was the 18.01.15 incident but GP2's statement refers to this having been the previous evening.*

[19] *During the course of the Review, GP2 provided additional observations that when A2C stood in her way to block her exit, she swore and lightly punched him in the abdomen. A2C appeared reasonably relaxed and friendly and when she "punched" him - it was not aggressive, it was done gently and possibly to move him out of the way. Mrs BB did not appear to be angry with him. She was trying to get past him but was unable to. She then sat down again and A2C stood by the door for the rest of the consultation.*

[20] *A2C's account is based on 3 police documents – A2C's signed statement 09.10.15, his initial unsigned statement taken on 26.01.15, and the witness statement made by PC3 who interviewed A2C on the morning of 21.01.15. This initial account by A2C was given without his being aware that Mrs BB's body had been found.*

[21] *A2C's signed statement 09.10.15.*

[22] *GP2's signed statement provided to the Police dated 03.02.15.*

which this had to be done. [23] A2C told GP2 that he could not take Mrs BB in the agitated state she was in, and GP2 said to ring family members to see if they could help. [24]

Record of the Consultation

4.77 GP2 made the following note of the consultation

"Problem: *(D) Restlessness and agitation (First).*

History: *Cause not clear / swearing / agitated*
Carer clearly concerned for several days
Wandering last night
Difficult to get a history

Examination: *T36.4 P80 Denies pain / urinary symptoms*

Comment: *Carer will take to AE as a place of safety for assessment / will contact A"*
Thank you"

4.78 GP2 printed this entry off, along with the previous three entries from the notes and her medication / allergies / active and significant past problems (including Unspecified dementia), and put these in a sealed envelope for A2C to give to A&E.

Events following the GP Consultation

Explanatory Note

The following is based on the statements given to the Police by A2C, A2M and C.

4.79 After leaving the surgery, A2C tried to ring A but could not get a reply, so then rang C to see if she could help take Mrs BB to A&E, but C said that she was not available that evening, and would be out first thing the next morning but would call when she was available.

4.80 At 17.30, A2C rang A2M and told him that because of Mrs BB's agitation, the GP had been unable to obtain a urine sample and had advised A2C to take her to A&E to have a test to rule out any infection. A2C said that Mrs BB did not want to go to hospital and had told him to "f… off", and was becoming more upset. A2C also informed A2M that the family would not be able to assist until the following day. [25] A2M could hear Mrs BB shouting in the background and advised A2C to take Mrs BB home, prepare a meal and offer support to attend A& E once she was more settled.

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[23] *PC3's witness statement of her notes of the initial interview with A2C on 21.01.15*

[24] *According to PC3's witness statement, A2C stated that he did not believe that he had the authority or suitability to transport Mrs BB on her own, so he made contact with C, and it was arranged that they would take her to A&E the following day.*

[25] *In his police statement, A2M said that he assumed that A2C had driven Mrs BB to surgery but could not get into the car to go to A&E.*

4.81 Having done this, A2C rang A2M to say that Mrs BB was more settled. On hearing this update, A2M said that he would visit the next day, and take a urine sample to the GP surgery if A2C was unable to get her to A&E. [26]

4.82 A2C then made the following note about the consultation and eventual outcome:-

"A doctor's appointment was made for today at 4.50pm. Went to the Doctors and he suggested that we go to the A&E. Spoke to my manager who said he will bring a urine bottle tomorrow and take a sample. Also informed C who agreed that she stays overnight till tomorrow. Most of the decisions will be seen tomorrow."

4.83 While A2C wrote up his notes, Mrs BB closed the blinds and curtains, and was watching TV. A2C left at 18.00 and followed his normal procedure where he and Mrs BB "high-fived" each other and he waited for her to lock the door. A2C then waited in the car outside for 10 to 15 minutes to make sure she had settled and was not leaving the house.

21st January 2015

4.84 The following morning on 21.01.15, when Mrs BB was not at home, A2C walked to the residential home and when he discovered she was not there, rang A2M who asked him to check some of Mrs BB's other usual routes including Sainsburys. When A2C reported back there was no sign of her, A2M said he would inform SW3, and told A2C to remain at the house.

4.85 A2M rang SW3 to inform her of developments, and the GP consultation the previous day, and explained that due to her distress, he and A2C had felt it would be better to take her to A&E the next day.

4.86 At 11.30, 2 PCSOs called at the house, and A2C explained the situation.

4.87 Meanwhile, that morning at the GP surgery, a GP receptionist had asked GP2 if Mrs BB still required a visit because, unbeknown to GP2, her name had put on the visit list the previous day. Having checked the NNUH hospital system and found no record of any investigations or that Mrs BB having been admitted, GP2 confirmed that Mrs BB should be telephoned and if she was still at home, a visit was required. He then added the following additional comments into the clinical notes:- [27]

Examination: Swearing and lashing out at carer
Only allowed very limited examination
Distressed at having been brought to surgery.

Comment: Not safe to be at home alone.

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[26] *A2M said in his police statement that he did not know that GP2 had said that it was not safe for Mrs BB to be left alone, or that she had to go to hospital that night. If he had known that, he would have made arrangements for staff to have stayed, and he would have contacted Social Care. Cost would not have been an issue because there have been other cases where the agency has been able to claim money back from Social Care later. A2M said that he was not aware that the family were available that night because A2C had said they were not.*

[27] *GP2's statement explains that he thought that Mrs BB's GP, GP3, would likely want to see her that day and therefore the additional entry was to add detail and clarify his thinking, and make it clear that a visit was needed.*

4.88 GP2 later discovered when allocating the visits for the day [28] that GP3 was not in surgery and therefore he decided to visit Mrs BB himself. He tried ringing her several times without reply, and also tried to ring A 3 times which went straight to voicemail. GP2 visited the home at 12.30 and found A2C there. When GP2 asked if A2C had taken Mrs BB to A&E, A2C explained that he had spoken to his manager A2M the previous evening and had made a decision that he, A2M, would take her to A&E the following day. A2C informed GP2 that Mrs BB was missing and had not been at home when he arrived, and he had informed the police and C. GP2 asked A2C to contact the surgery when she was found. A2C said that he prayed that she would be found safe.

4.89 The body of Mrs BB was found lying in a ditch by the side of the road by a member of the public at 10.35 am. The location was about 400 yards beyond the residential home but not a road which formed one of her regular routes to the home.

4.90 At 14.00, after Mrs BB's body had been found, A2C attended the police station at the request of the Police with the care folder so that officers could view any relevant information to complete the sudden death report. A2C provided a brief history and account of recent events and was then informed that her body had been found. [29]

4.91 A2C then contacted the surgery around 15.00 and informed GP2 that Mrs BB's body had been found. GP2 discussed the situation with GP4, who was the Practice safeguarding lead, who advised GP2 to discuss what had happened with the Adult Safeguarding Team in the Clinical Commissioning Group which he did before afternoon surgery. He explained the sequence of events and his concern that Mrs BB had not been taken to hospital the previous day.

4.92 The post mortem recorded the cause of death as hypothermia and dementia.

PART 3 ANALYSIS OF AGENCY INVOLVEMENT

5. INTRODUCTION

5.1 The picture from the preceding narrative is one of agencies, on the whole, working in isolation. Therefore the most effective way of presenting most of the analysis of the key events is to consider in turn each agency's involvement, which helps to draw out the reasons why this occurred.

5.2 The analysis of individual agency's involvement is then followed by a separate section which covers developments during the final week preceding Mrs BB's death where there was multi agency involvement.

5.3 First, however, in order to ensure that Mrs BB remains at the centre of this SAR, the analysis begins with a short profile based on information provided by her family. The insights about her life, interests, personality, and values provide invaluable insights to help understand her behaviours and response to agencies who were seeking to support her.

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[28] *The surgery usually allocate the visits around 11.00 each morning.*

[29] *PC3 put in her witness statement of 21.01.15 that A2C seemed "genuinely shocked".*

Profile of Mrs BB

5.4 Mrs BB was born within the county and met her husband at a local beauty contest. Mr BB hailed from London and was a long distance lorry driver. The couple had 4 children – 3 daughters A C and D, and a son B. Mrs BB was a full time mother and never worked The family moved house very frequently which was said to be at Mrs BB's instigation, and she enjoyed furnishing the latest home.

5.5 Her relationship with her husband was clearly important to her as seen by the pattern of regular visits. Residential staff noted that Mrs BB generally had a good relationship with her husband although it fluctuated according to her mood. It was only in the last few months that this changed dramatically when she quickly became frustrated with him, and as she became more dis-inhibited, she became more abusive and negative.

5.6 The children and grand-children were also very important to Mrs BB. Professionals commented on how much she enjoyed the visits to stay with B, and appearing sad if A did not come to see her with whom she was said to have a very close relationship.

Personality

5.7 The descriptions from the 2 daughters who contributed to this Review provided some quite contrasting aspects to Mrs BB's personality and lifestyle. On the one hand, she was said to be quite a "bubbly" person, and in her younger life, loved getting dressed up and going out, and enjoyed shopping in Norwich.

5.8 On the other hand, she was said to be a very private and independent lady, who was not a sociable person by nature, and shunned large groups. Although she would chat to strangers, she never had many friends after the family moved the first time. Mrs BB did not like people in her house, and was reluctant to have carers - sometimes cancelling her husband's carers as she did not like them interfering, and she rarely spoke, or interacted with her own carers. There was one perception that Mrs BB lacked confidence and may have felt inferior at times.

Health Issues

5.9 Mrs BB took great pride in her appearance and had high standards of personal care, and although she did not like having the colostomy bag, managed this well. She maintained these high standards until the latter stages of her dementia.

5.10 According to information provided by some members of the family, Mrs BB experienced some mental health issues during her life which manifested itself through periods of manic type behaviour – alternating with low moods when she did not do any cooking or housework. According to the family, this resulted in one in-patient stay once in a psychiatric hospital. Later, Mrs BB found it hard to cope with her husband's ill health and limited mobility, and sought help from her GPs because she was feeling tired and stressed.

Impact of the Onset of Dementia

5.11 The first references to Mrs BB's deteriorating memory were in 2012, and Mrs BB expressed her dread of developing dementia like her sister. She struggled to maintain her previous routines.

5.12 Mrs BB continued to display her independence, and was not very receptive to the home care provided and, often being out when the carers called. Carers found Mrs BB to be very strong willed, impetuous and unpredictable in her behaviour. This made it very

challenging in trying to negotiate with her. Mrs BB appeared to have little insight into the risks when she was outside of the home, and generally did not engage in the discussions with social workers and carers around these. She appeared to resent the close supervision when the carer from Home Care Agency 2 was shadowing her outside of the home. However, although frequently trying to "lose him", and being abusive when out walking, her demeanour changed towards him was very different when he took her out for drives out, and appeared happy, relaxed and more chatty than usual, particularly when revisiting places where she grew up.

6. PRIMARY CARE INVOLVEMENT

6.1 The Practice has a number of GPs who each had on average of 1800 patients on their list at that time. They are supported by a range of Practice Nurses. Whenever possible, the practice organises appointments and visits to maintain GP continuity with patients, but there are unavoidable occasions when this cannot be achieved. In Mrs BB's case, GP3, her named GP, had the most contact but 3 other GPs had some occasional involvement.

6.2 Analysis of the GP records reveal that although at times there was frequent and purposeful engagement with GP services, there were several periods when there was a substantial interval between the appointments where Mrs BB was seen:-

February to July 2012:	5 month interval
December 2012 to May 2013:	5 month interval
August 2013 to December 2013:	4 month interval
December 2013 to December 2014:	12 month interval

These intervals reflect the fact that to an extent, GP involvement is dependent on their being alerted to a problem or appointments being booked by the patient or their family.

Assessment of emerging memory issues and referral for specialist assessment

6.3 There was prompt assessment in 2012 of Mrs BB's developing memory problems by 3 GPs, including her named GP, which resulted in the referral for a specialist assessment by the Memory Service, and pro-active efforts twice in May 2013 to try and secure a progress update.

6.4 That was at the point that Mrs BB was seen twice in relation to her low mood where the outcome was medication being prescribed, and referral to the specialist nurse in the Frail Elderly Team. Although the GP recorded a plan to review in 3 weeks, this did not happen because an appointment was not arranged by the family. The Review heard that in situations such as this where the issue is seen as a low concern, it is left with the patient and family to decide if they want to take up the suggestion of the follow up appointment. In situations where the GP views the situation as more serious, the GP will ensure a date is set at the time for the follow up appointment.

6.5 When Mrs BB was next seen by GP3 in mid July with A, the notes only refer to the discussion of the diagnosis of pre-diabetes, and therefore it is not known if Mrs BB's previous low mood,[30]or memory issues were covered in the consultation. By that point, GP3 would have received the Memory Team's letter, and it would have been an opportunity to review the situation given that the situation had changed with the withdrawal of the specialist service, and to follow up the findings from GP1's consultation on 22.05.13. That consultation had referred to Mrs BB being depressed and lonely, but she had not been taking the Citalopram which GP1 had then restarted. However as Mrs

[30] *the initial month's supply of the Citalopram would have run out by the end of June*

BB was seen with A at the July appointment, there would have been the opportunity for A to have raised any concerns.

6.6 The Review was conscious that the 10 minutes allocated for each GP consultation poses real challenges because of the limited time this provides for issues to be explored with patients, and to record the outcome.

6.7 When Mrs BB was seen with B on 29.07.13 by the Practice Nurse to review the diabetes blood tests, appropriate dietary and shopping advice was given. Although she noted that this was a "difficult situation", with Mrs BB having dementia, living alone with some family back-up, these observations were not sufficiently concerning for her to raise these with GP3. The 6 month review date planned was in line with the usual time periods for reviewing conditions such as pre-diabetes.

6.8 There was no further Primary Care involvement until December 2013 when Mrs BB attended for her flu jab, accompanied by C. They were reminded of the need to re-arrange the blood test which had been missed at the beginning of the year, but despite this, and 3 subsequent letters sent on 18.12.13, 08.01.14, and 22.01.14, Mrs BB and C did not make an appointment.

6.9 After that, a year elapsed before Mrs BB was next seen in December 2014 when she attended for her seasonal flu jab. There would normally have been the "safety net" of an annual dementia review and this was the intention when GP3 recorded Mrs BB's diagnosis on the electronic patient record in September 2012. When GP1 carried out his home visit on 22.05.13, GP1 also recorded this as a Dementia Review. Therefore a further review should have been held in May 2014, but this did not take place, because the code used to enter the diagnosis, "unspecified dementia", was not picked up when the routine search was carried out to compile the list of reviews due. The problems in relation to IT systems and coding have been an issue nationwide, but are improving as a result of further development work.

Communication Issues

6.10 The missed blood test appointments referred to in paragraph 6.8, highlight an important issue as to how the GP Practice communicates information about appointments to patients with dementia, and the benefit of keeping a member of the family in the information loop. Letters, and reminders, were sent direct to Mrs BB, and as a result the potential for appointments not being made, and DNAs, were increased for the following reasons.

6.11 First, Mrs BB may not have read, or absorbed the contents, if she was not functioning well at that point they arrived. The same comment applies in relation to the use of the automated telephone reminder service. Second, even if she did ring at the time to make the appointment, there was the potential for her to forget about the appointment because of her memory difficulties. Third, to maintain confidentiality should the letter be read by someone else, follow up letters after a DNA are written in non specific terms asking her to contact the surgery to discuss a non urgent matter. Therefore the importance of getting in touch might not be immediately apparent. In addition, the Review Team acknowledged that it is possible that at times Mrs BB might not have wanted to attend appointments because of her fear that she would end up like her sister who had dementia.

6.12 Although, on most occasions, a member of the family would have been aware of the need to make follow up appointments through being with Mrs BB at consultations, they may not have been aware of the reminders which might have prompted them into action. The Review was aware that Mrs BB's children all had pressures of their own to contend with.

6.13 The Review established that Mrs BB's patient record did not include contact details for all Mrs BB's family. Although there were contact details for 2 of the daughters, Mrs BB's record did not include those for A as shown by GP3 being unable to ring A back on 18.11.12. The Review Team acknowledged that the GP Practice would have faced difficulties in deciding which member of the family should be approached, because it would not always have been clear who in the family should be the "first port of call". This was because 3 of her children were involved in the contacts with the surgery at different times. However from 13.01.14, the position was clarified when a note was made on the GP records that all messages and appointments should be arranged through A, and this included his mobile number.

6.14 In addition, from 12.12.12, the surgery would have been under the under the impression from the records, that A was living with Mrs BB, because from that date until 17.03.15, A was registered with the GP with the same address as Mrs BB. Although this was not the case, A had not provided the surgery with his current address.

6.15 During the time period covered by this SAR, the usual practice was that after 2 DNAs, no further reminders were sent. Since then, the system has changed to avoid dementia patients slipping off the radar, so that after 3 successive DNAs, the patient's name is passed to the Lead Nurse Practitioner to review what further action might be taken to engage with the patient.

Final GP Consultation 21.01.16

6.16 The Review analysis of the final GP consultation will be covered later in Section 14

7. MEMORY SERVICE - NSFT

Service Arrangements

7.1 The service delivered by the Memory Team, which is 1 of 3 teams within the DCLL, can involve 5 planned visits. The initial assessment is carried out by a Band 6 nurse. If medication is deemed suitable, 4 further visits are made by a Band 5 nurse to commence, and monitor, the medication trial before arranging handover to the GP for on-going monitoring and prescription of medication – usually after 10 months. On discharge the GP is advised to re-refer if necessary in the future.

Involvement with Mrs BB

7.2 The assessment in October 2012 was thorough and resulted in the decision that it would be appropriate to try Mrs BB on the dementia medication, and arrangements put in place for Home Care Agency 1 to provide support in prompting her to take the medication.

7.3 When Mrs BB was not at home for the 7 week review, the standard problem-solving strategies were adopted by first trying to contact the nest of kin, and when that was unsuccessful, contacting the home care agency. The discovery from them that Mrs BB was not taking the medication consistently, because she was not always at home when the carers called to prompt her, was a significant issue because for the drug to have any chance of making a difference it has to be taken consistently.

7.4 This factor was the driver for the decision to discontinue the medication trial and the team's involvement because of Mrs BB's non-compliance. In reaching this decision, it was noted that Mrs BB was already receiving home care and no other services had been identified as being required. If there had been, the Review Team heard that the normal arrangement would be for further discussion to take place within the service to consider what further steps should be taken.

7.5 The Memory Team's decision was made without any discussion with the GPs, whose 2 progress chasing calls had not been returned. The Review Team's assumption was that when the Memory Team's work with Mrs BB had stalled following the abortive visits, the receipt of the GP messages then triggered the internal discussions resulting in the decision to send the letter without returning the GP's calls. The GP therefore had no opportunity to influence the outcome. This would have been particularly important as the Memory Team's assessment had indicated that Mrs BB's dementia was not low level.

7.6 The Review Team's view was that more enquiries could have been made to try and identify family members who might be able to arrange a successful visit by approaching the GP, or Social Care as the commissioner of the home care service. The Review Team heard that the Memory Service now adopts a more pro-active, problem-solving, approach when there is a DNA. These are discussed within team meetings to explore the possible reasons, and what steps might be taken to increase the chances of successful contact. In addition, there is now more liaison with the GP, and other agencies involved, in reaching a decision as to whether to persevere.

Communication with Patients and their Families

7.7 The usual practice is that if a person attends an appointment with a family member then at that point there is discussion with the patient if they wish to consent to information being shared with a family member, and for correspondence to be sent to that person. However, this has not always been documented formally, and may be the explanation for what happened in Mrs BB's case. While the original appointment letter had been addressed to Mrs BB and sent to C's address, all future correspondence was sent direct to Mrs BB's home. A letter should also have been sent to Mrs BB to confirm the ending of the Team's involvement but this did not happen. It has not been possible to establish if this was an administrative system failing.

8. SOCIAL CARE

8.1 Although the earlier narrative covers assessments carried out in 2012 and early 2013, the analysis focuses on the involvement from November 2013 because this was more significant in how the case developed.

Response following EDT Referral 23.11.13

8.2 Overall, this was a good practice example of effective action and liaison between the Police and EDT which addressed the immediate problem and a referral being passed to SCCE for follow up. In line with standard practice following any EDT involvement, the referral was triaged by the SCCE Practice Consultant (PC1) resulting in the case being passed through to the Locality Team for assessment.

8.3 The activity request forwarded by SCCE was considered by a Locality Practice Consultant (PC2) who made a professional judgment that the presenting information did not make the case high priority compared to others coming in, and was therefore appropriate for allocation to an assistant practitioner. Once case allocation has been decided, business support staff make contact with the service user and / or the family to arrange the visit taking account of the AP's availability. Each AP has 2 slots each week blanked out in their diaries for picking up new cases.

8.4 The Review explored whether allocation to an AP, and a planned visit 16 days later, was an appropriate response given the indications in the referral about Mrs BB's presentation, the potential MCA issues, and the possible increased levels of risk. Information already held on Carefirst [31] might have suggested that the case was complex which would warrant the input of a qualified social worker.

8.5 The following contributory factors were identified which influenced the allocation decision:-

- the high volume of work in the Locality Team;
- the limited options available when allocating cases;
- Mrs BB's case was not very different to many other cases requiring action;
- there was a safety net in place with carers going in, and the family were engaged, which was a more favourable position than cases requiring allocation where risks were apparent but no services were in place.
- given the high number of referrals needing to be screened alongside other duties, the Practice Consultant may only have time to look at the latest referral, rather than all the historical information held on Carefirst.

8.6 The Review learned that APs are trained to identify where a MCA may be required, [32] but not to carry out the assessment which is done by a qualified social worker. APs are instructed to report back in these situations, and if the case appears so complex that it needs qualified social worker input. This did not happen in Mrs BB's case until November 2014 despite the accumulating risks, and the various points where mental capacity issues needed to be considered.

8.7 The Review Team accepted that it would have been reasonable to allocate the case to AP1 in the first instance given all the factors listed above, but an earlier visit should have been attempted. In making this observation, the Review Team agreed that it was important to avoid this SAR making recommendations around assessment visit deadlines which might be unrealistic.

Response to the Cancelled Assessment – 11.12.13

8.8 AP1 said he made several attempts to re-arrange the visit but there is only 1 recorded on Carefirst in January 2014. The Review Team did take into account that A was not easy to contact, and did not always return calls. The drift which occurred after the visit was cancelled, highlight some system issues in relation to supervision arrangements, and some drawbacks in the way NCC has set up the Carefirst electronic record system.

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31 *Carefirst is the computer software system used by Social Care to create an electronic case records in respect of all involvement with service users.*

32 *2 courses are provided for Assistant Practitioners. The MCA Independent Advocate training is mandatory, and attending the MCA Level 1 Awareness Course is strongly recommended. The latter course is mandatory for qualified social workers.*

Electronic Case Record Issues

8.9 Norfolk is one of many local authorities which use the Carefirst system which was developed by OLM. Each authority configures the standard system to meet its own requirements, and therefore the comments made about how this works in Norfolk is not applicable to its functionality elsewhere in the country.

8.10 Within the Norfolk adapted version of Carefirst, no "flag" appears when a visit remains outstanding. The only "back-stop" is the browser which identifies overdue reviews. In Mrs BB's case, a review date would have been set for January 2014, a year after the original assessment in January 2013. However, when a new assessment is arranged before the original review falls due, there is a lack of clarity as to what happens to the existing review date. The Review Team agreed that this should be left on the system until the new assessment has been completed and a new review date can be entered. This did not happen in Mrs BB's case, and therefore managers did not pick up that both the assessment, and the original review, remained outstanding.

8.11 A further challenge for managers in spotting that a review is overdue is that the default setting on the browser listing these is organised to show first those that are most overdue, and several pages have to be scrolled before the most recent ones will show up. This is because the list includes low priority cases where service users are in a stable placement but remain on the system because of continuing funding support.

8.12 The Review also identified that there are insufficient "controls" built into Carefirst which makes it possible for changes to be made to information or dates previously entered, without authorisation by local managers or the IT section.

Response to Referral 03.01.14

8.13 The telephone call AP1 made to Mrs BB was an insufficient response to the description from a neighbour of Mrs BB saying she was "not ok", and having a glazed expression. That information provided more evidence of possible concerns about Mrs BB's mental deterioration. The referral information was more significant, and concerning, in the context that there had been no recent MCA assessment, and Mrs BB had felt sufficiently unwell to go to the GP herself, but had then declined to stay. There was no apparent consideration as to whether there was a potential mental capacity issue.

8.14 Given these issues, the Review Team questioned how much reliance could be placed on the reassurance given by Mrs BB over the telephone, rather than through a visit, or a follow up discussion with the family. AP1's action stemmed from his understanding that there was a policy of no unannounced visits operating in Social Care. However, the Review Team was subsequently assured that this was not the case.

Workload and Supervision Issues

8.15 When AP1 went on planned sick leave on 30.01.14, there was no advance review of his caseload to put in place contingency arrangements for priority work to be covered. The supervision records contain no mention of Mrs BB's case, and therefore it is assumed that it was not considered for reallocation.

8.16 By way of context, AP1's caseload had been growing to a level well above the norm for an AP. In part this was because he had been required to bring 20 cases with him from SCCE when he took up his new post, and then due to AP vacancies at that time, there was a period when AP1 was asked to take on more new cases than would be usual. His caseload continued to grow because work on existing cases was not being completed, and these were not being closed within the standard 6 week time period.

8.17 AP1 told the Reviewers that he had asked managers for space to clear his work, but there is nothing recorded in supervision regarding this. The extent of the problem was not picked up until PC3 took up post in July 2014 at which point she triaged his caseload at the request of TM1, and AP1 was found to have a caseload of 60. During that process, PC3 did not identify Mrs BB as high priority because Mrs BB's case was neither the oldest, nor the highest risk which are those with high needs but no services in place.

8.18 A contributory factor to these issues not being picked up earlier was the supervision arrangements whereby APs are supervised every 8 weeks by qualified social workers,[33] who in turn are supervised by the Practice Consultant. These arrangements mean that the Practice Consultant does not have direct oversight of an AP's caseload, or the quality of the work. Information received by the Review indicated that the quality of the supervision by the qualified social workers is variable, and this was an issue in AP1's case. In hindsight, both PC3 and TM2 [34] felt that the style of the previous supervisor was unlikely to uncover the lack of throughput of cases, and that Mrs BB's case would only have been discussed if he raised it.

8.19 In August 2014, after the caseload review, PC3 took over his supervision so that the workload and performance issues could be addressed directly, and targets set and monitored. AP1 was also removed him from the rota for picking up new work.

8.20 Subsequent to Mrs BB's death, the supervision arrangements in this team have been strengthened and these are explained in the Review findings later in the report.

AP1's Assessment 27.08.14

8.21 The outcome *"services to continue, but with more support intended"* did not adequately address the information which had emerged during the assessment. AP1's perception was that Mrs BB had low level dementia, and this may have contributed to insufficient weight being given to the risks around road safety, asking strangers for lifts, and the descriptions of her getting lost or being disorientated. No steps were taken to gather information from the GP, the residential care home, or the home care agency to inform the assessment.

8.22 The Review Team's conclusion was that at this stage, in formulating a revised care plan, more attention should have been given to the need for a MCA. It was to be a further 3 months before a MCA was carried out.

Level of Funding Allocated for Mrs BB's Care

8.23 Although, following the assessment, the level of the Personal Budget allocated to fund Mrs BB's care increased substantially, this did not reflect the reality of Mrs BB's situation and needs. This was because of the disconnect between the information gained through the assessment, and that inputted into the Personal Budget Questionnaire (PBQ) which is used to set the value of the funding. This came about because too much out of date information was pulled through from previous assessment forms, and insufficient detail was included about the current situation. This meant that the preponderance of out of date information skewed the calculation and the resulting budget awarded fell short of what was really required.

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[33] *each full time qualified social worker supervises 1 AP*

[34] *TM2 took up this post on 30.09.14*

8.24 The Review established that there is the scope for flexibility in setting the amount of the personal budget because the PBQ calculation is treated as an indicative figure, and managers have discretion to approve a higher budget where it is clear that this is insufficient to meet the immediate needs of the service user. There are also no obstacles to prevent moving straight from a low level of service to provide intensive home-based support or residential care if the need is identified. An example might be if the family carer goes into hospital or care.

8.25 This did not happen in this case because the difficulty PC3 faced was that her decision was reliant on the information within the assessment documents or recorded on Carefirst, and these did not include sufficient details about the current level of risk. PC3 felt her hands were tied in terms of what she could agree because AP1 had not tested out the increased support options agreed at earlier points in the case. Hence she directed AP1 to carry out further work to update the assessment and the forms to support a fresh calculation.

8.26 This episode was a missed opportunity to secure a personal budget, and implement a new plan, which matched Mrs BB's needs. This only occurred 3 months later when SW3 carried out her assessment. Although the revised personal budget approved by PC3 was insufficient to fund residential care, it would have funded a substantial increase in the home-based level of support. However, although work on updating the Care Plan was commenced, it remained incomplete, and AP1 did not make any changes to the existing level of service.

Response to Wandering 14.11.14

8.27 There was no apparent follow up by AP1 or discussion with a manager when a member of the public had found Mrs BB 'wandering' and took her to the residential home. Following B's telephone call 4 days later on 18.11.14, AP1's recording captured the seriousness of the situation, the potential MCA issue and the need to talk to other practitioners. However, this was not reflected in his response to B where the onus was placed back on the family to resolve the issues, including contacting the GP, rather than taking any action himself. The Review Team agreed that this referral had warranted an urgent response.

Events leading to MCA Assessment – November 2014

8.28 It emerged from the interview with AP1 that the trigger for his email to PC3 raising the possible need for a MCA assessment was his reading a newspaper report about a lady being found dead in a pond, and his concern that Mrs BB's wandering could end in a similar outcome. Although PC3's reply indicated a degree of frustration that the case had stalled due to agreed tasks having not been followed through, PC3 maintained a focus on Mrs BB's needs and quickly made a decision on 25.11.14 to allocate the specific task of carrying out the MCA to SW3 who was part of a multi-agency team working with people with dementia.

SW3's Mental Capacity Assessment 27.11.14

<u>MCA Purpose and Process</u>

8.29 SW3 moved quickly to carry out the assessment within 2 days of PC3's request, and recorded that the purpose was to assess whether Mrs BB understood her care needs and the risks posed to her. SW's recording of the assessment was very detailed, and well organised, making it easy to see the issues and findings. It is clear that considerable attempts were made to try and secure Mrs BB's engagement

8.30 Although a considerable amount of ground was covered, the Review Team concluded that the MCA did not fully explore all the decisions that had to be made. These perhaps would not have been immediately clear to SW3 as she was in effect "going in cold" having had no previous involvement with Mrs BB. Although she had a detailed discussion with AP1, she did not gather any information from other professionals other than from the residential home manager. The assessment would have benefited by approaching the GP, the Memory Service and Home Care Agency 1 to "get a feel" and gain their knowledge and perceptions. Had SW3 engaged everyone in the process, the issues and full extent of the risks, would have become much clearer, and information shared about incidents and behaviours which were not previously known to all practitioners.

8.31 Notwithstanding the above comments, the Review Team acknowledged that SW3 faced a major challenge in carrying out her assessment, and drawing up plans, because of the outstanding work which should have been carried out previously. In effect she was making up for lost time, and the Review Team acknowledged that she achieved a lot in 4 days compared to the previous year's work.

Night time risks

8.32 The most significant issue arising from the assessment was how the information from the family was treated about the risks arising from Mrs BB going out at night which was their greatest concern. Their view was recorded in the Carefirst observations (the running records), but were not included in the MCA or Best Interests documents. In contrast to the family's view, in setting out the rationale for the care plan, SW3 cited the day time visits to the residential home as the biggest risk.

8.33 SW3's thinking behind this was that the evening risk was unproven and speculative. The family had not provided details of any specific incidents, and there were no known evening incidents recorded on Carefirst. The police involvement that Social Care was aware of, related to either incidents during the daytime, or evening incidents where Mrs BB called the Police from her own home. Although B raised this as a concern on 27.11.14, she did not refer to this again within the frequent telephone calls and exchange of emails with SW3.

8.34 Therefore SW3 considered that the reported evening risks could not be given the same weighting as the daytime risks which were proven. That is why she did not include it in the MCA form. SW3 explained that she would now approach this differently, and include the same information in all the various documents for completeness. In seeking to check out the evening risks further, considerable reliance was placed on assistive technology as the means to achieve this. However, as events turned out, this proved to be problematic and was unable to deliver the solution that SW3 and PC3 had hoped for.

8.35 While acknowledging the reasons for SW3's approach, the Review Team concluded that the information from the family should have prompted further probing of the family's accounts, and more enquiries with other agencies. This might have resulted in a different plan which addressed the possible evening risks.

Revised Care Plan

8.36 The plan to extend the home care support by 2 hours over the lunch period could be seen as a logical next step as this would cover one of the known main risk periods – the lunch-time visit to the residential home. It would also enable the carers to spend more time with Mrs BB with the aim of establish a relationship with Mrs BB, and learn more about her patterns of behaviour. Up to this point, Mrs BB had not engaged with the carers, and from their accounts, rarely conversed with them. SW3 discussed this extra

support and the AT referral with B on 03.12.14 who confirmed she was happy with these plans.

SW3's Assessment 16.12.14

8.37 SW3 moved swiftly as soon as she saw that the extra 2 hours support was not working, and commissioned the 9 hour day-time support service from Home Care Agency 2. This was an unusual and expensive care package which was intended to keep Mrs BB safe during the daytime, and provide a breathing space while the family, with SW3's support, found a care home that was acceptable to them. There was no time limit placed on how long this support would be provided, and as a result, there was no undue pressure on the family and SW3 to finalise the residential care solution. With hindsight, Social Care staff wished they had put in a time limit "to concentrate everyone's minds".

8.38 The Review Team questioned whether this was the right care package as opposed to opting for emergency respite care, given the increasing risks that were recorded at the time. The assessment noted that the family had reported that Mrs BB had been out at numerous times during the night time, and the risks had increased due to the cold weather and the dark. The Review Team agreed that information suggesting that a service user may be wandering in the evening should trigger a more robust assessment. However, these identified risks were not referred to in the support plan, and the 9 hour daytime package would not address these.

8.39 One apparent significant contributing factor which influenced SW3's planning, was her focus on trying to take into account what Mrs BB might want pending her move into permanent residential care. There is good coverage in SW3's recording of the need to consider the least restrictive option in the interim in seeking to minimise the risks, and working within Mrs BB's routines, and at her pace. In this, SW3 displayed great sensitivity in applying a person centred approach to planning, but possibly too much when viewed in hindsight, in not opting for the safest option of respite residential care.

8.40 This leads to an important issue about the need to consider whether the involvement of an independent advocate is required within the Best Interests Decision process, particularly in situations such as this case, where the involvement of family members fluctuates, and there is some uncertainty as to whether there is consensus on the preferred outcome. In Mrs BB's case, the preferred plan was for Mr and Mrs BB to be placed together near B in the South of England which would have affected the degree of contact with the other 3 children. In addition, SW3 had to take into account the wishes and interests of both Mr and Mrs BB, and at times these had not been the same, especially in the light of the difficulties in their relationship, and the information previously shared that Mrs BB did not want to move with him.

8.41 The Review Team's perspective was that if a practitioner attempts to take on the independent advocacy role, there is a danger that they can lose their objectivity and become too focused on the service users' wishes rather than reaching a decision based on a more detached evaluation of all relevant information and risk factors.

8.42 In arriving at these observations, the Review Team acknowledged that this was a complex situation, and SW3 faced the challenge of trying to make up for lost time. It was clear to the Review Team that SW3's input reflected a professional who was conscientious, hard working, and compassionate throughout, SW3 was trying to apply the least restrictive options, but having to test these very quickly given the risks which had not been addressed earlier.

8.43 The Review Team was also aware of 2 other significant contributory factors during her involvement. One was that SW3 was dealing with 35 cases, all of which were complex and high risk, and this inevitably affected the amount of time she could devote to this one

case. Second, she was not able to call on the assistance of AP1 after he went off sick in mid December 2015.

9. POLICE

9.1 The Police were involved on 8 recorded occasions [35] as follows:-

01.10.13	Call from Mrs BB – 2am - flood
05.11.13	Call from Mr BB re dripping tap
23.11.13	Call from Mrs BB – someone possibly at the door
25.11.13	2 x 999 calls from Mrs BB – tap problem
11.06.14	PCSO's see Mrs BB appearing to be looking lost
06.09.14	Call from a member of the public
31.10.14	Call from a neighbour
18.01.15	Call from the residential care home – evening visit

9.2 On each occasion, there was a prompt response which, either through their own enquiries, or with the assistance of other agencies, established that Mrs BB was safe. In the incidents involving face to face contact, officers dealt with the situation diligently and systematically, and showed a caring and sensitive approach towards Mrs BB. Their first step after ensuring Mrs BB was safe, was to make contact with A to ensure the family were aware, and to secure their involvement if at all possible. In all the incidents, the Police did not end their involvement until they were satisfied that there was a family member, or agency, who was aware of the situation, who could reasonably be relied upon to pick up any further action required.

9.3 However, of these 8 incidents, just 3 resulted in the Police contacting other agencies to enlist help or share information. These were the calls from Mrs BB on 01.10.13 about the leak, on 23.11.13 when she thought someone was at the door, and the 999 calls on 25.11.13.

9.4 The Review Team agreed that would have been important for information to have been shared with Social Care about the other 5 incidents as this would have helped build a picture of how her dementia was impacting on her every day life, the frequency with which Mrs BB was found appearing lost or disorientated, and the nature of the associated risks. The earlier analysis has drawn out the difficulties Social Care experienced in evaluating the full extent of the risks because much of the information was anecdotal or general statements provided by the family not backed up by specific examples. The police information may not have been decisive in tipping the balance on the plans made by Social Care, but it would have been of great assistance and might have indicated the need to for more urgent intervention at various points

9.5 In depth exploration of the June and September 2014 incidents during the Review provided some helpful insights into the rationale and criteria that influence decisions on whether information needs to be shared with Social Care. On both occasions, officers concluded that it was unnecessary to pass on information because they felt reassured by the family's explanation that the GP and Social Care were aware of Mrs BB's situation, and action was in hand to address Mrs BB's needs. In addition, the home carers would be calling that teatime, and the family later that night. Therefore officers made an assumption that because Social Care was already involved, forwarding the information would not add anything.

[35] it is known that at least 1 other response was not recorded around September 2014

9.6 Analysis of these incidents also highlights the tendency in this case for information provided by the family to be accepted at face value without the need to check this out, and the onus being placed on the family to inform other agencies, as appropriate, about the latest developments and changes in Mrs BB's situation.

9.7 With the benefit of hindsight The Review Team's conclusion was that in each instance, information should have been shared with Social Care. Awareness of the June 2014 incident might have enabled social care managers to pick up sooner that the cancelled assessment remained outstanding. The September 2014 incident 10 days after AP1's assessment on 27.08.14, and might have added impetus to the care planning.

9.8 Similarly, although SW3 became aware of the incident on the evening of 18.01.14 through the family, had that been report come from the Police informing EDT, it may have resulted in more status and significance being ascribed to the information and influenced the response. An additional contributory factor which may have affected the officer's decision not to share information, was that the advance checks made prior to the officer being despatched did not pick up the previous occasions when the police had been involved.

Recording of Incidents / Intelligence Gathering

9.9 The above analysis led to consideration of what information is recorded within the Police systems, and how much use is made of this when further incidents occur. This is an important issue given that viewed in isolation, each incident could reasonably have been viewed as low level, and the potential significance would have only been picked up when viewed in their totality.

9.10 It became clear that not all the police involvement with Mrs BB had been recorded given PCSO2's account of the September 2014 incident that there was no information on the CAD system about PCSO3 having walked Mrs BB home some 2 weeks earlier. The Review Team heard that officers have discretion as to what they log onto the CAD system, and sometimes they do not consider that the matter warrants this, and therefore they just inform Control to report that they are busy with a task, (such as returning someone home, or dealing with a stray dog), without having to provide full details.

9.11 Until recently, incidents involving adults at risk have not automatically been passed through to the Multi Agency Safeguarding Hub (MASH), but this is now gradually changing with the introduction of the new Athena system, and a referral form has been designed to mirror the one that has been in use for some time for child protection cases.

9.12 However, at this stage, not all police officers will be aware of the system's purpose and capabilities, or the requirement to submit reports in all cases, because roll out of the new system across the agency is being carried out on a phased basis. Therefore at this point, it is important for agencies not to assume that all incidents are being recorded and passed on. It will be important to test the resilience of the new Athena system in terms of the extent of officer awareness and use.

10. ASSISTIVE TECHNOLOGY TEAM (ATT)

10.1 Assistive technology refers to devices or systems that support a person to maintain or improve their independence, safety and wellbeing. It tends to refer to devices and systems that assist people with memory problems or other cognitive difficulties, rather than those that are used to aid someone with mobility or physical difficulties. They can support people in carrying out everyday tasks and activities, enhance a person's safety, support their social participation, and monitor their health. While assistive technology

may not be suitable for everyone with dementia, for some people it can sometimes help them to live well with the condition.

10.2 The possibility that the provision of assistive technology might help to reduce the risks to Mrs BB formed a key component of Social Care's care planning. In the event, this proved not to be possible, and the analysis focuses on 2 key issues. The first is how the organisational arrangements at the time affected the planning and completion of the assessment. The second is the challenge of identifying workable assistive technology solutions when a service user with dementia lives alone, and the dependence on the family's support to enable these to be effective.

Assistive Technology Service's Assessment – 11.12.14

10.3 It was not possible to establish a detailed picture of what transpired during the visit, or explore the practitioner's view at the time, because she no longer works for the service, and A did not respond to invitations to contribute to the Review. Therefore the Review has been entirely reliant on the case record which was relatively brief for reasons that are explained later in the analysis.

10.4 There were issues about the quality of the referral to the ATT and lack of detail. The referral form only listed that a Buddi system was to be considered, and there was no mention of the other options, such as pressure pads, which had previously been mentioned during internal discussions within Social Care. Nor was there any recorded discussion of these in the subsequent telephone call between AP1 and ATT1.

10.5 During that call the information that Mrs BB unplugged the telephone and sockets at night, led to a joint acknowledgement that AT solutions might not work in this case. However there appears to have been no reference to whether there were any "tamper proof" solutions as previously highlighted by SW3 in her discussions with AP1.

10.6 After his call with ATT1, AP1 did not share with SW3 the unlikelihood that referral to the ATT would deliver the hoped for outcomes. This would have provided her with the opportunity to consider adjusting her overall plan.

10.7 It is not known if A's subsequent rejection of the Buddi system was because the family would be unable to assist with the 2 hour daily charging of the device, or not having a computer / smart phone to monitor the device. It is not recorded whether it was explained to the family that if they could not monitor the device themselves, they would have the option of ringing the Buddi control centre to check the location of the device.

10.8 The subsequent lack of feedback from ATT on the outcome of the assessment, was the norm during that period, and largely stemmed from the organisational arrangements and operating practices at that time which are summarised below.

<u>Organisational Context</u>

10.9 The assessment was carried out when the ATT was located within Norse having been transferred out of NCC management in 2009. This change in organisational arrangements created a number of challenges and difficulties, the main ones being:-

- the previous close links with the community teams had been lost because ATT practitioners were no longer co-located within the Community Teams, and had moved to home-based working;

- there was no longer access to Carefirst to obtain, or transfer, information about the service user;

- the design of the referral form, submitted by Care Arranging, meant that ATT received very little information on the case circumstances, and what solutions were being sought.

- the commercial ethos within Norse meant that the ATT was under pressure to achieve rapid throughput. This meant little time for advance preparation, completing assessments, post assessment feedback, together with an expectation that the most cost effective solution would be opted for, and follow up visits should be avoided. One consequence was that referrers would not be contacted about the planned visit, or the outcome unless the referrer flagged up this in that box that this was wanted.

10.10 Since the service's return to NCC management in late 2015, there have been positive changes including:-

- renewed access to Carefirst;
- improved links with teams;
- new operating guidance and recording policies.

11. HOME CARE AGENCY 1

11.1 Home Care Agency 1 provided services to Mrs BB from 21.01.13 until 17.12.14 which comprised 15 minutes calls twice daily to provide medication prompts and assist with food preparation, and an additional 2 hour escort service during the last 10 days of involvement.

11.2 6 inter-related issues have emerged from the analysis:-

(i) the number of abortive visits and the response to these;
(ii) the information recorded by the carers when making visits;
(iii) inconsistent reporting of issues by the carers to the office;
(iv) the lack of information entered onto the Mrs BB's care record held at the office;
(v) the lack of liaison and information sharing between Home Care Agency 1 and Social Care.
(vi) the lack of auditing of the care records in line with agency policy

In order to explore these in more detail, it will be helpful to provide some contextual information about the organisational structure, record keeping and operational practices.

Organisational Arrangements

11.3 Home Care Agency 1 is a large, long established, home care provider operating in the East of England, and does a lot of business with Norfolk County Council.

11.4 The management structure within the local branch office comprises a Manager, a Co-ordinator, and 4 Team Leaders who carry out assessments and reviews, and supervise the carers. All staff and carers receive basic awareness training from the in-house trainer which includes dementia awareness. There is annual update training.

Records

11.5 Records are maintained in 2 locations – the office, and within the service user's home. The office electronic file, called Staffplan, comprises the:-

- Schedule – containing details of the care package;
- Staff roster
- Journal – for logging any reports or calls relating to the service or the service user

11.6 Office staff tend to record incoming calls on a paper communications log which should then be entered onto the individual service used electronic record the same day.

11.7 A blue folder is left at the service users home in which the carers record on the Daily Task Sheets / Communication Logs (daily logs) the service provided, any issues of concern, and action taken - including calls made to the office to report these. The notes made by the carers in the daily logs should correspond with the Journal entries made by office staff.

Audit System

11.8 Agency policy requires the daily logs to be reviewed at the month end by the team leaders to check for any missed visits, and that the time spent matches that agreed with the commissioner. The audits should pick up any changes in the service user's situation or presentation.

Response to Abortive Visits

11.9 In Mrs BB's case, there was an unusually high percentage of abortive visits. For example, over the 12 month period between November 2013 and November 2014, out of 700 visits made, Mrs BB was not at home on 270 occasions – an abortive visit rate of 38 per cent.

11.10 Examination of the daily logs revealed that these abortive visits were not routinely reported to the branch office unless there was a specific issue of concern. When the carers did ring in, the information was not recorded by office staff in the Staffplan Journal. The lack of recording was not confined to the abortive visits, and it was rare for a record to be made of the occasions when carers reported that Mrs BB was agitated, feeling low, or had lost her keys.

11.11 This lack of compliance with agency procedures, was not picked up retrospectively because the month end audits were not carried out. Had these been done, it might have led to some retrospective sharing of information with the family and Social Care.

Liaison with Social Care

11.12 The Review established that the Council's social work team was not aware of the pattern of abortive visits which would have been important information to take into account because of the possible implications for Mrs BB's welfare, and in planning her care.

11.13 In exploring why this was, it appeared that Home Care Agency 1 may have sometimes shared that information with the Council's Procurement Team which is a requirement contained in the contract. It is possible therefore that Home Care Agency 1 assumed that the information would then be passed on internally to the social work team rather than having to make direct contact itself. However this did not happen because the Procurement Team too would probably assume that Home Care Agency 1 would raise any concerns about Mrs BB directly with the social work team. It will be important that work is carried out to clarify the reporting requirements and communication pathways.

11.14 In addition to the missed visits, there were a number of specific incidents and issues which should have been reported, and 4 different examples are included here to illustrate why this would have been important. The first was the request to follow up Mrs BB's 999 calls about the dripping tap on 25.11.13. Feedback was not required on the practical issue per se, but would have been important in sharing any observations about Mrs BB's mental state, and overall welfare, given that she had resorted to ringing the emergency service.

11.15 A second example was the observation made by the carer on 19.10.14 that Mrs BB had gone out without her coat, and the back door was unlocked with the keys on the inside. This issue of Mrs BB often going out inappropriately dressed for the weather was an issue later reported by the residential home.

11.16 There were also 3 occasions close together in mid November 2014, when the home carers discovered that Mrs BB has mislaid her keys. On the second occasion, Mrs BB was locked in, and the carer had to climb in through the window as there was no key in the key safe. These incidents were appropriately reported to the office but not recorded in Staffplan, nor were they shared with Social Care. This would have been important information suggesting that Mrs BB's memory might be getting worse, and the risks were increasing of her being locked in, or locking herself out of the house.

11.17 Later that month, the agency was asked by AP1 to check on Mrs BB as the family had reported that she had not visited Mr BB for 4 days. The Co-ordinator did not feed back to AP1 after checking with A who provided reassurance that everything was fine.

11.18 All of these examples point to a significant contributing factor in this case as time went on, that many professionals became de-sentised to the possible risks to Mrs BB. In the case of the home care agency, this became apparent from the Case Group discussion with the Co-ordinator who explained that if Mrs BB was not in when the carers called, they left her a note, and they not unduly worried because they were aware of her movements because the carers often saw her in Sainsburys and other shops, or guessed she had gone to the residential home. In addition, A1C's understanding was that Mrs BB had good road sense, and he was unaware that Mrs BB had been flagging down strangers for lifts.

11.19 These frequent sightings, and knowledge of her patterns of behaviour, appear to have imbued a false sense of security, and did not trigger consideration that her patterns of behaviour might be significant and should be reported back to social care. The daily sightings of Mrs BB in town were accepted as her usual routine.

Evening Risks

11.20 A1C shared with the Reviewers that the agency was aware that Mrs BB's wandering in the evenings was an issue, because the carers out doing their teatime calls would see her in town when the shops were closing. He cited his personal experience of once returning Mrs BB home on a Saturday teatime when it was dark outside, after he encountered her appearing disorientated in Sainsburys. However there is no evidence that this was reported to EDT as claimed, or subsequently recorded on Staffplan.

11.21 The potential evening risks also featured in the discussions about the possibility of a 9 hour daily service when Home Care Agency 1's view was that a continuous daytime service would not be address the evening risks. The Review Team was concerned that there was no record that Home Care Agency 1 had ever previously alerted Social Care to this perceived risk. It would also have been important for home care agency 2 to be aware of this but when the latter did not seek any handover information, Home Care Agency 1 were not proactive in offering to provide this.

11.22 Social Care also bears some responsibility for the lack of information sharing because it was not proactive in requesting periodic feedback or specifying the types of events and behaviour which needed to be reported back. Social Care also did not progress chase specific incidents of concern

Conclusions

11.23 The Review established that the agency has initiated action to ensure adherence to agency policy and procedures, and the approach to risk assessment in relation to service users with dementia has been tightened up. These will be referred to further in the Review findings, and have resulted in commissioning managers noting the improvements.

12. HOME CARE AGENCY 2

12.1 Home Care Agency 2 is a small agency, with approximately 30 care workers, which was established in 2011. It tends to pick up personal assistant type work which requires the provision of several hours service each day.

Involvement with Mrs BB

12.2 As Home Care Agency 2 was commissioned at short notice and requested to commence the service the following day, there was little opportunity to carry out an advance assessment or gather information from Home Care Agency 1 about their experiences. The assessment, care plan and risk assessment documents were therefore completed within the first 48 hours which is allowed under the standard home care contract issued by NCC. This might explain why those initial assessments appeared to underplay the potential risks described in paragraph 4.64.

12.3 The approach adopted was to work with Mrs BB's decisions on what she wanted to do each day, and ensure she was safe.

Perceptions of Mrs BB

12.4 Within the Case Group interviews, both A2M and A2C described Mrs BB as very strong willed, impetuous and unpredictable in her behaviour. This made it very challenging in trying to negotiate with her.

12.5 In terms of her demeanour, there were stark contrasts. At times she appeared rather sad and unhappy, particularly if A did not come to see her. She enjoyed the contact with B and the visits to stay with her, and did not want to return from these, often saying "I want to go back to B". Mrs BB clearly enjoyed the trips out, especially revisiting places from her childhood. The lunchtime visits to the residential home were generally good, where she ate well, but as time went on, her increasing frustration with Mr BB became apparent.

12.6 Mrs BB appeared to resent the close supervision when A2C was shadowing her outside of the home, and was often abusive to him. On the practical side, keeping up with Mrs BB was a challenge because she was so fast on her feet, and would abruptly change direction as she used 4 or 5 different routes to go to town. She displayed little awareness of road safety, and quick reactions were needed as she would suddenly set out into the road without warning, and needed to be pulled back from oncoming cars.

12.7 On arrival home in the afternoon, Mrs BB's usual routine was to switch on the TV and say "You can go now" which was the cue for the carer to leave. She appeared settled at this point. Mrs BB had a ritual of turning off the telephone socket at night, and the power sockets except the one for the TV, and the carers noted on arrival that she would switch them back on as soon as he got up in the morning.

12.8 A2C said that he did not have any undue concerns about Mrs BB until the increase in Mrs BB's agitated behaviour from 18.01.15 onwards. The analysis of the agency's involvement from that date onwards will be covered in Section 14.

Lack of Liaison between Home Care Agency 2 and Social Care

12.9 Given the level of assessed risks when the service was commissioned, the Review Team would have expected that there would have been an explicit agreement initiated by Social Care as to the frequency with which Home Care Agency 2 should provide feedback on how the service was working, and the types of developments and behaviours which should trigger some immediate contact. However there is no record that any expectations were put in place to supplement the standard wording in the home care contract.

12.10 There was limited information sharing between Home Care Agency 2 and SW3. This was said to be in part due to the short term nature of the contract. According to A2M, information was shared just before the contract was due to expire when A2M rang SW3 to see if it was to be extended. This feedback was not recorded by SW3. The only references to the service in SW3's recording were her observation of Mrs BB and A2C together on 14.01.15, and the feedback from B. Both of these were positive, and would have given no indication about the extent of the challenges that the carers were experiencing. When these were shared with SW3 during the case group discussions, she expressed her surprise because she had not been made aware of these.

Commissioning and Skills Issues

12.11 SW3 commissioned Home Care Agency 2 because she understood it had previous experience of working with older people with mental health issues. The Review heard from A2M that although the agency has not promoted itself as a specialist mental health service, it has built its reputation locally through its work with individuals with mental health issues. A2M is a dual registered mental health and learning disability nurse, and A2C had previous experience of working in mental health and learning disability services.

12.12 However, the Review did not see evidence to confirm these credentials, and questioned whether Home Care Agency 2 had the skills to provide this particular kind of PA service to service users as challenging as Mrs BB. When considering A2C's approach to certain events during his involvement, the Review Team thought it was unlikely that A2C had the skills to manage someone with significant cognitive impairment. The management approach he adopted was "not to wake the sleeping tiger" but to just follow her. He did not appear to know how to de-escalate her behaviour, as seen by the incident in Sainsburys, and the occasion when a member of the public intervened. It appears that he was unsure how to respond and defuse the situation. When interviewed, A2C presented as a very gentle and patient person, and the Reviewers felt it was these attributes which got him through the long hours with Mrs BB day after day.

Agency Learning

12.13 A2M explained that since this case, the agency now keep Social Care regularly updated via a telephone call followed up with a confirmation email. If they are unable to speak to the allocated worker, they contact SCCE. The agency is also more selective in only agreeing to take on cases where there is a clear care plan and timescale for involvement, because the uncertainty in open ended short term commissions creates difficulty in planning delivery of the service, and giving a clear remit to the carer. A2M observed that he is now more aware of the limits to the carer's role, that while they may have the willingness to take on tasks, they do not have the power to influence decisions, and this can leave them vulnerable.

13. RESIDENTIAL CARE HOME

13.1 The residential care home where Mr BB was placed in February 2013, was situated about a mile from Mrs BB's home on the other side of the main shopping area. To get there on foot entailed her crossing busy roads.

13.2 The home was never approached officially to provide support to Mrs BB, or to monitor Mrs BB's welfare. Nor was it asked to be part of a co-ordinated multi agency strategy to manage the risks arising from Mrs BB attending the care home unaccompanied. RCM was aware that other agencies were involved, but until SW3 took over, it was not obvious who was doing what, and she did not sense that there was any ongoing dialogue between agencies.

13.3 In effect therefore, the support given by the home, including lunch each day, developed by default and largely through their own initiative. Initially, Mrs BB did not visit regularly, but at some point she began to visit daily, usually at lunchtime, having been dropped off by A, and from then on, the home provided her with lunch.

13.4 The Review Team commended staff for the welcome and sensitive support shown by staff to Mrs BB throughout, which to a degree provided a safety net. However, the level and manner of the caring support may have sometimes have unwittingly masked the full extent of the risks Mrs BB was exposing herself too when making her way to the home.

13.5 As 2014 progressed, various incidents and issues were brought to RCM's attention by staff who became increasingly concerned either through observations when Mrs BB visited, or from their local knowledge through living in the town where Mrs BB's behaviours were well known. These indicated that Mrs BB was becoming more confused and / or being exposed to physical and health risks. Examples included:-

- often arriving "in a muddle";
- arriving soaking wet because she could not work out how to open her umbrella (April 2014);
- flagging cars down to bring her to visit her husband;
- being escorted to the home by a stranger who was walking her dog;
- giving her purse to staff in Sainsbury's when paying for items;
- arriving once with her nightdress under her day clothes;
- visiting pattern becoming more erratic – Mrs BB often visiting several times a day but quite frequently only staying a few minutes.

13.6 The extent of staff's care and concern was illustrated by staff sometimes taking Mrs BB home to avoid her walking back on her own, and SCRM alerting SW3 to issues about the condition of the home, and then doing some cleaning.

13.7 In the absence of any formal role, or contact from Social Care, staff did not initially share this information directly with AP1, but did inform the carers from home care agency 1 asked them to pass this on. However, as shown by the earlier analysis, this did not happen. From September 2014, RCM brought these to AP1's attention most weeks because they were having regular during discussion about another resident. She also raised it when making a safeguarding referral on 19.11.14 in respect of some property of Mr BB's which had gone missing. This led to AP1 ringing her the next day when her perception was that he appeared put out that she had raised the concerns. In the various conversations with AP1, she sensed from his responses that he was feeling under pressure and had a heavy workload.

13.8 In terms of future practice, the Review heard that RCM would always ensure staff recorded significant information of their own volition, and not be hesitant about referring any concerns or risks. They would raise concerns with any family members first, and if in the absence of this, they would then raise any safeguarding concern with the MASH.

Links with the Family

13.9 Another issue explored during the Review was the level of contact with the family, and how this affected consideration of whether to share any concerns with them. Within the Case Group interviews, staff shared their perceptions that the family relationships appeared complex, and subject to change, which made it difficult at times for staff to work out who they could go to raise any issues.

13.10 Staff were aware that Mr BB received regular telephone calls from B, and who would visit when she came up during the year, bringing Mrs BB with her. C also visited on occasions but not with any consistency. The home was not aware of D until she telephoned Mr BB on the day Mrs BB's body was found. D has since visited Mr BB weekly.

13.11 The home's main contact was with A. When he first started to drop Mrs BB off, and she stayed for lunch, RCM contacted him because he had not checked first if that was acceptable, or to check whether a financial contribution was required. When RCM asked him whether he would like to make this a regular thing, she experienced A's response as somewhat abrupt, and RCM agreed in her discussion with the reviewers that she was cautious about approaching him about other matters. She was conscious also that there was little consistency, or predictability, as to whether he would drop her off and collect her, and he did not stay.

14 EVENTS PRIOR TO MRS BB'S DEATH

Introduction

14.1 This part of the analysis considers how professionals responded to Mrs BB's increasing agitation over the week prior to her death. It will look at the GP consultation and subsequent developments on 20.01.15 as a whole because of how issues within the consultation had an impact on subsequent developments.

Increase in Mrs BB's Agitation

14.2 Between 14.01.15 and 18.01.15, the daily records made by the home carer. A2C, indicated that Mrs BB's behaviour was becoming more agitated, erratic and verbally abusive, culminating in the entry on 18.01.15 that Mrs BB's use of the F word had got worse every day.

14.3 The Review noted the marked contrast between these observations with the comment frequently recorded that there were "no issues today". The Review established that the bad language, and hostile behaviour, was something the carer had become used to, and therefore was not regarded as anything out of the ordinary which needed to be raised with his manager so that the situation could be shared with Social Care and / or the GP. This was a missed opportunity to discuss with those agencies whether further assessment was required in the light of the changes in behaviour.

Mrs BB's Evening Visit to the Residential Home 18.01.15

14.4 With hindsight, the Review Team concluded that this visit was another key point in the case. Although the incident was de-escalated through the involvement of the police, the Review concluded that the lack of contact with either EDT or the out of hours GP service, was a missed opportunity to secure appropriate health and social care input.

14.5 Although the police officer had formed the opinion that it was not safe for Mrs BB to be on her own, and may have assumed that the family would stay with her overnight after collecting her, there was no certainty that this would be the case, particularly as they said they would be taking her back to her home. The Review concluded that this was a significant issue because once Mrs BB was displaying such extremely agitated behaviour, and with her history of leaving the house unaccompanied, it was no longer safe for her to be left alone.

14.6 Therefore once the immediate situation had been defused, contact with EDT would have allowed the latter to consider whether any urgent follow up action was required that evening to assess Mrs BB's mental health, and to ensure she was not left alone that night. A contributory factor which may have affected the officer's decision not to share information was that the advance checks made prior to the officer being despatched did not pick up the previous history of police involvement.

14.7 Although the incident was reported to SW3 the next morning through various sources – the email from M, a telephone call from RCM, and the voicemail message left by A2M – the focus remained on bringing the search for a residential home to a swift conclusion. If a referral had been received from the Police on the night of the incident, this might have resulted in more status and significance being ascribed to the information and influenced the response. Given that there was now evidence of Mrs BB going out in the evening, an immediate risk assessment needed to have been considered.

Analysis of Events on 20 January 2015

14.8 When A2C was worried that Mrs BB's behaviour was more concerning than usual, he displayed the required sense of urgency in reporting the situation to his manager, then arranging the GP appointment, and finally adopting an element of subterfuge in order to ensure he got her to the surgery.

GP Consultation

14.9 It is important to re-iterate that there are some significant variations in the accounts about Mrs BB's behaviour during the consultation, and what was discussed and agreed. It is not the role of the Review to try and reconcile these different accounts, and in any event, these did not affect the Review's ability to draw out the learning, and describe what might be viewed as best practice in handling similar situations in the future.

14.10 The context to this consultation was that Mrs BB had last been seen by a GP 18 months previously in July 2013, and the only contact during the previous year, was when she attended for the flu vaccination with C on 04.12.14. Therefore, the GP practice did not have any up to date overview about Mrs BB's cognitive functioning and behaviour as no concerns had been raised by the police or social care, the care agency or the family. In addition, GP2 was not her named GP, and had seen her just once before in July 2012.

Mrs BB's Presentation and Behaviour

14.11 The Review acknowledged that there were different accounts as to the degree and nature of the agitation being displayed by Mrs BB. According to A2C, Mrs BB tried to leave the surgery several times, whereas GP2 referred to her only having to be prevented from leaving once, and she was seated for 95% of the consultation. However, there was clearly a degree of agitation which needed to be taken into account in formulating a plan and assessing any potential risks. This conclusion is based on the fact that GP2 was unable to complete all the tests, subsequently recorded that Mrs BB was "swearing and lashing out at the carer", [36] and described Mrs BB as being "acutely confused and agitated" [37] in his statement to the police.[38]

The Decision that Mrs BB needed to be taken to Hospital

14.12 The Review Team understood GP2's clinical judgment that Mrs BB needed to be in hospital, given the recent history, and the presentation of dementia with overlaying delirium. GP2 explained that the possible options available to him were referral to A&E or referral to the Medical Assessment Unit (MAU). The possibility of approaching mental health services was not seen as an option because it would usually be very difficult to secure their involvement until all possible physical causes of a change in behaviour had been ruled out.

14.13 GP2's rationale for choosing the A&E option rather the MAU, was that the diagnostic possibilities included, amongst others, progression of dementia, infection, metabolic causes or an intracranial bleed. GP2 did not know for certain therefore, if there was a medical diagnosis causing Mrs BB's delirium, and there would have been no certainty that the MAU would have accepted the referral.

14.14 In addition, GP2 had gained the impression that the medical unit was quite busy through his contact earlier that day when arranging the admission of another patient. GP2 confirmed however, that this was not the key factor in the decision, and that there was no advantage in trying to refer Mrs BB to MAU when A&E was a better alternative in terms of access, safe assessment and onward referral for other specialist investigations as necessary.

14.15 The Review explored whether contacting Social Care to discuss the situation would also have been an option because the Review heard the perspective from Social Care that had GP2, or later A2M, contacted SCCE or EDT, a night sitting service could probably have been arranged immediately. This would have kept Mrs BB safe, and provided a breathing space while professionals considered the appropriate next step.

14.16 GP2's view, however, was that there was no reason to involve Social Care, and that Mrs BB needed clinical assessment in the hospital before social care plans were considered. His concern was that there was a reasonable chance that Mrs BB had an undiagnosed, and untreated cause, of her worsening confusion, so therefore the only safe option was referral to hospital. In GP2's view, trying to achieve "a breathing space" would not have

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36 *See paragraph 4.107*

37 *GP2 clarified during the Review that this latter description, and the conclusion that it was not safe for her to be at home alone, was based largely on the history given. GP2's description of Mrs BB was of an anxious and confused 84 year old lady who weighed 44kg. In GP2's view, there was a low level of aggression and irritation, but she was not a physical threat, and she was a danger to herself from wandering but to no one else.*

38 *GP2's witness statement 03.02.15*

been the appropriate clinical response, and even if he had established this service was available, it would not have changed his decision.

Arrangements for Implementing the Plan

14.17 GP2's rationale for asking A2C if he was prepared to take Mrs BB to A&E was that this might be less stressful for Mrs BB to have a carer she knew taking her there, and also it might be useful for the hospital to be able to get a history from A2C who knew her well. On the basis of both accounts, it would appear that A2C agreed to do this, although as explored a little later in the analysis, A2C's explanation is that he would not be able to do this on his own.

14.18 GP2 believed therefore that there was an agreed plan which would result in Mrs BB being taken to A&E and being in a place of safety. However, within minutes of A2C leaving the surgery, that plan had fallen apart because of Mrs BB's agitation and refusal to go to hospital.

14.19 In carrying out its analysis of why this happened, the Review identified that the greatest point of risk of something going wrong is when responsibility for action is transferred between agencies / practitioners, and drew comparisons with the baton being handed over in a relay race. The Review concluded that there were a number of practice points which may have prevented the baton being dropped in Mrs BB's case, which included issues around communication, information sharing, risk assessment of the options for getting Mrs BB to hospital, and contingency planning.

Issues on how the Plan was Drawn Up

14.20 The Review noted that situations where responsibility for action is being transferred from one agency to another, require a different approach to those which takes place within the same agency where tasks can be delegated and instructions given. In this case, GP2 was entering into an arrangement with another agency which required the situation and issues to be explored jointly, and the production of an agreed plan which was co-produced.

14.21 A2C had the most knowledge of what to expect in terms of Mrs BB's behaviour, and experience of strategies he had adopted to manage this and keep her safe. It was important therefore that during the consultation A2C was given, or took, the time and opportunity to share these insights, and contribute his views about the options for getting her to hospital. However, from both professionals' accounts of the consultation, there appears to have been little joint discussion about the possible risks and how these could best be handled. A consequence of this was that there was no agreed contingency plan for A2C to implement in the event that Mrs BB refused to go to hospital, or the carer encountered any other practical difficulties in getting her there, or was unable to enlist the support of the family or his agency.

Mental Capacity Issues

14.22 The Review established that during the consultation, there was no formal assessment of Mrs BB's capacity, but concluded that in effect two "informal" assessments were carried out and best interests decisions made. One was the judgment made by GP2 that Mrs BB needed to go to hospital and be in a place of safety. The second when A2C and GP2 were effectively party to a best interests decision when A2C prevented Mrs BB from leaving the room against her wishes, and GP2 did not intervene and tacitly allowed him to do this.

14.23 The Review heard that in considering the likelihood of Mrs BB agreeing to go to hospital, GP2 saw no reason to test out her level of engagement by carrying out a formal mental capacity assessment. This was because a management plan had been agreed, and his perception was that Mrs BB had listened to what was being said, and neither she, nor A2C, had raised any objections. GP2 clarified that if Mrs BB had stated that she did not want to go to hospital, he would have carried out an assessment to determine if she had capacity to make that decision.

14.24 In the light of all the information gained through the Review, GP2 acknowledged that it was quite possible that Mrs BB lacked capacity, and that in effect, he had made a "best interests decision", albeit an informal one. The Review noted that the perspective of the Primary Care professionals involved in the Review that the approach was not unusual. GPs are frequently required to make decisions which take into account mental capacity issues, but it is not always possible to complete, and record, a formal MCA assessment process, within the 10 minutes allocated for each consultation.

14.25 The significance of the informal nature of the GP2's assessment and best interests decision was that this did not empower A2C and A2M in any way in managing the situation which developed after the consultation. Had a formal decision been made, and recorded, if Mrs BB was deemed not to have capacity, this would have enabled GP2 to explain to A2C that this gave the necessary authority for Mrs BB to be taken to A&E even if she refused to go. Such an outcome was a possibility given that Mrs BB was angry at having been brought to the surgery, had tried to leave the consulting room, [39] and had sworn at A2C, and punched him lightly in the stomach when A2C blocked her exit.

14.26 The Review concluded that it would have been important for the results of GP2's assessment to be communicated clearly to A2C. This might have helped to prevent the uncertainty that featured in the subsequent discussions between A2M and A2C on how to proceed. The Review heard that often, home carers' awareness of the application of the Mental Capacity Act is quite limited due to their role and lack of detailed training. It is possible that A2C may not have understood the implications of the informal capacity assessment process that had taken place within the consultation.

Transport Arrangements

14.27 The Review discussion of the issues around the transport arrangements for Mrs BB to be taken to A&E were lengthy and generated a wide range of perspectives. This was because this is not just an issue for primary care professionals when a patient needs to go to hospital, but a logistical task which many agencies have to deal with – for example for social care professionals arranging admission to residential care, hospital staff organising discharge arrangements, and professionals involved in admissions to psychiatric wards or transfer to a place of safety. This is an important observation in approaching the analysis of the plan that was made, because this had to be formulated rapidly, and GP2 and A2C did not have the advantage of the time that has been available to the Review Team to think through the options, and the associated risks with each.

14.28 However, the Review heard GP2's perspective that lack of time was not an issue and there was little discussion of any potential risks, and action to mitigate these. According to GP2, A2C agreed to take Mrs BB to A&E, and GP2 did not have any significant concerns about him doing this, and was aware that A2C had managed to drive Mrs BB to the surgery. The only discussion was about the route as A2C did not know the area, and

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[39] *There is uncertainty as to how many times Mrs BB attempted to leave. GP2 sates this was once. In his original police statement of 26.01.15, A2C said she tried 3 or 4 times.*

GP2 asking what time A2C was due to finish work and establishing that he was prepared to work late to take Mrs BB.

14.29 A2C's account is different in that according to A2C, he informed GP2 that he would not be able to transport Mrs BB safely to A&E on his own, and it was at GP2's suggestion, that he subsequently made contact with the family.

14.30 Had there been more time and the circumstances allowed for more discussion, this might have taken into account a potential key risk factor - the unpredictability of behaviour of people with dementia. This was something which was well known to A2C in respect of Mrs BB, and which had been an increasing feature in the days preceding the consultation, and on the day itself. This pattern of behaviour had been flagged up for GP2 in the patient notes made by the receptionist when the appointment was booked, and at the start of the consultation when A2C described how Mrs BB had been unusually agitated and aggressive, swearing frequently and confrontational. [40]

Issues relating to the need for a Place of Safety

14.31 The most significant issue in terms of how the situation developed after the consultation was that A2C apparently did not pick up that GP2 had concluded that it was not safe for Mrs BB to be left alone, and needed to be taken to a place of safety that night. This, rather than the need for further tests, was the most crucial judgment made by GP2. This needed to be explained clearly, and in a transparent way, so that urgency of getting her to hospital would be clear. Although GP2 explained that he communicated this clearly, A2C account is that he was unaware of this crucial information, and subsequent events show this was not passed on in A2C's subsequent conversations with the 2 key decision makers, A2M and C, who believed that taking Mrs BB to hospital was just about having tests done.

14.32 According to A2C's account, [41] GP2 made a quick medical assessment, and A2C's understanding, at the time, was that GP2 thought Mrs BB may have a UTI, but that due to her aggressive nature, and GP2's opinion that it would be difficult to get a urine sample from her, Mrs BB should be taken to A&E to assess her. [42] GP2 did not feel it was urgent enough to request an ambulance but that she could be taken there by carers or the family. A2C stated that he did not believe that he had the authority or suitability to transport Mrs BB on her own, so he made contact with C.

14.33 A2C's explanation was that he was unaware that GP2 had come to a view that it was not safe for Mrs BB to be left on her own, and she needed to be taken to hospital that night which would be a place of safety. A2C only became aware of that when he opened the sealed envelope on the morning after the consultation. According to A2C had he realised that she should not have been left alone, he would have stayed, and taken Mrs BB to hospital if the family had been available. At that time, A2C was staying in a room provided by the Care Agency, and was in no rush to leave, and had nothing to do that evening.

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40 *See paragraph 4.94*

41 *Witness Statement made by PC 3 on 21.01.15 who attended the scene where Mrs BB's body was found, and subsequently conducted the first interview with A2C to gain additional background information.*

42 *Witness Statement made by PC 3 on 21.01.15 who attended the scene where Mrs BB's body was found, and subsequently conducted the first interview with A2C to gain additional background information.*

14.34 In considering why this lack of shared understanding occurred, the Review identified two contributing factors. First, A2C's attention was necessarily directed on preventing Mrs BB leaving the room which meant it was possible that he missed, or did not understand the implications, of what GP2 was saying, particularly what would happen if Mrs BB refused to go, or he could not get her there because of her agitation.

14.35 Second, in explaining that Mrs BB needed to be taken to A&E, GP2 did not explicitly use the terminology "place of safety". This term was only included within the set of notes GP2 printed off to go with Mrs BB, which were placed in a sealed envelope and not shown to A2C. Therefore A2C did not see anything in writing confirming the outcome of the consultation and the reasons for the decision for Mrs BB to be taken to hospital. While it was appropriate to place any confidential medical information in the sealed envelope, there were no issues about a breach of confidentiality if written information about the outcome and plan had been shared with A2C because he had been present during the consultation. Had this been done, the risk of any misunderstandings about the plan and urgency could have been minimised.

Events after the Consultation

14.36 In looking at what happened after the consultation, the Review identified an important context, which was the challenges A2C had faced in working with Mrs BB over many days without any time off. There was evidence that she appeared to resent the close supervision when A2C was shadowing her outside of the home, and was often abusive to him. On the practical side, keeping up with Mrs BB was a challenge because she was so fast on her feet, and would abruptly change direction as she used 4 or 5 different routes to go to town. She displayed little awareness of road safety, and quick reactions were needed as she would suddenly set out into the road without warning, and needed to be pulled back from oncoming cars.

14.37 On that particular day, the challenges were greater than usual as Mrs BB's behaviour had been more unpredictable and erratic. She had been on several long walks, during which she had repeatedly told him to "F…off". He had therefore been trying to keep her safe, and deal with Mrs BB's agitated and hostile behaviour on his own for 9 hours.

14.38 The Review concluded that throughout that day, and in many different ways, A2C did more than could reasonably be expected of any carer having regard to his role, level of responsibility and training. He had contacted his manager to explain the situation and seek direction at every stage, managed to get Mrs BB to the surgery where she could be assessed, contacted the family for help, and kept her safe throughout his shift. He also displayed a concerned and conscientious approach by waiting outside the house after getting Mrs BB settled to check that she was staying inside.

14.39 After the consultation, A2C was about due to go off shift, but found himself in a difficult situation in that having agreed to take Mrs BB to hospital, he was then left with the problem of how to deal with Mrs BB's agitation, and how to respond to her refusal to go there. He made attempts to enlist the family's help to get her there that evening, but these had been unsuccessful because of the misunderstanding described above. A2C then took the appropriate action and informed his manager of the situation, and sought his direction.

14.40 A2C's actions were governed by the decisions made by A2M that he should take Mrs BB home to settle her down, and also the subsequent decision to substitute an alternative plan of A2M visiting the following morning to obtain a urine specimen if A2C was unable to get her to A&E that evening.

14.41 In terms of the decision needing to be made by A2M, the Review noted that he could hear Mrs BB shouting in the background, and he was aware from A2C's description that she was more agitated and confused than normal. An important point here is that A2M had first hand knowledge of Mrs BB because he had been the carer delivering the service initially prior to Christmas. Therefore he was well placed to understand the significance of Mrs BB's behaviour and the possible need to organise an assessment of Mrs BB's mental capacity when she refused to go to hospital. This was not something that A2C, as a home carer, had the authority or skills to do.

14.42 However the crucial issue which impacted on A2M's decision making was that he was not aware that GP2 had concluded that it was not safe for Mrs BB to be left on her own, and that she had to be taken to hospital that evening. Had he been aware of this, the Review heard that he would have made arrangements for staff to have stayed, and he would have contacted Social Care. Cost would not have been an issue because there have been other cases where the agency has been able to claim money back from Social Care later.

14.43 With hindsight, A2M acknowledges that there were a number of possible options open to him if he was unable to go out personally to assess the situation. These would have included contacting the GP to gain clarity about the outcome of the consultation, ringing EDT to explain the situation and seek advice, and ensuring 1 to 1 support was maintained until a new plan was agreed. The absence of an agreed contingency plan may partly explain why A2C, or A2M, did not immediately contact GP2 about the difficulty in carrying out the original plan. Had that happened, the Review heard from GP2 that if no family members were available, an ambulance would have been arranged despite his view that there was no clinical necessity for this.

Informing the Family

14.44 The plan agreed between GP2 and A2C for the latter to inform the family also turned out to have a significant bearing on how the situation developed, and did not work out as GP2 expected or intended. GP2's view was that it was reasonable to ask A2C to do this because he knew the family, he had their contact numbers, and all it required was a quick, and simple call to say where Mrs BB was being taken. GP2's view that it was sufficient for the family to know where she was, and once the hospital had assessed her, the family would probably have wanted to know the findings there. This news would most probably have not come as a complete surprise because the family already knew that Mrs BB was more confused than normal given that very recently, they had to take her home after her evening visit to the residential home on 18.01.15.

14.45 As A2C agreed to do this, from GP2's perspective he had no reason to doubt that the call would be made, and the family would receive accurate information. However, although A2C did inform C that GP2 had decided that Mrs BB should be taken to A&E, crucially, because of the reasons covered earlier, he did not convey the key point that this needed to happen that evening. C's position is that had she understood the urgency, she would have been available to visit that night to help get Mrs BB to hospital as she was at home and not busy.

Conclusion

14.46 The analysis of the events preceding Mrs BB's death raises some important learning about best practice around joint working in formulating a plan when dealing with crisis situations such as these, which is picked up in Section 19 of the report.

PART 4: SUMMARY OF FINDINGS, KEY THEMES AND ACTIONS TO TAKE FORWARD THE LEARNING

15 INTRODUCTION

15.1 Mrs BB's death was a tragic outcome, and additionally distressing to the family because of the particular circumstances of her death. With the benefit of hindsight, although these could not have been anticipated, there were many risk factors which meant that such an outcome was always a possibility.

15.2 In was noteworthy that during the Case Group interviews, some professionals, while understandably shocked and upset, were not entirely surprised when they heard the news that it was Mrs BB who had been found. In addition, the driver for AP1 escalating his concerns to PC3 in November 2014 about the potential risks was his reading about a woman who had been found dead in a pond.

15.3 However, a key finding from the Review was that at the time, no agency or professional was aware of the whole picture and the totality of the cumulative risk factors. This was because of serious gaps in information sharing and joint working. The gaps in knowledge about Mrs BB's cognitive functioning, and patterns of behaviour, affected the timeliness of their response, and the quality of risk assessments, at crucial points in the case. A consequence was that the care plans drawn up from September 2014 onwards did not address all the risks that are now known to have existed, and which might have prevented the eventual outcome.

15.4 In arriving at these findings, the following developments were particularly significant:-

(i) the drift in re-arranging the assessment cancelled in December 2013. Had this taken place sooner, the risks may have been identified much earlier, and Social Care would not have been playing "catch-up" and testing out service solutions in November 2014 which by the time were no longer sufficient to address the increased risks.

(ii) the services arranged following the November 2014 assessment only covered the daytime despite the evening risks being flagged up many times by the family as the greatest risk.

(iii) the lack of urgent follow up when the circumstances of the evening visit to the residential home became known to Social Care. The Review finding was that at this point, given Mrs BB's extremely agitated behaviour, and history of wandering, it was no longer safe for her to be left on her own.

(iv) the outcome following the GP consultation on 20.01.15 whereby Mrs BB was not taken to hospital, and was left on her own that evening. The Review identified a number of contributory factors which combined to cause this outcome.

15.5 The Review findings have identified a wide range of underlying system and practice issues which need to be addressed. For ease of presentation, these are organised within the following 10 themes, although it should be noted that there are close links between these, and some unavoidable overlap of the underpinning evidence:-

- Risk assessment and management;
- Multi-agency working;
- Information Sharing;
- Response to crisis situations and care pathways;
- MCA Assessment and Best Interests Processes;

- Care Planning;
- Assistive Technology;
- Supervision and Record Systems;
- Care Provider roles and responsibilities.
- Communicating information to patients and their families;

15.6 Within the coverage of each theme, there is a summary of the key findings, a brief reminder of the underpinning evidence, followed by an exploration of the learning and suggested actions identified by the Review Team to assist the preparation of an Action Plan to implement the Review recommendations.

15.7 In reaching its conclusions, the Review Team acknowledged the commitment shown by many professionals across all agencies in trying to support Mrs BB and keep her safe, and the many challenges this involved. The Review took into account the impact of organisational change and workload pressures – both for the agency overall and individual professionals.

16. RISK ASSESSMENT

16.1 The issues around the timeliness and quality of risk assessments were among the most important Review findings because of how these had a significant bearing on the course of events.

16.2 During 2014, there was a significant increase in the level of risk because of the following factors and behaviours:-

- Mrs BB frequently became lost, or disorientated, when outside of the home, and was sometimes inappropriately dressed for the cold weather,

- she displayed little awareness of road safety, and was prone to making impulsive decisions to set off into the road – sometimes flagging down cars to give her lifts;

- the increasingly erratic pattern of visits to the residential home;

- the family reports that she was leaving the house in the evenings or at night;

- she was experiencing some difficulty with her personal care;

- the reluctance to engage with the home carers;

- more frequent changes in mood, increased irritability, and dis-inhibited behaviour;

- there was evidence that members of the family were becoming increasingly tired and stressed in trying to support her, and their level of involvement also appeared to fluctuate either because of their own circumstances, or changes in their relationships with Mrs BB.

16.3 Although no single agency or professional were aware of all the above risks, those that they were aware of did not always elicit a sufficiently urgent response, because their significance was not recognised. The Review identified a number of factors which contributed to this.

16.4 Insufficient use was made of benchmark assessments of Mrs BB's cognitive functioning which would have drawn out the extent of the decline as 2014 progressed. A comparison of the results of the early assessments of Mrs BB's in 2012 with the information gained during the Social Care assessments in August and November 2014, show the extent of the deterioration, and the impact on her ability to go about her every day life safely.

However, risk assessments did not pick up on the significance of this trajectory of change.

16.5 The ability of some professionals to spot the potential risks was compromised because they became de-sensitised to these, and accepted Mrs BB's pattern of risky behaviours as the norm. This was evident from the explanation from the former Home Care Agency 1 Co-ordinator that when Mrs BB was not at home when the carers called, they were reassured by seeing her in the town.

16.6 This was also apparent from the carer from Home Care Agency 2 recording that there were "no issues today" despite referring to Mrs BB's increasing use of the "F" word, and her impulsive and erratic behaviour when she was walking. This behaviour was not seen as significant enough for it to be reported immediately to Social Care.

Wandering or Walking with Purpose

16.7 Another aspect to this "de-sensitisation was the view adopted by some professionals that Mrs BB was "walking with purpose". This description has been promoted nationally in recent years to replace the term "wandering" which was seen as having unhelpful and negative connotations.

16.8 However, accepting this description at face-value, brings with it the danger of not being attuned to the risks that may accompany this activity. That was apparent from the Reviewers' discussions with AP1, and also the former Co-ordinator of Home Care Agency 1, who were both quick to fall back on the description that Mrs BB was walking with purpose, this was her usual pattern of behaviour, and she was well known in the town. However, while it is possible that on some occasions Mrs BB may have been able to say where she was walking to, it was unlikely that she would have been able to describe how she was going to get there.

Evening Risks

16.9 With the benefit of hindsight, this possibly proved to be one of the most significant risk factors. However the seriousness of this risk was not recognised by professionals across a number of agencies, nor were they addressed in the care plans made by Social Care.

16.10 This risk was raised 4 times quite early on in 2012 by members of the family in C's referral to NCC 06.11.12, A's call to the GP 18.11.12, and A's calls to NCC and GP 01.12.12. However insufficient weight was attached to their information, and there is no evidence that these reports resulted in any further enquiries.

16.11 The Review Team understood why SW3 treated this risk as speculative, and unproven when it was raised by B during the 27.11.14 assessment visit because no specific incidents were cited. Although there was a plan to test these claims out through the provision of assistive technology, the family needed to have been probed for further details, and supplemented by enquiries with other agencies such as the home carers or the police.

16.12 Once there was evidence of Mrs BB going out in the evening through her visit to the residential home on 18.01.15, there needed to be an immediate risk assessment because once Mrs BB was displaying such extremely agitated behaviour, and with her history of leaving the house unaccompanied, it was no longer safe for her to be left alone.

Contingency Planning

16.13 The Review findings showed Social Care did not set deadlines for plans to be implemented to ensure that services were in place that matched the level of assessed need and risk, and there insufficient contingency planning to ensure a well thought through alternative plan could be triggered quickly id the risks increased. This was evidenced by:-

(i) no time limit being set for completion of the outstanding work identified by PC3 in August 2014, and insufficient monitoring of progress to ensure these were completed without further delay;

(ii) no time limit was set for securing a residential placement which added to the challenge of keeping Mrs BB safe in the interim;

(iii) although emergency respite care was identified as the fall back option in SW3's assessment and care plan, there was no explicit identification of what developments would trigger that option;

Learning

16.14 The Review identified the following key learning points:-

(i) robust risk assessments are vital at all stages of professionals' involvement with service users who have dementia;

(ii) risk assessments must take account of the accumulating evidence of changes in a service user's cognitive functioning and patterns of behaviour;

(iii) greater use should be made of chronologies of key events to make it easier for case planning to take account of all relevant historical information about previous incidents, incidents and concerns;

(iv) agencies need to develop a shared understanding of what constitutes high risk, and thresholds for action;

(v) due consideration should be given to information about risks reported by the family, alongside that provided by other professionals, and appropriate enquiries made to check this information out;

(vi) it is important that where people with dementia leave the house unaccompanied, whether with purpose or not, there is a robust assessment of the potential risks and consequences;

(vii) when considering risk factors, and thresholds for intervention, mention of someone leaving the house in the evening should "ramp the case up", and trigger a more robust assessment;

(viii) in cases of high risk, care plans should include consideration of alternative contingency courses of action, and there is a shared understanding of when, and how, these might be triggered.

(ix) good quality supervision is an essential mechanism to help staff to take a step back, and reflect on situations, to minimise the problem of risky behaviours becoming normalised, and staff becoming de-sensitised to the risks;

Possible Actions considered by the Review Team

16.15 The Review Team agreed that it will be important for agencies to review existing guidance, tools and support that staff can draw on, so that they are equipped, and feel confident, in identifying and assessing risk and knowing what action to take.

16.16 In developing multi-agency guidance, the Review Team concluded that consideration should be given to the inclusion of descriptions of possible scenarios and risk factors which should prompt action when staff encounter these. It was recognised that this will need careful thought because it will be difficult to define all possible risk factors and situations that professionals may come across. In addition, it will be important to avoid the guidance being overly prescriptive, as each situation will be unique and professionals must be able to exercise their own professional judgment.

17. MULTI-AGENCY WORKING

Summary of Main Findings

17.1 The extent to which agencies worked in isolation was one of the most striking and worrying features in this case and contributed to the following consequences:-

- assessments and plans did not reflect a multi-agency approach, and other agencies were not routinely approached to gather information and obtain their perspectives;

- agencies lacked knowledge of each other's services, organisational arrangements, role and responsibilities;

- there was never an agreed lead agency or lead professional to co-ordinate multi agency involvement;

- no multi agency meetings were held to share information about emerging risks and agree action.

Evidence in this Case

17.2 At various stages assessments were made by the GPs, the Memory Team and Social Care but these were largely carried out without any contact with other agencies.

17.3 4 assessments were carried out by Social Care (03.01.13, 23.01.13, 27.08.14, 25.11.14). In none of these was there any evidence of other agencies being approached to provide information and their perspectives, other than the residential home as part of SW3's assessment in November 2014.

17.4 The assessment carried out by AP1 at the end of August 2014 did not cover all the relevant issues in sufficient depth, and the lack of contact with other agencies meant a full picture of Mrs BB's situation and needs was not achieved, and no additional services were arranged. When the risks increased markedly towards the end of 2014 and in January 2015, there were no steps taken to systematically involve agencies in joint problem-solving.

17.5 In addition to the absence of a multi agency approach, there was a lack of appropriate internal liaison within Social Care when 2 assessments were proceeding in parallel in 2012 and 2013 when different teams were involved which arose from Mr BB no longer living at home. The social work staff did not contact each other to share information and co-ordinate plans. It was only in December 2014, that a joined up approach was achieved when SW3 requested that she become the allocated worker for both of them.

Learning and Actions to take forward from this Review

17.6 The Review identified that there is a major gap in handling cases of high risk because there are no agreed multi-agency procedures in place for professionals to meet to share information, and formulate multi-agency support, unless these meet the criteria for being handled within the formal adult safeguarding procedures. This is a significant gap because there are many cases similar to Mrs BB who do not meet the safeguarding criteria unless there is a clear case of self-neglect.

17.7 The Review concluded that in order to secure the appropriate degree of multi-agency ownership and involvement, two levels of multi agency meetings need to be in place. First, steps should be taken to strengthen joint working at a local level so that forums exist where cases involving emerging risk can be discussed to share information and co-ordinate support. Second there should be an agreed mechanism to escalate cases where there are continuing concerns about high risk cases where action either has not been, or cannot be, resolved through the local arrangements. These high level multi agency meetings could be organised along the lines of the Multi Agency Risk Assessment Conferences (MARAC) which are used to share information and formulate plans in the most high risk cases of domestic violence. In addition, practice guidance could usefully describe what situations might be viewed as high risk, and what best practice would look like in terms of a co-ordinated multi-agency response.

Local Arrangements for Inter-Agency Working

17.8 The wider benefit of these would be in helping to build closer links between local agencies which is vital to deliver effective and co-ordinated care. The Review established that at present it appears that the closer one gets to the front-line of service delivery, the links and working relationships are weaker.

17.9 The Review agreed that whatever local arrangements are agreed, it would be important to include a representative from local care providers as this would potentially bring many benefits. Providers would bring to the table their direct knowledge of the service user, and be able to brief their carers on the updated position on the risks identified and actions required.

17.10 A starting point would be to map the current arrangements within each locality to see whether new forums would need to be established or if there is potential to build on existing arrangements. For example, within the locality where Mrs BB lived, the GP Practice holds 2 types of meetings where at risk patients are discussed. There is a daily meeting at 11am to discuss visits which need to be made that day. Although the Review was informed that there is an open invitation to professionals in the community to discuss any patients about which they have concerns, it became clear that some local agencies were not aware of this opportunity.

17.11 The other forum where at risk cases are discussed, is the Multi-Disciplinary Team (MDT) meetings which are held every 4-6 weeks. These consider the top 2% of patients where there is a high risk of hospital admission in order to explore what interventions can be provided to prevent this. Although some patients discussed have mental health issues, the majority of patients discussed tend to be those with serious physical problems. The Review heard that Mrs BB's case was not considered within the MDT meetings because the GP Practice was not aware of the escalating issues in the last few months of her life.

17.12 The MDT meetings are attended by practice staff, members of the frail elderly nursing team, district nurses, occupational therapists, community physiotherapists, and one of the Integrated Care Co-ordinators (ICC) employed by Social Care. There are a number of these ICC posts across the County, which were established to build to build closer

links between Social Care and Primary Care through each ICC being linked with a number of GP Practices. However, the Review was uncertain that this has been achieved fully, and there is thought to be some GP practices where a formal link is yet to be established.

18. INFORMATION SHARING

18.1 The Review identified many missed opportunities to share information which hampered agencies' ability to respond appropriately to the increasing risks. The cumulative effect of these was to weaken the safety net around Mrs BB that the services provided were intended to deliver.

18.2 Failures in information sharing have been a recurring theme in safeguarding reviews in adults and children's cases around the country. Quite often the finding has been that professionals were aware of when they should have shared information, but failed to do so. In this case, the finding was markedly different in that, across all agencies, there was insufficient awareness of what information should be shared, when, and with whom. In this case, many professionals did not seem aware of the need to share information in order to:-

- ensure identified increases in risk were known and could be acted on;
- report difficulties in making contact with Mrs BB, and therefore the inability to deliver the agreed service;
- provide feedback on the progress of commissioned services;
- enlist support in making delivery of services effective;
- enable other agencies to adjust their plan / service in the light of changes in circumstances or new assessments.

18.3 Examples of the different types of information about risks which were not shared, and which were particularly significant in how the case developed included:-

- Home Care Agency 1 not informing social work staff directly about the abortive visits, and the many incidents which suggested Mrs BB's memory and level of functioning were deteriorating. Although some information was passed back to the Council's Contracts Team, neither recognised the need to check that social work staff were aware of this. Had this happened, this would have given the latter the chance to review the situation.
- Home Care Agency 2 not sharing the evidence of the increase in Mrs BB's erratic and agitated behaviour, and the challenges involved in keeping her safe. This might have led to more urgency being injected into the search for a residential placement, or the implementation of the contingency plan of emergency respite care.
- the Assistive Technology Team not reporting back that no solutions could be provided to mitigate the risks;
- the occasions when the Police did not share information about their involvement which meant Social Care were not aware of all the incidents where Mrs BB was found lost or disorientated.

- The GPs not sharing with Social Care the information received from the family that Mrs BB was prone to wander. This was due to the GP Practice having limited knowledge about this issue.

Raising Professional Awareness of when to share Information

18.4 The Review recognised that while the ultimate objective is to support the development of a culture where sharing information will require a major change of mindset. The challenge is not just about raising awareness of the importance of information being shared, it is also about how that information will be viewed by the receiver, and whether it is likely to be seen as relevant to their role, and therefore acted on. The Review heard many examples of negative experiences in the past where the information shared has not been well received, or invoked a response. The can all too frequently lead to professionals starting to second guess the likely response, and deciding that there is little to be gained from trying to share the information. In view of this, the Review identified that a realistic starting point will be to focus work on securing increased understanding of the need to share information about risk.

Police Role in Intelligence Gathering

18.5 Until recently, incidents involving adults at risk have not automatically been passed through to the Multi Agency Safeguarding Hub (MASH), but this is now gradually changing with the introduction of the new Athena system, and a referral form has been designed to mirror the one that has been in use for some time for child protection cases.

18.6 However, at this stage, not all police officers will be aware of the system's purpose and capabilities, or the requirement to submit reports in all cases, because roll out of the new system across the agency is being carried out on a phased basis. Therefore at this point, it is important for agencies not to assume that all incidents are being recorded and passed on. It will be important to test the resilience of the new Athena system in terms of the extent of officer awareness and use.

18.7 It will be important therefore to maximise the potential benefits of the Police's new Athena system to provide a full picture of previous incidents and identified risks in relation to adult referrals. This would entail the Multi Agency Safeguarding Hub triaging adult referrals, and researching their systems, to mirror existing arrangements for handling child protection referrals. Although there are considerably fewer adult referrals than child protection, it is recognised that there may be a resource issue in order to achieve this.

Role of the Family

18.8 The Review established that agencies relied on the family to alert them to emerging risks or changes in her situation. For example, when there was little or no contact with Mrs BB the GPs made understandable assumptions that the family would get in touch as necessary if there were problems – reflecting an approach that "no news is good news". Similarly after the November Social Care assessment was cancelled by the family, further action was only taken after prompts from the family.

18.9 There were also many instances where the onus was placed on the family to inform other agencies of new incidents and concerns. This was evident in the conclusions reached by police officers in the June September and October 2014 incidents that there was no need to make contact with Social Care or the GP directly. It was also reflected in members of the family being re-directed at various points by Social Care, or the NCC Customer Service Centre, to make contact with the GP where a health or medication review was being sought.

18.10 The role of the family is a key issue when considering the arrangements for mobilising support to keep people safe. In recent years, the national trend has been one of increasing reliance on families, and the voluntary sector, to monitor risks, and fill the gaps in public agency support, arising from the increasing service demands on statutory agencies against a background of budgetary pressures.

18.11 Where the level of family input this is frequent and consistent, agencies can feel more confident that they will be approached if the family have concerns, or are not coping. The cases which are most worrying to professionals are those, such as Mrs BB, where there are changes in which family members are providing support, and inconsistency in the level of input. It is essential therefore, that the likely family input is taken into account within assessments and care planning, and kept under review.

18.12 It is also important that agencies recognise the help and support that informal carers need, and in particular, make it easier for families to obtain help without the risk of them feeling they are being passed from pillar to post which could lead to them giving up in trying to contact the appropriate agency. A long standing principle in national guidance is that once a family make contact with an agency, they should be helped to get the information to all the relevant agencies, and should not be required to repeat their story.

Community Support

18.13 On several occasions, there were official reports of neighbours and members of the public stepping in to help Mrs BB when they found her seeming lost, distressed or disorientated. However, it is likely that these recorded interventions do not reflect the true scale of the community's involvement given the many references to Mrs BB asking for help from strangers. It is possible that on some occasions, members of the public did not see it as necessary to report their involvement after helping Mrs BB because they would have regarded this as the kind of help one should give. In a way therefore, either perhaps unknowingly, or through a lack of knowledge of local agency arrangements, the intervention of the public may have masked from agencies the extent of the difficulties Mrs BB was experiencing, and the risks.

18.14 The level of community response in seeking to protect Mrs BB was clearly something to be welcomed, and should be flagged up as "good news" when this Review is published. In order to harness, and build on, this existing level of public support, local agencies should jointly explore steps that can be taken to promote the development of dementia friendly communities. Key objectives will be to raise awareness of the importance of passing on information where people have concerns, and to publicise the role of local agencies and contact numbers. This initiative will require a step by step approach, and targeting local supermarkets and retailers would provide a logical first step in the light of how often these featured in Mrs BB's case.

19. CRISIS MANAGEMENT

19.1 The analysis of the events preceding Mrs BB's death, and the events during and after the consultation with the GP on 20.01.15, raises some important learning about best practice around joint working to plan the next steps when dealing with crisis situations.

19.2 In respect of the GP consultation, the analysis in Section 14 identified that the greatest point of risk of something subsequently going wrong is when responsibility for action is transferred between agencies. Reverting to the earlier analogy of a baton being handed over in a relay race, for this to go smoothly there needs to be a clear handover and the baton grasped firmly. Unfortunately, this did not happen in this case. Although GP2 believed that there was an agreed plan which would result in Mrs BB being taken to A&E and being in a place of safety, the plan fell apart within minutes of the carer leaving the surgery because of Mrs BB's agitation and refusal to go to hospital.

19.3 The most significant issue in terms of how the situation developed after the consultation related to the misunderstanding about the need for Mrs BB to be taken to hospital as a place of safety that evening. Although GP2 thought he had communicated this clearly, A2C's account is that he did not pick that up, with the result that this information was not passed onto A2M and C. The Review heard that had they been aware of this, they would have acted differently and ensured that Mrs BB was taken to hospital that evening. Equally, GP2 would have arranged an ambulance if he had been informed that the original plan for the carer to take her there could not be implemented.

19.4 The learning from this is that where 2, or more, agencies are involved in responding to a crisis situation, the plans made should reflect co-production by all agencies involved, and are underpinned by effective communication and full information sharing, This is essential to:-

- ensure all possible risks are considered and assessed jointly including the options for getting a patient to hospital;

- achieve clarity about roles and tasks to be carried out;

- reach agreement on a contingency action, and reporting back arrangements, if a professional wishes to change, or is unable to implement the agreed plan;

- minimise the chances of information not being passed on to the family or managers of carers involved in this situation are minimised.

19.5 In formulating a plan, it is recognised that there are range of graduated options that professionals can choose from. These will be related to a range of factors which need to be taken into account including the level of risk, the unpredictability of behaviour of people with dementia, and the degree of urgency. Where the risks are assessed as high, this needs to "up the ante", and requires professionals to adopt a more "belt and braces" approach – what the Review termed "the gold standard".

19.6 One situation that requires the gold standard approach is where a practitioner makes a judgment that a person with dementia needs to be taken to a place of safety because if it not safe for her to be left alone, and it is agreed that another professional will take on the task of taking her there. It is vital that the practitioner explains the reasons for this clearly, and the degree of seriousness that sits around that step to avoid the possibility of any misunderstanding.

19.7 It is also important that the practitioner makes a record in sufficient detail of what has been agreed and what someone has been asked and agreed to do. This should then be shared with the person who will be taking the patient. As this case has shown, if that does not happen, there is a risk of the information not being understood and / or being mis-communicated later.

19.8 The importance of doing this is demonstrated by several research studies which have shown that patients do not pick up everything that is discussed within a consultation. [43] Recording, and sharing, what has been agreed offers better protection for all parties involved – the patient first and foremost, but also the professionals involved who can become second victims if something goes wrong.

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[43] *"Patients' memory for medical information" - Journal of the Royal Society of Medicine – May 2003*

19.9 In addition, where a carer is involved, the importance of professionals checking that the outcome has been understood is becoming ever more important given that the demography of the home care workforce continues to become increasingly diverse. Where English is not the carer's first language, the risk of misunderstandings is likely to be greater.

19.10 In this case, written information was not shared with the carer to confirm what had been agreed and the action required. The Review heard that GP2's approach was no different to usual practice and that the majority of GPs do not write a message, or hand over a note at present. The Review acknowledged that work pressures facing all professionals / across all agencies means that writing down everything that has been agreed in every case is not sustainable. Therefore GPs need to tailor what they record choosing from a set of graduated menu of options which match the seriousness of the situation.

19.11 In recommending a different approach, the Review identified that a level of mutual respect and trust is required between those involved to ensure there as much information sharing as possible, while maintaining appropriate levels of confidentiality, particularly where a patient is deemed to have capacity and has not given consent has not been given for personal or medical information to be shared. Where, a patient has been assessed to not have capacity, information can be shared in her best interests.

19.12 However, while confidential medical information may need to be handed over in a sealed envelope to be passed on at admission, there is no reason not to explain and share the contents of a referral letter, or similar note, which explains the reason, and purpose, of the referral to hospital. This can be relatively simple and the Review heard of one GP's practice of writing on the envelope "go to A&E now".

Transport Arrangements

19.13 The Review consideration of the issues around the transport arrangements in this case generated a wide range of perspectives. In drawing out the learning, the Review identified that a robust risk assessment of the transport options is essential when a person is exhibiting any form of confused or agitated behaviour.

19.14 The importance of co-production also applies to these assessments and the consequent plans drawn up. The Review identified that a significant contributory factor as to why the plan did not work out in this case as intended was the limited discussion and joint planning as to how the plan to take Mrs BB to A&E could be carried out.

19.15 In undertaking these assessments, there are 2 issues to address. First are the arrangements viable in terms of the type of transport available if an ambulance is not deemed necessary, or there are time issues before one may be available. Second is the assessment of whether the arrangements will be safe for the service user and those transporting the person. In approaching this task, paragraph 17.6 of the Code of Practice on the Mental Health Act 1983 provides a helpful checklist of issues for those involved to consider so that patients are transported in the manner which is most likely to preserve their dignity and privacy, consistent with managing any risk to their health and safety or to other people. [44]

19.16 The Review concluded that where the person is, or has recently been, exhibiting any level of agitated behaviour, a safe approach is to avoid a plan which involves a professional or family member transporting a person with dementia in their own transport without assistance As a minimum 2 people should be involved in order to ensure

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[44] *Mental Health Act Code of Practice – Department of Health 2015*

everyone's safety, and to help keep the person calm and reassured. [45] This is also the position adopted by the trade union UNISON in its advice to its members within the health service that drivers should not, in any circumstances, carry passengers without being accompanied by a colleague, unless they are confident the passenger does not pose a risk.

19.17 The Review considered whether the practical arrangements are really ones for the care agency to resolve after the consultation. However, on balance, the Review concluded that it would be better to deal with these issues, and address any likely problems within the consultation to avoid the sort of problem which arose in Mrs BB's case.

Informing the Family

19.18 The Review concluded that family members need to receive relevant information as soon as possible when a decision is made that a relative needs to be admitted to hospital in an emergency, and they have not been present at the consultation which led to this. This conclusion was reached through applying the test of what would professionals want or expect to happen if it was their relative, and also in the hindsight knowledge that in this case the family were saying that they would have responded differently if they had known the full story.

19.19 As per the preceding learning on best practice approaches to formulating the plan, the need for effective communication, and full information sharing, is vital for explaining the reasons for the decision and the arrangements being made, so there is no uncertainty, and the family can seek answers to any immediate questions they may wish to raise about the decision and next steps.

19.20 The Review's consideration of the options for informing the family again generated a wide range of perspectives, particularly on whether this is a task which can be appropriately delegated to a third party such as a carer, or whether the responsibility should remain with the GP.

19.21 One line of thinking, taking account of the mis-communication difficulties in this case, was that the decision to send a patient to hospital with Mrs BB's kind of presentation is such a significant development that it warrants the GP Practice taking responsibility for informing the family. The advantage of the information coming from the GP, is that the family will hear at first hand the reasons for the patient needing to go to hospital, and the degree of urgency.

19.22 The counter view was that because of GPs' workloads, and the constraints of the 10 minutes consultations, GPs would not have time to contact the family, and there are many situations during a GP's day which could be viewed as equally significant. The Review heard that although urgent admissions are not a regular occurrence, they are not infrequent.

19.23 In acknowledging that it may be difficult sometimes for a GP to take on the task personally during a busy surgery, the Review explored the option of whether the GP could brief another member of staff to carry out the task who would have access to the notes of the consultation, and the GP, if the family wanted further information. The Review heard some reservations about this option but agreed that there would be merit in exploring this further by establishing the approaches adopted by GP practices across the county to informing the family.

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[45] *"You are not alone" – UNISON guide to lone working in the Health Service 2007.*

19.24 The Review accepted that the arrangements need to be decided on a case by case basis, and that there is a range of graduated options which practitioners can choose from dependent on the particular circumstances and the risk factors. In some cases in might be appropriate for the task to be taken on by the person who accompanied the patient to the appointment. In that situation, it is essential to check that the person understands the reason for the decision, as described earlier.

19.25 In the light of the findings from this case, there are 2 situations which perhaps warrant the "gold standard" approach of ringing the family direct as well as checking the other person understands (in writing if necessary) what action they are to take. One is if the practitioner has any doubt as to whether the information will be passed on accurately. Second is where a decision is made that a patient needs to be taken to hospital as a place of safety because of the seriousness of that step.

Places of Safety

19.26 The Review agreed it would be helpful to comment on issues which arose during the discussions around places of safety, and to draw out the distinction between what are officially designated as places of safety in law, which is a hospital or police station, and settings which might be considered as safe for patients displaying the health and behaviour issues similar to Mrs BB.

19.27 The Review considered the question as to whether it might be viewed that at the final appointment with the GP, Mrs BB was in effect in a safe setting, but once she left the surgery with the carer, that was no longer the case and there could be no guarantee that she would continue to be safe. The Review heard however, that in practical terms, the surgery could not be viewed as a safe place because of the limited staff on site, and the physical aspects of the building. These factors would make it difficult to keep a patient in that setting for any considerable amount of time pending secure transfer to another placement – whether that was hospital, a care setting, or a member of the family taking the patient to their own home.

Multi Agency Involvement

19.28 The exploration of this issue was linked to a wider one about the possibility of greater joint working in these types of situations. The Review concluded there may be some scope in the future for joint problem solving and mutual help in crisis situations in order to hold the situation while the appropriate medical or social care arrangements can be made. This could include situations where there may be a delay in securing appropriate, and safe, transport arrangements for a patient to be taken to hospital. The Review heard that the anticipated slow response times from the ambulance service can be a key contributory factor affecting GPs' decisions. Anecdotal evidence indicated that it is not unusual for there to be a wait of several hours in cases which have not been assessed as warranting an emergency response.

19.29 The Review established that there was the potential for SCCE or EDT to immediately mobilise additional carers to provide a sitting service within the service user's own home, to keep a patient safe until safe transport arrangements can be arranged. Equally this service could provide a breathing space while professionals consider the appropriate next step.

19.30 In Mrs BB's case, the Review agreed that her presentation and needs had moved beyond the point where this would have been appropriate. Looking to the future, there may be situations where the provision of a sitting service might form a part of a multi-agency response.

19.31 Within the Review discussions, there was some sceptism as to whether Social Care would be willing to assist in what might be viewed as a wholly medical issue, and which traditionally has been one for the GP to resolve. However, the conclusion reached by the Review was that this could be achieved if there were to be a commitment from agencies at top level which could be passed down to operational teams. In advancing this proposal, the Review was struck by the level of commitment and openness on the part of front line managers within the Case Group discussions to this kind of joint problem solving approach.

19.32 The Review established that some GPs may not have up to date information about these emergency sitting services, because they tend to refer cases to the Integrated Care Co-ordinator who acts as the conduit for mobilising the appropriate services from Social Care. Therefore this could be a problem if the ICO is not available when a crisis arises. In addition, there was some uncertainty as to whether the close links which exist between the ICO and the GP Practice involved with Mrs BB is mirrored across all GP Practices. It was agreed therefore that work should be undertaken to establish the wider picture. Where immediate access to the ICO is not possible, GPs need to be reminded that SCEE or EDT should be approached for advice on how to access these.

19.33 Linked to the above point is the need to ensure that all agencies are aware of the role of SCEE and EDT as a potential source of assistance in crisis situations. In this case, there were examples of missed opportunities to involve them included:-

- no contact being made with EDT by the police officer or residential staff during the evening incident on 18.01.15;

- the manager of Home Care Agency 2 not making contact with the NCC Customer Care Centre or EDT as events unfolded before, and after, the GP consultation on 20.01.15 when he was unable to speak directly to Mrs BB's social worker.

19.34 Similarly, there is a need to remind professionals to seek the assistance of the GP where there may be urgent health issues requiring assessment. This was an avenue which was not always understood as was evident from the fact that there is no record that at any point in the case, was an approach made to the GP by Social Care Staff to discuss changes in Mrs BB's functioning and whether a medical review was required. This would have been particularly important when SW3 became aware of Mrs BB's extremely agitated behaviour during the evening visit on 18.01.15.

Involving Mental Health Services

19.35 With regard to the involvement of mental health services in crisis situations, it became apparent during the Review, that based on past experience, a range of professionals base their decision-making on the assumption that seeking to involve mental health services will be a "non starter", where there is a possible physical cause. While there will be many cases where physical causes may be the cause of the agitated or delusional behaviour, there will be some where there is a mental health component. It will be important therefore, to draw mental health services into the work on care pathways following this Review, in order to agree the type of situations where mental health services will accept a referral.

20. ROLES AND RESPONSIBILITIES - CARE PROVIDERS

20.1 The Review identified a number of important findings relating to the role, responsibilities, and working practices of home care providers, and also residential staff who find themselves in a position of providing support to relatives of residents. In the light of these findings, there are a number of issues to be addressed.

Recognising Risk

20.2 With the reduction in ongoing care management by Social Care staff because of the volume of work, home carers have increasingly become the "eyes and ears" for statutory agencies in monitoring a service user's situation and reporting any changes in levels of functioning and risks. However, despite an obvious commitment to do a good job, it is clear in this case, that staff of the 2 home care agencies were not sufficiently equipped to see the significance of changes in Mrs BB's level of functioning, the risks arising from her patterns of behaviour, and about what matters needed to be reported.

20.3 A priority therefore must be to strengthen the training and supervision arrangements for home carers so that they are better able to recognise and report when a service user's behaviour is problematic. In addition, home care managers need to understand what issues should be reported directly to social work staff or Primary Care in addition to information that is reported back to commissioning staff to evidence compliance with the contract

Levels of Responsibility

20.4 This Review has also established that there is a lack of clarity about what are reasonable expectations of home carers in providing services outside of the commissioned remit, including the extent to which it is appropriate to expect carers to transport service users to medical appointments or hospital. The Review identified some concerns about a paid carer being placed in a position which involves transporting a service user who is exhibiting agitated behaviour without assistance, and that this goes beyond what should be reasonably be expected of their role given the potential risks and limited training.

20.5 It will be important therefore for home carers to have clear guidance on how to act if they find themselves placed in this situation, and which gives them the confidence to raise issues when working with qualified professionals such as doctors or social workers. The Review noted that this can be difficult for carers to do given the inherent power imbalance arising from the differential in their professional status and expertise. The Review heard that this dynamic is a regular feature for example in carers' involvement with GPs - deferring to their expertise and accepting GP decisions without question. If challenged by managers, carers' standard reply would usually be "he's the doctor".

20.6 Home Care Agency 1 is already tackling the learning from this case through a 5 pronged initiative involving:-

- updated policies and procedures on risk assessment;
- a risk register to maintain details of all service users with dementia;
- an escalation policy to be applied when there is evidence of deterioration, and / or an increase in the number of incidents of concern;
- a revised menu of mandatory training;
- a series of learning events to share the lessons from this Review with all staff.

20.7 It will be important that the learning from this Review is shared with all care providers, perhaps through a series of "road shows", and they be asked to apply a similar approach.

Home Care Working Practices and Commissioning Issues

20.8 The Review identified major concerns about the unusual daytime escort type of service that was provided by home care agency 2, and the lack of robustness in the commissioning arrangements. The Review concluded that it was dangerous practice to allocate a worker to shadow Mrs BB for 9 hours single handed without a break given the challenges of dealing with her agitated and hostile behaviour, and trying to keep her safe during her many walks during the day. The risks of tiredness setting in were also increased by the fact that the carer was allocated to carry out these long shifts day after day without any time off.

20.9 It is essential that Social Care commissioning staff take immediate steps to ensure this practice is not replicated in the future, and that all home care providers are informed of this. Commissioners should also hold early discussions with home care providers to agree how the kind of intensive service should be provided in order to ensure the safety of both the service user and carers. This should also involve ensuring that care agencies have clear arrangements in place to respond to situations where a carer is due to go off shift and a service user may be left at risk.

20.10 This case has identified issues about the lack of robustness in the commissioning arrangements. The speed in commissioning Home Care Agency 2 meant there was insufficient time to check out the credentials of the agency in being able to deliver the desired objectives. Equally, it meant that the agency had little time to gather any handover information, and complete the standard assessments before commencing the service. It is essential that commissioning agencies approach the task so that they can be assured that an agency has the requisite skills, and safe working practices, to carry out particular tasks requested.

Role of Residential Staff

20.11 Given the Review finding regarding the uncertainty experienced by residential staff about their role, it is recommended that where agencies ask care homes / day services to play a role in supporting, or monitoring, family members when visiting residents, this should be placed on a formal footing and confirmed in writing. Any agreement should:-

- specify the nature of support / monitoring,
- confirm the care home's willingness and ability to carry out the role, and identify any limitations of the support to be offered;
- clarify how, and when, information will be shared by both parties.

21. MENTAL CAPACITY ASSESSMENT AND BEST INTEREST DECISION-MAKING PROCESS

21.1 Wherever possible, full adherence to best practice around MCA requirements, is important for 2 reasons. First, and foremost, it provides the best chance of achieving a good quality assessment, and where the service user lacks capacity, an appropriate outcome which addresses her needs. Secondly, if something later goes wrong, there will be an audit trail to show that the decision has taken into account all relevant information and opinions.

21.2 However, although all agencies have policies and procedures covering MCA requirements, the Review identified the following underlying practice issues:-

- there continues to be a lack of awareness about when a formal mental capacity assessment should be carried out;

- there is inconsistency in the quality of MCA assessments undertaken;

- on occasions, professionals are not aware that they have in effect carried out a MCA assessment, and made a best interests decision;

- MCA processes do not routinely involve all relevant professionals to share information and perspectives;

- insufficient consideration is given to whether an independent advocate is required where there are differences of opinion, and potential conflicts of interest, between the service user and family members, which would raise doubts as to whether the latter can act in the service user's best interests;

- some groups of professionals are either not allowed, or lack the training and confidence, to undertake MCA assessments even when they may be the best person to undertake these through having the most knowledge of the service user.

Lack of Awareness that a Best Interests Decision had been made

21.3 There were 3 instances during the events on 20.01.15 where professionals had in effect carried out assessments of Mrs BB's capacity, and had made a Best Interests Decision, but had not recognised this process as such:-

(i) the decision made by A2C to take Mrs BB to the surgery for the appointment with GP2 against her wishes, and he used an element of deception to get her there;

(ii) the decision reached by GP2 that Mrs BB needed to be taken to A&E;

(iii) when A2C prevented Mrs BB from leaving the consultation by blocking her way, and GP2 did not challenge this action and tacitly allowed A2C to do this.

21.4 In addition, A2C, had effectively made a best interests decision when deciding to continue to shadow Mrs BB everywhere to keep her safe after she had told him top go away and tried to get away from him. Moreover, the Review explored whether the manner in which this service was provided in effect represented a deprivation of liberty and required an application being made to the Court of Protection having regard to the guidance issued by the Law Society, and the Department of Health following the Cheshire West judgment in April 2014. The Review agreed that further advice on this issue should be sought to guide future practice.

Involvement of Other Agencies

21.5 The lack of involvement of other agencies was evident in SW2's assessment on 23.01.13 where she reached her conclusion with without any apparent contact with the GP or Memory Team. At that point, the concerns about Mrs BB's level of cognitive functioning were less serious, so it may have appeared less crucial then to consult other agencies. However the lack of consultation with other agencies was of greater significance in SW3's assessment in November 2014 which only took into account the views of one member of the family, and the residential home.

21.6 The Review established that this was not unusual, and that BI meetings with professionals would generally only take place in a small number of very high risk cases. The Review noted the mutual frustrations of both Social Care and GPs around this – the former about the lack of GP engagement, and the latter about not being asked to contribute.

21.7 In explaining the reasons why there are shortfalls in complying fully with MCA requirements in this case, both Social Care, and the GPs involved, cited the major challenges arising from the unrelenting pace and volume of work. Their perspective is that while a multi-disciplinary approach is the ideal, the focus is necessarily on achieving throughput, and having time to reflect is a luxury that is rarely available.

21.8 In exploring this issue further, the Review was mindful that MCA assessments are carried out in 2 types of situations - those that require an immediate judgment, and those which are less urgent. While acknowledging the time constraints in the former, this is not as powerful a mitigation in the latter, and workload pressures should not be seen as a justification for trying to achieve a more inclusive approach.

Actions to be taken forward

21.9 The Review has highlighted the need for more training so that all professionals understand the requirements of the MCA, and how to put these into practice. Of particular importance is the need to:-

- equip those practitioners who have regular contact with the service user with the knowledge and skills to identify and assess situations where there are potential issues around mental capacity or to seek further advice immediately if they do are unsure about situations they encounter;

- ensure that a sufficiently detailed record is made of the reasons why a MCA assessment has been carried out or considered, and the outcome;

- seek the views of other agencies who are involved, or may have relevant knowledge of the service user to inform the assessment;

- to ensure that the outcome of assessments is recorded.

- communicate clearly to other professionals, the service user, and their family the outcome of the assessment, and the implications of any best interests decision made, particularly where responsibility for implementing the decision is being transferred between agencies;

- always give consideration as to whether there is a need to involve an Independent Advocate within the BI process when there was evidence of possible differences of opinion, and conflict of interest, within the family.

21.10 On this latter issue, The Review Team's perspective was that if a practitioner attempts to take on the independent advocacy role, there is a danger that they can lose their objectivity and become too focused on the service users' wishes rather than reaching a decision based on a more detached evaluation of all relevant information and risk factors.

22. ASSISTIVE TECHNOLOGY

22.1 Throughout the case, some professionals had unrealistic expectations, and an over-reliance within their care planning, on assistive technology being able to reduce the risks, and monitor Mrs BB's movements, both inside and outside the home. These persisted because on 3 occasions a referral was not made as planned. The first was SW2's assessment of 23.01.13 when the plan was not actioned. The second was the referral forwarded to the Locality Team on 25.11.13 by SCCE which was not followed up after the Social Care assessment was cancelled. The third was the lack of referral as agreed in the discussions between AP1 and PC3 in August 2014.

22.2 These oversights came to have a significant impact on subsequent case planning. Had an AT assessment been carried out earlier, it may have identified that providing AT solutions might prove problematic, and could not be relied on to reduce the risks. As it was, AT remained a key plank in the care planning in August and November 2014, but proved to be a false hope given the problem of Mrs BB disconnecting the telephone and electrics at night, and the family not being in a position to monitor a tracking device.

Actions to be taken forward

22.3 The limitations of assistive technology as a means of reducing risks for people with dementia living alone was a key finding from the Review, and underlines that in these circumstances, finding workable solutions are heavily dependent on the family's support to enable these to be effective.

22.4 The Review established from the Case Group discussions that the problems that emerged in relation to AT are a wider underlying issue. The experience of AT practitioners, is that many professionals have insufficient knowledge of what AT can, or cannot do, and are not aware of the potential limitations of AT in monitoring the movements of a person with dementia who lives alone, both inside and outside the home.

22.5 There are clearly major problems if the service user disconnects the telephone and electric sockets. For example, property exit sensors are linked to the Community Alarm, and therefore will not work if the service user switches off the power to the Community Alarm, or disconnects the telephone because no alerts will get through to the call centre. Although provision of tamper proof boxes around power sources is a possibility, at this stage, it is not included in the ATT's standard remit, or list of prescribed equipment sourced through NORSE. However, it would be possible to explore this in exceptional cases.

22.6 Pressure mats do not always deliver the benefits professionals might expect because often people with dementia are suspicious of them, and will do their best to walk round them. Although they can be hidden under a normal door mat by the exit door, other people may trigger the alert when coming in and out of the house.

22.7 The AT Manager described how educating other professionals is an important part of his team's work. It will important therefore for this work to be given official support by agencies so that professionals across all agencies gain knowledge about the latest products, and understand what particular equipment can do, and just as importantly, will not do.

23. CASE MANAGEMENT, SUPERVISION AND RECORD SYSTEMS

23.1 The earlier analysis showed that later in 2013 and the first half of 2014, Mrs BB disappeared off the radar of the 2 key agencies. This was manifested by no annual dementia review being arranged by the GP Practice in May 2014, the cancelled November 2013 Social Care assessment visit not being re-arranged for 9 months, and the original Social Care annual review, scheduled for January 2014, not taking place. This missed review, and the delayed assessment, proved to be one of the key turning points in the case. The Review identified a number of contributory factors for these missed events.

Agency Case Record Systems

23.2 Weaknesses in both agency's IT systems were a contributory factor. The problems relating to the application of the coding system in the GP Practice was described in paragraph 6.9. The Review heard that the GP Practice involved has been working hard to eliminate the issues around the coding system. It will be important that a check is carried out on the position in other GP practices across the County.

23.3 In Social Care, the way Norfolk CC has configured the Carefirst electronic case record system does not make it easy for managers to spot when visits, assessments and reviews are overdue, as described in paragraphs 8.10 to 8.12. In addition, there are insufficient "controls", which makes it possible for staff to delete or alter dates and information previously entered without manager or IT section authorisation.

23.4 Social Care has embarked on procuring a replacement electronic record system, and it will be important that the design work addresses all of the issues which featured in this case. Bringing these initiatives to a successful conclusion will be important, because the Review noted that where agency's reminder systems fail, there is a heavy dependence on the family to act as a safety net in flagging up concerns, and this cannot always be relied upon.

Supervision Arrangements in Social Care

23.5 Another contributory factor to overdue assessments and reviews not being picked up was the supervision arrangements for assistant practitioners which were described in paragraph 8.18. The supervision of assistant practitioners by qualified social workers makes it difficult for Practice Consultants to keep abreast of the current situation of cases, and the progress and quality of the work.

23.6 An additional challenge facing managers is that where there is an allocated worker, any information, or assessment requests from the family or other agencies, are passed direct to the worker, and supervisors and managers will not be aware of these unless the worker informs them. An example of this was that the Practice Consultant was not aware of B's request on 15.07.14 for an assessment which went direct to AP1, but was not acted on. Similarly, PC3 was not aware of the information which went direct to AP1 on 14.11.14 that a neighbour had found Mrs BB "wandering", which was not responded to until B also referred to this in a call with AP1 a few days later.

23.7 The earlier findings on risk assessment highlighted how the provision of structured supervision is a key mechanism for identifying risk, and ensuring timely completion of agreed tasks. This has been recognised in the local team who dealt with Mrs BB's case, where the supervision arrangements have been strengthened. Supervision now takes place monthly, and staff are required to prepare for this by printing off a list of their current cases and adding notes outlining the position on each, and tasks which still need

to be done. This information is then shared with the Practice Consultant and Team Manager.

23.8 This is a local initiative and does not necessarily reflect standard practice across all teams within the county. It will therefore be important that Social Care carry out a review of how effectively the supervision arrangements are operating in other teams.

Case Allocation Issues in Social Care

23.9 Linked to the learning in relation to supervision, is the issue of case allocation given the problems around case management and risk assessments when the case was held by an Assistant Practitioner, and identified 2 key factors affecting these decisions. The first is that the high number of referrals of complex, and high risk situations, rule out all these being allocated to qualified social workers. Second, the workload of front line managers creates challenges in prioritising referrals, and deciding on the appropriate type of worker, because there is insufficient time to look back at the case history to identify the likely level of complexity.

23.10 In this case, and against this background, the conclusion of the Review was that while the allocation of Mrs BB's case to an Assistant Practitioner was appropriate at the outset, it should have been re-allocated sooner to a qualified worker. It will be important therefore for Social Care managers to check that the supervision arrangements are working effectively in identifying cases which either require allocation to a qualified worker or co-working.

24. COMMUNICATION WITH SERVICE USERS AND THEIR FAMILIES

24.1 The Review established that informal family carers may not have been aware of appointments or service arrangements because agency systems and practices did not always identify a member of the family with whom this information should be shared. As a result, the likelihood of missed appointments, and non delivery of a planned service, was increased.

24.2 Although the evidence in this case largely related to the GP Practice and the Memory Service, who both wrote direct to Mrs BB, the Review established that there is an issue across all agencies on how they communicate, and share information, with patients and their families. The Review also established that many agencies did not have up to date information about all the children, and sometimes were unsure of who to contact due to their fluctuating involvement.

24.3 In order to ensure that agencies adopt appropriate arrangements for passing on information, the Review identified that a number of things need to happen. As soon as agencies become aware that a service user has dementia, a "flag" needs to be entered on the electronic case / patient record to this effect.

24.4 Steps also need to be taken to ensure the record contains full contact details of the primary family carer, and of any agreement that they will be recipient of any communication. This would need to be agreed by the service user if they are deemed to have capacity. GP practices which use a touch screen for patients to log in their arrival for an appointment, will need to think through how the reception staff can check this information. Once this information has been obtained and entered on the system, it will become the family's responsibility to report any changes to these arrangements so that the records can be updated.

25. STRATEGIC CONTEXT

25.1 The analysis and findings has so far focused on drawing out the learning on the many practice and system issues which the Review has established are not unique to Mrs BB's case. This is reflected in the large number of recommendations. In making these, the Review Team acknowledges that it is departing from the generally accepted approach in conducting safeguarding reviews that these should be few in number, and focused on actions which will make a real difference.

25.2 In addition to addressing these specific issues in the Action Plan, it will be important for partner agencies within Norfolk to review its overall strategy in developing future service arrangements for meeting the needs of people with dementia given the national evidence on how the number of people with dementia will continue to rise. The evidence from this Review is that services across the board are already under pressure, and experiencing real challenges in meeting the need and delivering a prompt and high quality service against the background of continuing budgetary pressures.

25.3 Research conducted for "Dementia UK: second edition" [46] shows that, in 2013, there were 815,827 people with dementia in the UK, 773,502 of whom were aged 65 years or over – a ratio of 1 in 14 for that age group. If current trends continue, the number is forecast to be 1,142,677 by 2025 - an increase of 40% over the next 12 years. The costs of dementia to the UK economy is estimated to be £23 billion a year - more than the costs of cancer, heart disease or stroke. By 2040, the predicted costs are expected to treble.

25.4 There are around 540,000 carers of people with dementia in England, and it estimated that 1 in 3 people will care for a person with dementia in their lifetime. Half of them are employed and it is estimated that 66,000 people have already cut their working hours to make time for caring, while 50,000 people have left work altogether.

25.5 In February 2015, the Prime Minister published "The Prime Minister's Challenge on Dementia 2020" [47], which focused on boosting research, improving care, and raising public awareness. In his introduction, David Cameron made the following observations:-

"Dementia also takes a huge toll on our health and care services. With the numbers of people with dementia expected to double in the next 30 years and predicted costs likely to treble to over £50 billion, we are facing one of the biggest global health and social care challenges – a challenge as big as those posed by cancer, heart disease and HIV/ AIDS."

"Our vision is to create a society by 2020 where every person with dementia, and their carers and families…..receive high quality, compassionate care from diagnosis through to end of life care. This applies to all care settings, whether home, hospital or care home."

25.6 Within the document, the Government's key objectives for 2020 include:-

- Increased public awareness and understanding of the factors that increase the risk of developing dementia;

- Equal access to dementia diagnosis as for other conditions, with a national average for an initial assessment of 6 weeks following a referral from a GP;

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46 *Alzheimer's Society, 2014*

47 *The 2015 document was the successor to the original challenge document launched in 2012.*

- GPs playing a leading role in ensuring coordination and continuity of care for people with dementia, as part of the existing commitment that from 1 April 2015 everyone will have access to a named GP with overall responsibility and oversight for their care.

- Every person diagnosed with dementia having meaningful care following their diagnosis, which supports them and those around them, with meaningful care being in accordance with published National Institute for Health and Care Excellence (NICE) Quality Standards, including:-

    - receiving information on what post-diagnosis services are available locally and how these can be accessed;

    - access to relevant advice and support to help and advise on what happens after a diagnosis and the support available through the journey.

    - carers of people with dementia being made aware of and offered the opportunity for respite, education, training, emotional and psychological support so that they feel able to cope with their caring responsibilities and to have a life alongside caring.

- All NHS staff and social care support workers have received training on dementia appropriate to their role;

- All hospitals and care homes to become dementia friendly health and care settings;

- Over half of people living in areas that are recognised as Dementia Friendly Communities

- All businesses encouraged, and supported, to become dementia friendly

25.7 Given this national context, a priority step for Norfolk agencies update its strategy for responding to the needs of people with dementia.

26. MULTI AGENCY RECOMMENDATIONS

Introduction

26.1 The recommendations to implement the learning from this Review are organised within the following priority themes which address the areas of greatest concern:-

- Risk assessment and management;
- Joint working and information sharing;
- Mental Capacity Assessment processes;
- Home Care Provider Roles and Working Practices
- Agency systems

Risk Assessment and Management

1. *NSAB should request all agencies to update their procedures, guidance, training and supervision arrangements to incorporate the learning from this SAR to ensure staff have the skills and tools to recognise risk and take appropriate action. Agencies should remind staff that in cases of high risk, care plans should include consideration of alternative contingency courses of action, and there is a shared understanding of when, and how, these might be triggered.*

2. *NSAB should request a report from the police on how effectively the Athena system is affecting practice in reporting incidents of concern in respect of adults at risk, and on the potential for, and resource implications of, the MASH to research their systems to share the full picture of risks known to the police.*

3. *NSAB should request Norfolk County Council to draw up a plan for the ongoing dissemination of information about what assistive technology solutions are available and may be useful in reducing risks in respect of people with dementia, and particularly those living alone.*

Joint Working and Information Sharing

4. *NSAB should request member agencies to agree inter-agency arrangements for joint working in cases where people with dementia are considered to be at risk. These should include:-*

   (i) forums within each locality where local agencies and care providers can share information and co-ordinate multi-agency support;

   (ii) a process for escalating concerns in cases of high risk, including the convening of high level multi agency meetings where plans have not, or cannot be agreed locally;

   (iii) practice guidance which describes:-

   - *factors and behaviours which may constitute high risk;*
   - *thresholds for information sharing;*
   - *the need for co-production in formulating a co-ordinated multi-agency response;*
   - *the factors which need to be taken into account when deciding how to implement a decision that a service user who is displaying agitated behaviour, needs to be taken to a place of safety, including the arrangements for informing the family. .*

5. *Social Care and the Clinical Commissioning Groups should review how effectively the role of the Integrated Care Co-ordinators is building links between Primary Care and Social Care, and explore how liaison and joint working can be developed further.*

Mental Capacity

6. *NSAB should request all agencies to assess how effectively the requirements of the Mental Capacity Act are being adhered to, and report back to NSAB on action taken to revise their policies, procedures and training to assure the Board that:-*

   - *all staff develop the necessary level of knowledge and skills to identify potential issues around mental capacity, and take the appropriate action.*
   - *the outcome of MCA assessments, and implications of any best interest decision reached, are communicated clearly, particularly where responsibility for implementing the decision is being transferred to another agency.*

Home Care Provider Roles and Working Practices

7. *NSAB should request that Social Care commissioners take steps to organise a series of learning events to share the learning from this Review with home care providers, and monitor providers' progress in implementing the following:-*

   - *updating policies and procedures on risk assessment, and the maintenance of a risk register of all service users with dementia;*

   - *an escalation policy to be applied when there is evidence of deterioration, and / or an increase in the number of incidents of concern;*

   - *procedures for maintaining support and seeking assistance when it has been deemed that it is not safe for a service user to be left alone.*

   - *guidance for home carers when attending medical appointments which includes insisting on being given written confirmation from the medical practitioner of any action which is agreed will be undertaken by the carer following the consultation.*

   - *procedures for safe rostering which ensures a carer is not required to work single handed with a service user with dementia for extended periods without breaks during the day, and the working week.*

Agency Systems

8. *NSAB should request all agencies to ensure that where a service user / patient is known to have dementia:-*

   - *a "flag" is placed on the patient record to this effect;*

   - *the agency has up to date information, and contact details, of the primary family carer who is to the first point of contact;*

   - *arrangements are discussed and agreed with the patient / service user, and the family as appropriate, on who will receive correspondence from the agency about appointments or other matters.*

   - *client record systems are effective in ensuring dates are logged for assessments and reviews, and enable managers to spot quickly when these are overdue.*

9. *NSAB takes the necessary action to publicise to GP practices the need to maintain on patient records, appropriate, and up to date, information about relatives or others who the patient would wish to be informed of any new diagnosis and / or significant steps the GP decides are necessary to respond to the patient's presentation.*

SINGLE AGENCY RECOMMENDATION

10. *Social Care reviews its supervision arrangements to ensure that these enable managers to check the progress, and quality, of case management.*