Safeguarding Adults Review

Learning the lessons from the death of

GB

9 March 1951
-
11 April 2016

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1 Summary

1.1 GB was a 65-year-old man with a brain injury receiving social care and support, who sadly died following a fire in the house where he lived with his mother, SB. This review examines the quality of the contact with GB by health, social care and emergency services in the years leading up to his death.

1.2 There were undoubted pockets of excellent practice – some good inter-agency work (for example between police and adult social care, and community matron service and adult social care) and some exemplary practice from the GP, the hospital trust, and ambulance and fire services.

1.3 However, there were some practice issues that arguably dropped below the standards that could be reasonably expected. It appears, from the initial evidence supplied, that very little was done actively (with the commendable exception of the GP practice) to directly find out from GB himself his views, wishes and feelings. Bradford Adult Social Care belatedly provided subsequent evidence that while the social worker did primarily discuss GB's care with SB, GB (who they say was shy, quiet and a man of few words) was always present; and their long-term experience of GB and SB's relationship did not raise any concern of neglect, abuse or control. Nonetheless, it appears that all too often workers across all services relied either instinctively or deliberately on communicating through SB – thus, in my view, contributing to her becoming the seemingly unchallenged decision-maker.

1.4 There also appears to be a lack of professional consistency over GB's capacity to make decisions for himself. While recognising the complexity of capacity, all too often, it seemed as if there was an assumption of *a lack of* capacity rather than one *of* capacity. Even where specific capacity assessments took place, I think the integrity and robustness of those decisions remain ultimately less than convincing.

1.5 Although there are examples of good information-sharing between agencies there are also occasions where this seemed it could have been more widely and routinely improved.

1.6 Overall, there was also a troubling lack of urgency in dealing with raised concerns or safeguarding alerts, and a lack of clarity on SB's ability to care for GB in a consistently safe way. Indeed, had a safeguarding meeting been called following information provided by Lancashire Constabulary, this might have led to a more concentrated approach from, in particular, adult social care and police. There are clear issues of cross-border information-sharing that need to be improved.

1.7 Nonetheless, I do consider that lessons will, indeed, be learnt from all of the issues raised by this review – and it is commendable that some have already been addressed.

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2 GB

2.1 GB was born on 9 March 1951. He was the son of SB and sister of JB. He had two daughters – HB and PB – from his marriage to JL.

2.2 In his last 25 years GB lived in Ilkely, with his mother SB. They would usually holiday and spend weekends at a hotel and holiday complex in Lancashire, where SB owned a lodge.

2.3 In 1981, GB was arrested by West Yorkshire Police for drink-driving ("over prescribed limit"). While in custody at Otley Police Station, GB attempted to hang himself. Although unsuccessful in taking his own life he sustained hypoxic brain injuries – which meant although there was a partial supply of oxygen to the brain it was inadequate for the brain to function normally. The injuries were irreversible and resulted in GB having a "significant cognitive disability" – causing, for example, communication and memory problems.

2.4 GB's family say that following his brain injury, GB's daughters and his sister found it difficult to maintain their relationship with him. They add they were also discouraged from seeing him by SB, and became estranged. From this time SB became GB's primary carer. In recent years, additional care and support was provided by personal assistants and home care agencies through the direct payments scheme run by Bradford Adult Social Care.

2.5 On 18 March 2016, GB and SB were the victims of a fire at their house. Sadly, GB died as a result of the fire on 11 April 2016. He was 65 years old.

2.6 As West Yorkshire Police state: "It is apparent from the investigation that no other suspects were identified. It is clear that the fire was started from inside the premises and that both occupants of the address where within when the fire took hold. Neither occupant tried to escape nor nothing prevented them. The door was locked from the inside. The evidence gathered aligns to the fire being deliberate and caused by accelerant."

2.7 Although SB survived the fire, she sadly died in her holiday home just under a year later while being investigated by police for murder/manslaughter. The death of SB concluded the investigation by police.

3 Why this report?

3.1 The Care Act 2014 requires Safeguarding Adults Boards to review what has happened in cases where an adult who needs care and support either dies or suffers serious harm, and where abuse or neglect may have been a factor.

3.2 The Bradford Safeguarding Adults Board (BSAB) agreed the case of GB met the criteria for a Safeguarding Adults Review (SAR). All public services (including adult social care, health services, police and fire service) that were involved with GB in the last few years of his life have taken part in this review. They have each looked at their involvement to identify if their responses could or might have been different or improved.

3.3 The BSAB appointed Graham Hopkins as the independent author of the report. He is director of *do the write thing* (a company that provides training, consultancy and events on, for example, effective recording in social care). He is author of *Plain English for Social Services, The Write Stuff – A guide to effective writing in social care,* and *An Inspector Calls - A Practical Look at Social Care Inspection.* A former head of inspection and full-time journalist with the social work magazine, *Community Care,* he has worked in social care for over 30 years.

3.4 The purpose of this review is to understand and acknowledge what happened; understand and agree where things could or might have been done differently; and to learn lessons for the future. This report will look at the evidence presented by all involved to help improve the way that people in the Bradford area can get the best possible care, support and protection.

3.5 The BSAB agreed the following terms of reference (although not involving the author):

> *The Purpose of the Safeguarding Adults Review is to establish whether there are lessons to be learnt from the circumstances which resulted in the death of* ***GB*** *who was subject to four safeguarding adults concerns. The review sought to address two principal questions:*
>
> - *Were safeguarding concerns identified, reported and responded to as safeguarding adults concerns prior to the incident which resulted in the death of GB.*
> - *How effective and proportionate was the multi-agency response and was it in keeping with the expectations specified in the West Yorkshire Multi-Agency Procedures for Safeguarding Adults at Risk of Abuse?*
>
> *The review is to look at the way in which professionals and agencies worked together to safeguard adults at risk of abuse and set out the lessons to be learned from the responses by professionals and agencies in terms of effectiveness and proportionality. Specifically, the review will seek to address:*
>
> - *The interface between health services, the Council adult social work services, the police and respective adult safeguarding leads*

with a clear focus on what intelligence could have been used to alert to the situation prior to the serious incident.

- *The role of the City of Bradford MDC adult social work services in terms of both micro-commissioner of the support provided to GB and as the lead agency for responding to safeguarding adult concerns, the flow of information and relationships with other agencies, the decision-making process being followed by operational adult social work services and how it operated in this situation.*
- *The actions taken by West Yorkshire Police, from their initial intelligence to the subsequent decisions in relation to potential criminal investigations at various points up to the incident occurring.*
- *The involvement of health services in the support of **GB** and how concerns were reported and acted on.*
- *The involvement of West Yorkshire Fire Service and how concerns were reported and acted on.*
- *The extent to which the wishes, feelings and views of **GB** and their carer were established in keeping with the statutory principles of the Mental Capacity Act 2005.*

Consideration of the extent to which current practice and improvements implemented since the incident address the concerns identified from the review process.

3.6 To meet the terms of reference, the review will look at the way each agency:

- put GB's views, wishes and feelings at the heart of decision-making;
- treated GB's capacity to make decisions for himself; and
- understood the relationship between GB and SB, and SB's ability to care for him safely.

4 Reviewing the evidence

4.1 Following the death of GB, Bradford Safeguarding Adults Board took the decision to commission a Safeguarding Adults Review. A tender to appoint an independent author was published on 8 August 2017. Graham Hopkins was selected on 7 September 2017.

4.2 A Safeguarding Adults Review discussion meeting was set up on 31 October 2017. This meeting required each agency to provide individual management reports (IMRs) detailing and analysing their involvement with GB. Although a deadline was set for February 2018, this was extended. A second meeting - to discuss the reports – took place on 18 May 2018. A draft report was submitted in June 2018. However, following some management and communication difficulties, the final report was delayed as comments on the draft report from agencies involved in GB's care were not passed to the author – until a meeting set up in October 2019.

4.3 While I recognise the difficulties in trying to co-ordinate responses from a variety of different organisations, the length of time this review has taken is regrettable. And I would be saying this even if it had been published when it should have been in 2018. It is now over three years since GB died. This review should not have taken so long. On behalf of all involved, I unreservedly apologise for this unexpected and unacceptable delay. I especially apologise to GB's family. This review has not been carried out in a way that respects their loss. GB should have been at the heart of this review – and, indeed, in this report I have certainly tried to be guided by that. But the time taken strongly suggests otherwise. I will be making further comment on this in the "lessons learnt" section and will be recommending a more effective approach to any future reviews that are carried out.

4.4 That said, I must also acknowledge the level of work put into providing the IMRs (the eight reports total 230 pages) and, importantly, for the honest and open way in which they have been written. I am confident that each agency has not been evasive or unclear about their actions. Some of the detail has been challenging to unpick and, at times, the cross-referencing has been conflicting. That said, each agency has highlighted examples of good practice but has admitted where things could or might have been done differently. This is commended.

4.5 This report considered all the evidence in the IMRs provided by:

- City of Bradford Metropolitan District Council Adult Social Care (ASC);
- West Yorkshire Police (WYP);
- Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG);
- Bradford Teaching Hospitals Foundation Trust (BTHFT);
- Bradford District Care Foundation Trust (BDCFT);
- Airedale NHS Foundation Trust (AFT);
- Yorkshire Ambulance Service; and
- West Yorkshire Fire and Rescue Service (WYFRS).

5 Chronology

9 March 1951	GB is born.
18 May 1976	GB's daughter, PB, born.
11 May 1978	GB's daughter, HB, born.
1981	GB is arrested for drink-driving. Attempts to take own life by hanging himself in a police station – causing brain injury.
4 September 2008	GB sustains a fractured neck of femur in his left leg – has surgery two days later and remains in hospital until 6 March 2009.
01 October 2013	GP sees GB with SB: SB is concerned about GB's mobility and hip pain. GB is examined, review arranged and analgesia given.
29 October 2013	Review of analgesia. Social history taken and GB spoken with about the details of his week. Medication given – respite discussed (with mother): 'she is not keen'.
20 November 2013	GP sees GB and SB: GB is sleeping during day and awake at night. Medication altered and review arranged.
26 November 2013	Sleep pattern is now normal.
20 January 2014	A social care assessment is completed for GB. His care package to be provided through direct payments
17 April 2014	Telephone call to GP practice. Home care agency is concerned about medication stockpiled by SB who is unwilling to make an appointment or request a visit. Asked by agency not to mention (to SB) they had rung as concerned SB will not let them attend to GB.
24 April 2014	GB is seen by GP with SB. SB "denies reducing meds or having problems with meds". SB says she "is struggling with care doesn't want respite but GB agrees." GP refers GB to Adult Social Care for respite, mentioning concerns.
16 May 2014	Safeguarding alert received by Adult Social Care. Concerns raised by care provider around emotional and psychological abuse – and domestic violence.
25 May 2014	Safeguarding alert received by Adult Social Care. Concerns raised by care provider around potential neglect – as SB has cancelled care visits for GB.
28 May 2014	SB informs social worker that GB's personal assistant is

	providing care during the week.
03 June 2014	Social worker and manager discuss safeguarding concerns. Agree social worker to visit GB.
12 June 2014	Care providers inform social worker that GB had not received any care since 19 May 2014.
16 June – 2 July 2014	Social worker unsuccessfully attempts to contact SB/GB
3 July 2014	SB contacts social worker and says GB is receiving care and support from privately arranged personal assistant. Social worker offers to sort out weekend support – but SB declines.
23 July 2014	Home visit by social worker and team manager. GB is reported as "well kept".
30 August 2014	NHS111 receives a call from SB: "My son has brain damage and he has had a fall in the lounge and I can't get him up". SB travels with GB in ambulance to emergency department, Airedale General Hospital.
31 August 2014	GB moved to Acute Medical Unit.
01 September 2014	A referral is made to the hospital safeguarding adults team as "mum needs more help" and "mother struggling". Safeguarding referral accepted by senior nurse who makes contact with social work team
03 September 2014	Medical records note "social input needed as mother not coping at home".
04 September 2014	GB assessed as medically fit to be discharged home but remains in hospital "social sort out awaited".
10 September 2014	Discharged to a joint residential and nursing care home home.
14 September 2014	Assessment of GB completed by social worker.
16 September 2014	Safeguarding concerns from 16 and 25 May are closed.
17 September 2014	GB's case transferred to Physical Disabilities Team.
29 September 2014	GB returns home from the care home.
09 October 2014	GB allocated a social worker from Physical Disabilities Team.
09 - 23 October 2014	Social worker unable to make contact to arrange a home visit.

24 October 2014	SB tells social worker that GB has not had any support in place for 8 weeks.
27 October 2014	Home visit by social worker. Social worker arranges for home care agency to visit (5 November 2014).
21 November 2014	Social worker calls GP practice asking for a capacity assessment of GB. GP declines saying social worker should do this.
24 November 2014	Social worker makes an Independent Mental Capacity Advocate (IMCA) referral.
25 November 2014	Social worker offers SB a carer's assessment. SB declines.
5 December 2014	GB and SB move into a care home for respite care.
12 December 2014	Social worker completes a mental capacity assessment – and decides GB lacks capacity to choose where he wants to live.
16 December 2014	Social worker also asks GP for an opinion around SB's mental health.
18 December 2014	IMCA says that although GB was "limited in conversation he was able to express that he wished to return home". Also no concerns that SB was not acting in GB's best interests.
28 December 2014	SB and GB return home.
12 March 2015	Social worker requests that IMCA complete a mental capacity assessment and best interests decision as soon as possible.
10 April 2015	Police complete welfare check following telephone call that GB is being neglected. Police record "there are no issues with neglect and all in order at the address".
14 May 2015	Out-of-hours GP carries out home visit to GB at the holiday lodge. Notes record: "Not quite normal self, was violent to mum earlier in week. Has been O.K… Examined – nothing to find."
21 May 2015	West Yorkshire police receive report from Lancashire Constabulary concerning a possible assault by GB on SB.
17 June 2015	NHS health check on GB. He is referred to District Nursing team due to pressure area risk.

23, 24, 25 June and 23 July 2015	Failed attempts to make home contact with GB by district nursing team
22 July 2015	New social worker allocated to GB.
29 July 2015	Discharged from District Nursing team caseload following a final failed attempt to see GB.
14 November 2015	GB is seen at Royal Preston Hospital A&E.
23 November 2015	GP receives referral from Royal Preston Hospital for community physiotherapy for GB.
24 November 2015	Request from Kirkham Health Centre requesting a patient summary due to a request for a home visit as GB has registered as temporary resident there.
3 December 2015	Safeguarding concern raised by Lancashire Council. GB and SB admitted into hospital.
18 December 2015	Bradford Council agree to Lancashire Council carrying out a care assessment of GB.
22 December 2015	GB discharged to care home. Care Act assessment and Mental Capacity Act assessment sent to Bradford Adult Social Care.
13 January 2016	Safeguarding concerns are raised by social worker at "health integration" meeting; social worker and community matron agree a joint visit to GB.
15 January 2016	SB requests that direct payments be suspended (GB had £20,000 credit in his direct payments account at the time)
21 January 2016	GB is seen by GP while visiting SB – concerns about left hip after fall, plan for x-ray.
25 January 2016	Review completed of continence products for GB by district nurse team.
28 January 2016	X-ray taken – no fractures seen.
10 February 2016	Joint visit by social worker and community matron cancelled by SB by phone.
09 March 2016	"Health integration" meeting – agreed to make another joint visit by social worker and community matron; but date not agreed before death of GB.
18 March 2016	Emergency services receive reports of a fire at SB's house. Fire, ambulance and police services all attend. GB and SB are

	taken by ambulance to the emergency department, Airedale General Hospital. Police record initially a crime of "arson with intent to endanger life".
19 March 2016	GB admitted to ICU at Bradford Royal Infirmary, where he remained and (from 22 March) sedated until his death.
28 March 2016	Doctors await family to discuss tracheostomy to help GB to breathe. Consider an IMCA for decision if family not available to consent. An IMCA referral is sent.
02 April 2016	GB develops pneumonia. Doctors discuss with JB (GB's sister) GB's poor prognosis and plan to remove tracheostomy and palliate symptoms. JB agrees.
03 April 2016	PB and HB (GB's daughters) and JB arrive at hospital.
06 April 2016	Multi-disciplinary team meeting with IMCA. Decisions to "not treat aggressively" and "not for resuscitation" are discussed with family.
08 April 2016	Tracheostomy is removed and police informed.
11 April 2016	GB dies at 11.44am.
27 May 2016	SB is arrested during voluntary interview at a care home. A doctor had previously carried out a Section 12 mental health assessment upon SB and deemed her fit for interview.
10 March 2017	At around midday, SB is found dead in her holiday lodge.

6 Analysis

6.1 I consider the evidence requires me to analyse how the agencies:

- put GB's views, wishes and feelings at front and centre of their work;
- considered GB's capacity to make decisions for himself;
- viewed SB – as mother, as main carer and, critically, as advocate acting in GB's best interests;
- considered SB's ability to care for GB; and
- responded to and flagged up safeguarding alerts.

6.2 Inevitably some of these areas will cross-over, but I consider it important that we look at each of these separately and then consider how they blended together to best protect GB. From this analysis, I will consider the lessons learnt and make recommendations

GB's wishes and feelings

6.3 Central to any care and support we may provide to individuals is understanding their views, wishes and feelings. These then should inform what we do and how we do it. At times, we might need to disagree or compromise around these but we should give clear, coherent reasons why this is the case. Less formally, in any "human" service we provide, it must be a basic, natural, everyday action to ask someone "how are you?" This is what we mean by being "person-centred" or "person-led". It is, after all, the "guiding principle" in The Care Act 2014 (albeit that some of the work with GB pre-dated this).

6.4 The current Care Act guidance, for example, talks about building care "holistically around people's wishes and feelings, their needs, values and aspirations, irrespective of the extent to which they choose or are able to actively direct the process." However, in the case of GB – despite ample opportunities – there is little evidence that his views, wishes and feelings were sought directly. Almost exclusively, practitioners and providers channelled their energies both to and through SB.

6.5 GB's brain injury left him with memory and communication difficulties. He is described as being "slow" to respond. The impression I take, though, is he *can* respond; he just needs time. Again as the Care Act guidance tells us: "No matter how complex a person's needs, local authorities are required to involve people, to help them express their wishes and feelings, to support them to weigh up options, and to make their own decisions."

6.6 The records I have seen suggest that GB only appears to have been spoken to directly on very few occasions. This is not to assume, of course, that he wasn't spoken to informally or, indeed, more formally. Indeed, subsequent to the initially completed review Adult Social Care provided evidence from GB's most recent social worker who confirmed that GB was always spoken to on visits, that he was a very shy and quiet, "a man of very few words" and would have been able to disagree with any decisions being made. While acknowledging this, and that he may not have disagreed with decisions, there is no record that he *agreed* with them either. So, I am bound to consider this in the context of the information originally presented.

6.7 In this aspect, the GP practice has to be commended for consistently seeking GB's contribution to the discussion. On 29 October 2013, the record notes: "Reviewed analgesia. Social history taken and GB spoken with about the details of his week." The GP asks if GB feels sad – but GB says no. However, even here, SB's influence seems to over-ride: "Medication given - respite discussed (with mother) 'she is not keen'". Nonetheless, GB's thoughts on this are not recorded.

6.8 Again the GP is seen to speak directly to GB (24 April 2014) about possible respite care. SB declines the offer on the grounds she feels GB might not like it. But when asked directly, GB agrees to it. SB then also agrees. Tellingly, the GP and SB both feel that GB had the capacity to make such a decision. The GP submits a referral for respite care to Adult Social Care. This is, indeed, as the GP practice claims, an excellent outcome as it is the only instance recorded where GB is invited to challenge a "decision" by SB – with an alternative view that wins through.

6.9 GB appears unable to get his voice heard on 18 August 2015: the home care agency reports an episode where GB is violent towards a carer. The note says that GB had requested another carer but agency declined to do so because they felt "that carer was too friendly with SB". Although GB's behaviour is seemingly violent in this instance, this does suggest that he made the request himself and understood that it had not been complied with – perhaps causing frustration that his needs were not being met. So, on one of the very few occasions where we have evidence of GB expressing his wishes, it is over-ruled by the agency: citing SB as the reason.

6.10 On 15 June 2015, the home care agency record that "GB informed that he was okay." Earlier that year (6 January), a carer asked GB what support he would like her to provide and he said that he would like support to be put in place for his mother – which indicates insight on his part. Similarly, on 26 March 2015, GB is reported as saying he was happy and did not have any concerns. He also says he is happy with the support which personal assistant provides and wishes for this to continue. This suggests an ability to express his thoughts, if given the opportunity – and then recorded.

6.11 A contact telephone call on 24 November 2014 from the allocated social worker shows that "GB informed that he was unsure where his mother was and that his carers had not attended." Although not recording whether he was asked about his wishes and feelings, it does show that GB responded to direct questions. However, it also implies that the social worker was looking to speak to SB rather than GB.

6.12 On 18 December 2014, the Independent Mental Capacity Advocate (IMCA) says that although GB was "limited in conversation he was able to express that he wished to return home". Again this suggests that, if given time and patience, GB can make his own decisions – and, therefore, could let us know his views, wishes and feelings. However, the IMCA also adds that there were no concerns that SB was not acting in GB's best interests. Indeed, apart from a few concerns, this seems to have been the presumed assumption by professionals throughout.

6.13 Earlier, on 31 August 2014, the hospital social worker spoke "with SB and GB regarding returning home". GB is mentioned but concludes that "SB would find a residential home for GB to allow for more assessments…" Again perhaps suggesting that GB was present but not actively participating.

6.14 A week or so later, on 8 September 2014, a hospital social worker notes a "discussion with Mrs SB and GB … and a plan put in place regarding respite care". There is no clarity about how much of this was directed at or understood by GB specifically. Airedale Hospital records confirm two meetings took place around discharge planning – both with SB in attendance with GB. But, again, no specific record of GB's views, wishes and feelings. The impression remains that SB is the focal point not GB.

6.15 A home visit on 11 May 2015 sees the social worker discuss with GB about what he would do if mum was unwell: "he says he would dial 999. He could indicate his address and telephone number. He was also happy with the personal assistant's support." Again, this shows understanding and insight.

6.16 Following the fatal fire at GB's home, a hospital record on 1 April 2016 shows there was an an acceptance that, albeit with difficulty, GB could verbally communicate: "ICU discussion with GB's General Practitioner. Explained he had seen GB two months previously with a hip injury, stated he could say limited words, could stand with assistance but dependent on all activities of daily living, with his mother being the main carer."

6.17 During a continence review the staff nurse in the district nurse team recalls: "I don't remember asking or being told about how he was feeling. I can't remember any communication difficulties and that his mother spoke for him." Although worker is recalling from memory and the intervention is "straightforward" – it would question if there were no obvious communication difficulties, why not speak more directly with GB? It would have been good practice to have asked GB what he thought about his needs.

6.18 There are ample occasions where records show that GB's personal assistant(s) took him out. Nobody else appears to have had one-to-one time with GB. It is, therefore, a missed opportunity that that these times weren't better used to find and record GB's views, wishes and feelings.

6.19 Overall, despite one or two examples of good, positive practice my impression is that there is a lack of evidence that practitioners communicated directly with GB. It might have been time-consuming and frustrating but it should have been done. I suspect that channelling everything through SB became the preferred option. Practitioners, in general, did not seem to see SB and GB as different people: and simply saw SB and not GB as their client.

GB's capacity to make decisions

6.20 If a service user is deemed to lack capacity to make decisions, although professionally required, it is understandable why records might reflect conversations with family, friends and carers rather than the individual themselves. Nonetheless workers should find ways to, at least, get an impression about what someone is feeling and what they want – and record this.

6.21 For GB, I am unclear about his capacity. The law says, rightly, that capacity should always be assumed unless it is proved otherwise. However, apart from some specific occasions it does appear from the evidence that the opposite has happened: and GB

has generally assumed to have *lacked* capacity. If so, this possibly explains a seemingly over-emphasis of listening to SB rather than GB.

6.22 There is evidence that some workers were concerned about capacity: some said GB did not have capacity but other evidence points to him having capacity. It should be central to all work with GB. It should be clear in the records. It is a basic social work principle. The changing of workers might just add to the confusion but might also have provided opportunities to be more clear about this.

6.23 Above, I considered GB's ability to answer questions - a central tenet to establishing capacity. The evidence I viewed (and I accept that there may be other evidence I have not seen) suggests that GB did have capacity. For example, he answered questions that displayed understanding and insight. It does seem that he could have made some decisions. Further, a social work assessment of GB (14 September 2014), carried out while he was receiving respite care, concludes: can "communicate at a basic level and understand what he is being asked." Earlier that year (24 April) the GP records acknowledge that, the doctor (and SB) felt GB had capacity to make a decision about respite care and so no formal capacity assessment was required.

6.24 The Yorkshire Ambulance Service, called out following GB's fall on 30 August 2015, notes: "GB was recorded as having 'mental capacity' and 'consenting to treatment' on this occasion." GB's medical records also show that a letter dated 2002 (pre 2005 Mental Capacity Act) from a neuropsychologist stating "GB is able to make simple choices. He is unable to verbalise spontaneously but able to respond to questions." While recognising that capacity can, of course, fluctuate, all this evidence suggests a view of GB having capacity.

6.25 Clearly, we need to take account that for someone with a brain injury, understanding and insight might come and go. Things take time to process - and this slowness might be construed as a lack of capacity. GB also had memory problems, so forgetfulness could also be viewed in the same way. The Lancashire police report on 21 May 2015, following a call out to an alleged violent encounter, highlights the potential difficulty for people dealing with GB: "I asked him if he had left the house all day and he told me he had not. When officers first spoke to him he instantly said "I didn't hit her", although when asked about this later appeared to have no recollection of saying this. At some points GB did not appear to know where he was or how long he had been there, and gave different answers when officers asked him the same questions." This might well suggest confusion on GB's part – casting doubt on his capacity; equally, though, it might suggest that the tension, pressure and stress of police presence (irrespective of his guilt or innocence) has caused this reaction. It also calls into question GB's ability to verbalise spontaneously – although again circumstance may have had a role.

6.26 On 3 September 2014 a social worker at Airedale General Hospital is similarly confronted with such indecision to conclude that GB "has limited capacity to make informed decisions about his care or support needs". The hospital social work team manager also records that SB agrees that GB "likely lacks capacity to tell us his views wishes and feelings about going home or no." As the hospital now acknowledges, if that was the working view, a formal assessment of GB's capacity "should have been undertaken using the *Assessment of Mental Capacity and Best Interest Decision* tool (AMCABID)."

6.27 Five days later the social worker documents "plan to refer for an IMCA" (an Independent Mental Capacity Advocate). An IMCA should be used when:

- a decision needs to be made about either a long-term change in accommodation or serious medical treatment;
- the person lacks capacity to make that decision; and
- there is no one independent of services, such as a family member or friend, who is "appropriate to consult".

As the hospital also acknowledges in GB's case, "there is no further documentation in the clinical records to provide an explanation why an IMCA was being considered."

6.28 Following the fire at GB's home, I think the Bradford Royal Infirmary displays a more lucid understanding of the role of the IMCA: "Due to GB's almost continual sedation on Intensive Care Unit (ICU), his previous brain injury and subsequent hypoxic injury sustained in the fire, it was not possible to ascertain his wishes and feelings. There is evidence of frequent consultation with family members and involvement of an Independent Mental Capacity Advocate (IMCA) for specific decision making re withdrawal of treatment." On 28 March 2016 doctors are awaiting family to discuss tracheostomy: Three days later: "ICU contacted safeguarding team to discuss IMCA. Consulted with IMCA, informed not needed for decision re Tracheostomy as this is a medical decision and in GB's best interests." However, it is unclear on what grounds the IMCA advised this position.

6.29 In February 2014, the social care assessment suggests GB is lacking capacity – but no formal assessment is carried out. On 12 December 2014, GB's allocated social worker does carry out a mental capacity assessment and concludes that GB lacks capacity to decide where he lives. The GP practice receives a letter 4 days later "stating GB does not have capacity regarding where and with whom GB lives." However, the evidence (that "he was unable to comment on any perceived risks regarding him living at home with his mother") appears somewhat unconvincing. It is, commendably, questioned by Bradford's Adult Social Care's Mental Capacity Act manager:

> "there are significant areas where the assessment lacks details. It suggests that the lack of detail is to the degree where it is suggested that the first principle of the MCA "A person must be assumed to have capacity unless it is established that they lack capacity" has not been rebutted. This assessment does not act in accordance with the statutory principles of the MCA and I think that based on the documented evidence in the report it cannot be relied on as a defense about the decision that was made. The assessor has also failed to complete any information in the best interest section of the document so I am unaware if any of the principles of the best interest decision making have been followed."

6.30 A capacity assessment carried out by Lancashire Council in December 2015 concluded that GB did have capacity to decide where he should stay while his mother was unable to support him at that time. Again, Bradford's Adult Social Care's Mental Capacity Act manager believes there could have been more robust

evidence to back up the decision, but professionally concludes "that the person has capacity as we are unable to provide evidence to the contrary."

6.31 There is also, in my view, evidence of the social worker requesting others to do this job for them. I find this puzzling. On 21 November 2014, the social worker contacts the GP "requesting a capacity assessment" for both GB and SB. The GP with the most recent contact (some seven months before) with the family explains, correctly, that "capacity is time and decision specific and should be done by the person making the decision." The Mental Capacity Act (2005) Code of Practice (2007) states that "the person who assesses an individual's capacity to make a decision will usually be the person directly concerned with the individual at the time the decision needs to be made" and that "a person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made." I agree that here the GP "shows a clear understanding of the MCA principles and the Code of Practice."

6.32 Overall, the conflicting perceptions of GB's capacity are at the root of the work in this case – and, perhaps, indicative of the way it has been managed. Every practitioner should know that a person is assumed to have capacity unless there is solid evidence to suggest otherwise. In the evidence presented, I see no such evidence why GB may lack capacity – other than some practitioners simply questioning that he might lack capacity. It appears to me that practitioners have, in general, assumed that GB *lacked* capacity – rather than had capacity. If they had thought otherwise, surely they would have questioned and challenged SB's role and decision-making? As above, with finding out GB's views, wishes and feelings – the basic, simple question – "what do you think about that?" - appears to have been forgotten, overlooked or deemed unnecessary. Or simply unrecorded.

SB as advocate – and acting in GB's best interest

6.33 The seeming lack of purpose to find out GB's wishes and feelings coupled with a perceived ambivalence over his capacity, could surely have combined powerfully to form the assumption that SB – maternal main carer – was GB's advocate. After all, here is a mother who (appearances and circumstances suggest) has given up everything to care for her son: why wouldn't she have his best interests at heart? Indeed, on one occasion, it is recorded that GB "lights up during mum's visits" at the respite care home. However, add to that GB's reported slowness and communication difficulties – it is open to consider how much more efficient it must be to deal with mum - who is seemingly ever present and ever willing to take control, make decisions and move things on? Again, in subsequent evidence presented by Adult Social Care, the most recent social worker involved in the case confirmed they "never had any qualms about the care which SB provided to GB". It was always considered that SB did act in GB's best interests and that GB was "always well-presented and never appeared unkempt or uncared for, the property was always clean and tidy and never cause for concern." Again, while acknowledging this additional information, it could appear that everything was fine. However, it could also appear to suggest a possibility that because everything seemed to be okay, that professional curiosity was disengaged. It still remains easy to picture SB's forcefulness and presence holding an apparent sway over practitioners.

6.34 Families, rightly, can and should be very protective of each other. Nor is there convincingly consistent suggestion that there is wilful abuse or neglect occurring

here. There are, admittedly, some touchstone moments of great concern around their relationship but I am minded to consider that SB was trying to do (in her view, at least) her best by GB. Nonetheless, I also consider this perhaps fell short of what GB actually needed. Her ability to care for GB (regardless of her best intentions) is highly questionable; and by seemingly seeing SB as the first port of call practitioners have been unintentionally complicit in permitting potentially neglectful care.

6.35 The records are full of examples of people talking and listening to SB; of responding to her; of accepting her decisions; of trying to work around her confrontational or disruptive manner. It is clear that SB is the focal point of the care – not GB. On occasion, this was well-placed as concerns are raised about support for her in her caring role. However, overwhelmingly, contact with the family should have centred around GB with him involved in decision-making: but the evidence suggests this was not the case.

6.36 For example, on 8 September 2014, Airedale Hospital records a social worker visiting about safeguarding concerns around GB returning home: the worker "spoke with Mum – she will find a residential home for GB to spend a short time as a flexi bed arrangement to allow time to further assess." Records show that the social worker attempted to contact SB (not GB) on 23 May 2014; and again on 28 May where SB "declines" offer to reinstate previous care package; 3 July 2014 (after failed attempts) SB contacts social worker – but "declines" weekend support for GB; "extra care flat declined on behalf of GB by SB" (7 February 2014); "SB making decisions regarding care planning via direct payments" (8 April 2014); SB "cancels care on Saturday and Sunday" (17 April 2014)

6.37 Again, a home visit on 23 July 2014 – apart from entry that GB appeared "well kept" - the notes centre on SB not GB. "SB advised she is happy with the care provision in place"; "SB declined care provision on a weekend for GB and informed that GB did not shower at the weekend but he is able to complete all other aspects of his care independently" (which, if the case, begs the question: why the need for care and support?); the assessment of 14 September 2014 – "SB wants GB and SB to continue living together" – but what does GB say? In hospital (01 September 2014) the ward nurse notes that "SB requested residential care for GB".

6.38 SB tells new social worker on 4 November 2014 that she is too unwell to return from Ribby Hall Village after the weekend – and thus cancels the arranged meeting on the next day. GB and SB return home 10 days later – but no mention of how care needs have been met in this time? Strikingly, "SB *tells* social worker they will resume with previous PA" (my italics).

6.39 On 8 September 2014, the case file entry from hospital team manager reads:

- SB recorded to be upset and reportedly advising she 'felt like a criminal'
- SB advised that she did not wish for GB 'to be taken away from her.'
- SB reported that she thought that GB was not willing to get up of the floor because he 'was having her on'
- SB reported that GB has placed himself on the floor before.
- SB advised that GB was comfortable on the floor she brought him a pillow and a coffee.
- SB informed she wanted GB to return home.

- SB agreed that GB 'likely lacks capacity to tell us his views wishes and feelings about going home or no'
- SB advised GB is 'not mental'
- Flexi bed discussed at home
- IMCA discussed.

Following this "SB agreed for GB to have a short stay in nursing care home."

6.40 Similarly a home visit 11 days later by GB's allocated social worker prompts the following record:

- SB informed SW that her cousin had died and she was making arrangements for attending the funeral in Doncaster.
- SB advised that it was 'their wish' to move to the lodge at Ribby Hall.
- SB advised that if she and GB moved into Ribby Hall, she and GB would have to move out of the site for 3 weeks per year.
- SB advised she and GB would move into a hotel for this period of time.
- SB refused to re-arrange visit from home care agency.
- SB requested that support be restarted with the home care providers.
- SW recorded that 'both' would be going to and from Ribby Hall.

6.41 Indeed, the social work files follow this pattern repeatedly. On 18 February 2015, "SB requested for a decrease in GB's care provision during the week to enable her to purchase care at the weekend for GB." On 13 March 2015 – SB declines support at weekends. Even when another local authority – Lancashire County Council (where the holiday lodge is) - makes contact on 21 May 2015 we see "LCC care navigation confirm they have already spoken to SB". On 22 July 2015 when a newly allocated social worker attempts to make contact it is through SB. The worker wants to arrange a home visit but "SB declines". Again, the clear message should be: the worker is allocated to GB not SB. As such, the worker is *required* to see GB but apparently defers to SB. It continues: on 15 January 2016, "SB requests that direct payments be suspended – and declines increase in care package".

6.42 Even something the professionals consider to be "a straightforward situation" (an uncomplicated visit), it is SB who dominates. A continence products review notes that the nurse "recalled that GB's mother discussed the changes needed to GB's continence products which were acted upon". As mentioned earlier, the nurse comments "that his mother spoke for him."

6.43 As said, there are times, of course, where speaking with SB would be the best way – particularly around carer's issues. Indeed, on 29 October 2013, The GP practice notes: "Respite care is discussed with (GB and SB). The mother is not keen on respite care at this point and GP advises them to think about this." But as the GP practice, again correctly in my view, points out: "This consultation is prior to any safeguarding concerns and it does seem good practice to have the mother's agreement due to the main reason for considering this is the potential for carer strain."

6.44 Nonetheless, the overwhelming impression is SB is front and centre in this case and not, as it should be, GB.

SB's ability to care for GB

6.45 I am sure (as explored above) that SB, understandably, wanted to care for her son. There are many recorded examples, despite her words and actions, that practitioners had no fears that SB was neglectful, intentional or otherwise, of GB. However, good intentions do not necessarily result in good or acceptably safe care. In this case, there are, in my view, troubling question marks over the quality of care that SB was able – physically or emotionally – to provide. I can only deduce that these remained largely unanswered or unchecked because of the general acceptance that GB had limited or no capacity, that his wishes and feelings were not routinely sought and everyone saw SB as GB's advocate acting in maternal best interests.

6.46 There are reported occasions when GB's behaviour was aggressive or violent that should have alerted a more considered look at SB's ability to cope (for her own safety if not GB's). In addition to the incident cited in paragraph 6.25 above, on 2 April 2014 we are informed that GB had been "aggressive for 2-3 days" – and yet there is no record of any risk assessment. In December 2014, the social worker seeks legal advice (and spoke to advocate and GP) concerned that SB is becoming frail and showing signs of poor mental health. But the extent of neglect is unclear: as the local authority concede: "The actual evidence suggests that GB presentation is of being clean, happy and cared for."

6.47 Similar behaviour is recorded more fully over 13-14 May 2015. Adult Social Care notes that "home care agency advised Social Worker that GB was aggressive with SB at the lodge at the weekend; SB reportedly 'shook up' by GB's behaviours towards her; home care agency suggested that GB requires care on a weekend and independent time from SB" (13 May). Again: "Social Worker contacted SB who informed that GB was aggressive towards his carers this AM; SB informed that she was scared of GB and was ready to leave him; SB informed that ambulance came to the lodge however they did not admit GB to hospital; Social Worker agreed to contact GP for GB to rule out a UTI (*urinary tract infection*) or any other infections which may be causing GB's change in presentation."

6.48 Neither episode seemed to spark a risk assessment or consideration of changing needs for GB or, indeed, support for SB. The social worker did contact the out-of-hours GP on 14 May – as the GP practice records show: "Telephone call from Social Worker about an incident while at their Lodge in Lancashire on Monday. GB violent so Police and ambulance called. Mother says GB fell yesterday and is unsure of any injuries. GB has been unwell, sleepy and aggressive." The doctor speaks "to mother who says GB is not his normal self." The doctor follows up the call with a visit: "Has been O.K. Has some toothache and was due to go to the dentist. Examined – nothing to find. Plan to offer a contingency, to give analgesia if required and to use medication (diazepam) if needed."

6.49 Police are also called to this incident. Lancashire Constabulary's report expresses concern about SB's frailty: "The female informant also appears to be vulnerable, she is an 84 years old very small female, she appeared scared and at many points told officers that she is scared and that she is sad."

6.50 The same report also provides alternative and strong evidence of potential neglect: "The property they were living in was dirty, there was dry faecal matter scattered across the property, which SB handled without using any gloves and did not wash her hands and did not seem at all bothered about it being there and placed it on the side table. In addition to this there was trodden in faecal matter across the property. There were no windows open and all the curtains were shut even thought it was a nice day outside. The house smelt of faecal matter through. In the kitchen there was nothing of obvious nutritional value and the surfaces were dirty." None of this appears to have been acted upon. The report was sent to West Yorkshire Police – who emailed it onto Adult Social Care. But neither thought it worthy of a safeguarding alert.

6.51 The records repeatedly show that SB's ability to care for GB was questionable: her understanding of care, being unable to cope, her mental health and low mood, her behaviour and manner, her decision making, and her excessive drinking of alcohol.

6.52 West Yorkshire Police records show that when GB's long-term on-off personal assistant first came to work with him (in 1999) "he was not being stimulated. In her words he was a vegetable so she spent a lot of time with him, taking him swimming and developing his walking and language skills." Following GB's fall on 30 August 2014, the attending ambulance crew "found GB incontinent of urine and washed and changed him but found no apparent injuries." Nor did SB appear to understand the risks of leaving GB on the floor (suggested as being for up to seven hours).

6.53 The records show a catalogue of care breakdowns – often leaving GB without agency or personal assistant care for several days and sometimes weeks at a time (in addition to the weekends and time away in the holiday home). It's hard to clarify but records seem to suggest on one occasion it might have run to 50 days (16 May-23 July). Each loss of care can almost exclusively be laid at the door of SB's behaviour and actions.

6.54 The social worker following GB's respite admission into Troutbeck care home (5 December 2014) admits that care workers "found it difficult to provide the right care because of SB interfering and hampering their efforts." Indeed, Troutbeck's manager (8 December 2014) tells social worker that SB "can be erratic, finds fault with carers and will not leave GB alone." Two weeks later again reports concerns that SB was "ordering GB to put his pyjamas on at 4.30pm" (although another record suggests 4pm). On 21 November 2014, the GP records a telephone call from the social worker: GB "had daily care until recently as one by one agencies and personal assistant refusing to go in due to alleged behaviour of mother."

6.55 This "behaviour" generally includes not allowing carers to carry out their tasks, being abusive and making inappropriate requests. For example, on 8 June 2015 the home care agency informed Adult Social Care "that package of care has broken down; Carers reported that they had been sent away after one hour and requested that they sweep the leaves from outside." The new care agency a week later report that "SB was verbally abusive towards care staff at the weekend following alcohol use." This is followed up on 14 July 2015: "SB refused for home care agency to assist with cares."

6.56 Neither is there any shortage of concerns raised around SB's ability to cope. On 2 April 2014 carers report SB as "not coping" and "tired". The social worker visited on

23 July 2014, "SB appeared frail and breathless". On 8 June 2015, the home care agency "believe that SB requires support for GB and that they did not understand why this was not accepted."

6.57 Airedale Hospital's notes on 30 August 2014 show that the senior nurse safeguarding spoke to Adult Social Care around SB's "carer stress" - but was also clear that this stress had not resulted in abuse or neglect of GB. Further hospital notes record "mother struggling" (31 August 2014) and "social input needed as mother not coping at home" (3 September 2014). However, four days' later we see that "mother happy to take (GB) home: Await plan." The question needs to be asked: if the carer is "struggling" and "not coping" why would this be considered a good outcome?

6.58 Another consistent characteristic is SB's apparent excessive drinking of alcohol. On 21 November 2014, the social worker considers SB "might be drunk" as she was "slurring" her words – and cooking chicken (something the worker did not consider exploring further – despite the obvious risks). On 24 November 2014, a carer reports that "SB may have been drinking" - although the evidence was simply "a VK (*Vodka Kick*) bottle top on kitchen side". On 19 December 2014, the manager of Troutbeck care home reports SB "drunk in lounge" – "kissing members of staff and making allegations and being abusive." Three days later the home again raise concerns about SB's drinking and report she "may have attempted to drink and drive."

6.59 On 11 March 2015, GB's personal assistant raises concerns to the social worker about "SB's increased drinking alcohol in excess", saying SB has been "paralytic many times in the past few months," and is "hiding bottles of alcohol." She adds that she "visited the lodge and found GB laid on the floor and SB walking around intoxicated." On 24 March 2015 the personal assistant reports that "SB sounded drunk on phone" following 14 missed calls.

6.60 The home care agency also raise concerns in June 2015: "SB was verbally abusive towards care staffs at the weekend following alcohol use" (15 June); and "SB was drinking earlier in the week" - carers "feel that the drinking may be due to the lack of support which GB and SB have when at the lodge" (26 June).

6.61 There are also consistent concerns raised around SB's mental health. On 24 November 2014 carers report SB "presented low in mood". On 5 December 2014, the manager of Troutbeck care home "expresses concerns about SB's mental health". On 9 September, SB says "she feels depressed and she is not eating." On 27 January 2016, SB tells the social worker "that she cannot go on GB is not sleeping during the night" and has stopped "taking her anti-depressants due to them not working."

6.62 More concerning, on 14 April 2015, the home care agency informs the social worker that SB had said "she wanted to 'end it' because she did not feel supported." The GP follows this up but SB proves unwilling to discuss her mental health. A safeguarding concern raised by Lancashire County Council notes (on 28 November 2015) that SB "intoxicated, agitated, abusive, laughing, at one point she held a knife to her own throat." On 21 January 2016, SB told GP that "she has no family or friends, was socially isolated she would not be 'here' if it was not for GB." West Yorkshire Police records show that GB's personal assistant "eventually found herself at odds with SB who would get drunk and become violent towards her. SB was always reluctant to

get the help she needed, it became clear as she got older she struggled and on a couple of occasions stated, 'If I go he's coming with me.'"

6.63 Some of this could be seen as drunken exaggeration; however, given the circumstances surrounding GB's death the above is potentially volatile when read together (and, more so, when collated) with the previous police records – which reveal an earlier charge (in August 1999) of attempted murder by medication overdose – although this was dropped by the Crown Prosecution Service for insufficient evidence). But none of this was co-ordinated across the agencies. It would be unwise to suggest that GB's death could have been avoided had agencies been aware of this information, but surely they would have been more alert to the risks and acted with more consistency and urgency?

Safeguarding alerts

6.64 The local authority report five safeguarding alerts for GB between 2014-16. These were:

- 16 May 2014 – emotional and psychological abuse – and additionally 25 May 2014 – risk of neglect;
- 1 September 2014 – neglect;
- 21 November 2014 – risk of neglect;
- 5 & 23 December 2014 - raised by Troutbeck care home; and
- 21 January 2016 – neglect.

16 May 2014

6.65 A safeguarding alert is raised on 16 May 2014 by the home care agency stating a carer had witnessed SB shouting at GB and attempted to prevent him from going out with the carer. GB is described as "frightened" and SB attempted to pull his coat off. SB then asked GB and carer to leave – and would not speak to them upon their return. It is regrettable that the carer seemingly didn't use the time out with GB to, at least, find out GB's wishes and feelings around this incident (or if they did, that the conversation was not recorded). Providers are also concerned that SB wants to cancel care on Saturday and Sunday. The Access Worker tells the agency to carry on providing care anyway regardless of family wishes. Although presumably a decision made to protect GB's care needs – this probably could have been managed in more collaborative way.

6.66 The alert is soon closed on the local authority's safeguarding database as it is dealt with by social work team as a care management issue. However, the way it is managed, is indicative of the Adult Social Care approach – and is played out entirely through SB and not GB. For example: 23 May 2014 – "allocated worker attempted (unsuccessfully) to contact SB"; 28 May 2014 "allocated worker contacted SB" – offered to reinstate care package – but "SB declined."

6.67 On 3 June 2014, the "allocated social worker discussed safeguarding concerns with team manager". The manager agrees that these are not "additional concerns" (*that is, I assume, not new*) and "social worker to visit on return from leave" (which will be 17 June 2014). I find the same question recurring: where is the urgency? This smacks of "we are concerned" but not "that" concerned.

6.68 On 12 June 2014, SB contacts Adult Social Care "unaware why the service has stopped and GB had not received care (since) 19 May 2014." The social worker (having returned from leave) then makes several unsuccessful attempts to contact between 16 June 2014 and 2 July 2014. SB then contacts the social worker to say that privately arranged care is in place Monday-Friday. The social worker (I consider, rightly) offers to organise weekend care as well: "SB declined". But it is not SB's place to do so. Where is the worker's challenge to this "decision"? This is a basic social work function: to put themselves in the shoes of the service user, to see the world through the service user's eyes.

6.69 A home visit is planned on 10 July 2014 – but takes place on 23 July 2014. Social worker and manager to visit home to "assess risk of harm" – but there is no evidence of any discussion that took place. GB is recorded as "well kept" – but rest of record is about SB's thoughts: "SB identified concerns for GB and SB future in a large house; SB advised that she is happy with the care provision in place; SB declined care provision on a weekend for GB and informed that GB did not shower at the weekend but he is able to complete all other aspects of his care independently." By the time safeguarding team came back to agency – the care had been cancelled, although no attempts appear to have been made to establish the circumstances or investigate this.

6.70 A risk or care management plan can be an appropriate replacement for safeguarding investigation – but this should have been clearly documented. The regional policy has not been followed.

1 September 2014

6.71 At 7pm on 30 August 2014, SB called NHS111. She says: "My son has brain damage and he has had a fall in the lounge and I can't get him up". She says she had not witnessed the fall as she was upstairs. SB continues: "GB was currently on the lounge floor, he was warm and conscious, but kept falling asleep". She says GB was responding "normally for him". The ambulance arrives at 7.20pm. The Patient Care Record (PCR) reports GB was "on the floor, unknown how long". GB is recorded by the ambulance crew as having "mental capacity" and "consenting to treatment". The ambulance took GB (and SB) to Airedale General Hospital.

6.72 The emergency department staff make a referral to the hospital safeguarding team as "mother was struggling" and "mum needs more help". GB is admitted "due to poor mobility and concerns regarding Mrs SB's ability to care for GB at home." The hospital notes: "The Senior Nurse Safeguarding Adults accepted the referral on Monday 1 September 2014 and subsequently contacted Social Services (based at AGH) in order to determine Social Services involvement … Following discussion with the Physical Disabilities Team, the Senior Nurse was informed that the Team would visit Mrs SB on Thursday 4 September at AGH in order to establish if further support was required since Mrs SB was "suffering from carer's stress". The Senior Nurse Safeguarding Adults was clear that there was no indication that this "carer's stress" resulted in any type of abuse/neglect toward GB." On that day the social worker asks the hospital to report a safeguarding concern for GB – and aims to identify a "flexi-bed" in a care home "to allow for a period of assessment for GB".

6.73 It does seem from this record that a safeguarding alert was not raised following allegations that GB had been left on the floor for (up to potentially) seven hours "before medical assistance sought" (the ambulance is called). However, on 5

September 2014, social worker visits "SB at home without GB present to discuss concerns regarding the long lie". The worker records that SB did not appear to understand the risks that involved, felt she presented as frail and was "resistant for GB to have a period of short term care". It is intriguing that rarely does SB get challenged about such decisions. Presumably, workers are accepting that she can cope (or at least wants to cope). But perhaps she doesn't want GB away from her – out of her control? The questions – that professional curiosity should encourage - do not seem to have been asked.

6.74 The hospital team manager's record on 8 September 2014 again shows how communication travels exclusively through SB: "SB recorded to be upset and reportedly advising she 'felt like a criminal'; SB advised that she did not wish for GB 'to be taken away from her'; SB reported that she thought that GB was not willing to get up of the floor because he 'was having her on'; SB reported that GB has placed himself on the floor before; SB advised that GB was comfortable on the floor she brought him a pillow and a coffee; SB informed she wanted GB to return home; SB agreed that GB 'likely lacks capacity to tell us his views wishes and feelings about going home or no'; SB advised GB is 'not mental'; Flexi bed discussed at home; IMCA discussed; SB agreed for GB to have a short stay in a nursing care home" (so an assessment can take place). GB is subsequently discharged from hospital to the care home on 10 September 2014.

6.75 Similarly, the local authority record notes on 14 September 2014: "Assessment completed by social worker; Records indicate that GB requires full assistance with all aspects of his personal care. GB reportedly 'shy'; GB reportedly 'lights up' when his mother visits; Social worker recorded GB can communicate 'at a basic level' and understands what he is been (being) asked; SB wants GB and SB to continue living together." Here there are contrasting views on GB's capacity: On 8 September there appears an agreement that he lacks capacity but the assessment less than a week later appears to suggest that he is able to understand questions and his situation. On 10 September, the team manager closes safeguarding concern – and agrees on 17 September 2014 that SB can make arrangements for taking GB home.

21 November 2014

6.76 GB's new social worker (allocated on 9 October 2014) raises an alert that GB had no formal care in place and was at risk of neglect. The social worker also calls the GP practice: GB "had daily care until recently as one by one agencies and personal assistant refusing to go in due to alleged behaviour of mother. Social Worker is starting adult protection procedures and requesting a capacity assessment for both of them." But as explained above the GP, rightly, argued that they are not the right person to carry out a capacity assessment.

6.77 Linked to this, on 16 December 2014, after deciding that GB does lack capacity "around where and with whom he lives and concerns around non-malicious neglect", the social worker also queries SB's ability to care for GB. The social worker asks the GP for an opinion on SB's mental health and SB's ability to drive long distances. GP said that SB scored low on a memory test but would not comment on SB's ability to drive. Although SB declined support from a local care agency – as she wanted a previous carer to be re-instated (but they could not provide the care) – the alert was closed as SB "made arrangements for GB to have respite in a local care home".

6.78 Although dealt with, appropriately, as a care management response, once again we see GB's views, wishes or feelings are not sought or recorded; nor are there any details of other options discussed; there is no record of consent being requested or granted to share information; nor any specific evidence of neglect when care not in place.

5 & 23 December 2014

6.79 GB and SB are receiving respite care in Troutbeck care home. However, the home raise concerns after SB tries to get GB undressed for bed at 4pm (or 4.30pm) "ordering and shouting" at him to get his pyjamas on. The home is also concerned about SB's apparent drinking, that she may have attempted to drink and drive, and question her ability to care for GB at home. However, it is unclear how Adult Social Care respond practically to any of this. The social worker does advise the home to call police if SB does attempt to drink and drive and to flag up a safeguarding concern.

6.80 There do not appear to be any further enquiries, welfare checks, wishes or feelings, consent or mental capacity. GB and SB return home after the respite without any formal care in place. As the local authority says:

- *no documented evidence to inform that GB has capacity or lacks the decision specific capacity to consent to the safeguarding concern reported;*
- *there is no evidence to suggest that GB was contacted or consulted as a result of the safeguarding concern raised on his behalf:*
- *there are no recorded views, wishes or feelings for GB in regards to the alleged concerns which were raised;*
- *GB was not supported by an advocate for the safeguarding process;*
- *there is no documented evidence to suggest that measures were identified to reduce the risk of further similar incidents of alleged abuse;*
- *the safeguarding concern appears to have exited at stage 2 of the safeguarding procedures however there is no rationale or information provided to suggest that either a risk management response was required or whether an alternative process was followed;*
- *a strategy meeting and multi-agency response may have benefitted GB and SB;*
- *there is no documented information to indicate that SB was consulted as the person alleged to have caused harm or whether she was offered support of an advocate for the safeguarding procedures;*
- *GB and SB may have benefited from support of a family meeting and mediation regarding the concerns which were raised;*
- *there is no proportionality, accountability, partnership, prevention, protection or empowerment principles applied to the practice; and*
- *the concern was reportedly exited as 'care managed' however the safeguarding concern was on-going regarding SB however there is no evidence to suggest that any additional measures were identified to what was previously in place for GB.*

21 January 2016

6.81 An added layer of difficulty with this case is that GB and SB spent weekends and breaks away in Lancashire. This means they come under different geographical health, care and police services. What might (hopefully) be more routinely shared between services within Bradford, therefore becomes more challenging.

6.82 An example of this is: “a safeguarding concern was received from medical centre” on 21 January 2016: “I was contacted by a social worker at the Oakes regarding Mrs SB who cares for her disabled son GB. I was informed that when they were in Lancashire (Blackpool) (on holiday) there were apparent safeguarding issues raised when admitted to hospital that SB was intoxicated and her ability to look after son GB was at question, neglect issues. I was informed that they were placed in residential home in Lancashire (name unknown) but apparently been back in their usual place of residence (Addingham) over last two weeks.”

Other possible safeguarding alerts

6.83 Records also show that there were other instances that might have been or should have been flagged as safeguarding alerts. For example, on 17 April 2014 the manager of the home care agency phones the GP practice. “Concerned about medication stockpiled by mum who is unwilling to make an appointment or request a visit.” The practice responds promptly. A week later the GP discusses medication with GB and SB. SB admits to struggling with care but “denies reducing meds or having problems with meds”.

6.84 Some concerns of neglect by SB appear to be unfounded: the GP practice analysis suggests that there are no instances where GB did not attend a pre-arranged appointment at the GP surgery: “He attended for routine vaccinations x2 and a routine health check with the practice nurse and was brought by his mother. It is noted that GB’s mother demonstrates openness about GB’s medication, discussing it in many telephone calls in 2013, for example, asking for further treatment for constipation or to see a dentist as he did not co-operate well with oral examinations and required sedation. She is prepared to discuss a reduction in antiepileptic medication, noting that GB did not deteriorate/have an adverse response.”

6.85 Although referred by the Practice Nurse to the District Nursing team (on 17 June 2015), the team close the case (on 29 July 2015) following four failed attempts to make contact at GB’s house. It was known that GB “was looked after by his mother” and went away at weekends. Nor did GB meet their criteria of being “housebound” or “isolated”. So, the decision to close the case can be understood. There was no shared information around safeguarding – so no concern to the team about not gaining access. Under new protocols it would have flagged up previous safeguarding concerns under which staff would have raised the non-access as a concern. This can now be a seen by GPs and create an understanding of concern.

6.86 In December 2014, SB advises social worker that she had ‘lost it’ with GB, as he was walking, and wobbly, and she had shouted at him. It does not appear to have been flagged as a safeguarding concern and it’s unclear what action happened – if any – as a result of this.

6.87 In August 2015, police inform Adult Social Care about a fraud investigation being carried out on GB’s personal assistant – who has allegedly been financially abusing other service users. As potential victims, GB and SB were visited by police and the social worker on 1 April 2015 and one other subsequent visit. The officer “stated that she saw GB once during the investigation and had no concerns about neglect or any concerns that SB otherwise posed a risk to GB.” Again, the potential financial abuse does not appear to have been raised formally as a safeguarding concern. It also

means that GB's personal assistant is unable to care or visit him during the investigation – leaving GB, once again, without care support. SB is recorded as being "upset" that the personal assistant "would no longer be able to work for *her*" (my italics).

6.88 Police records also show that potential fraud had occurred previously. On 20 March 2013 SB had informed police that both she and GB had loaned money to GB's personal assistant – and while some had been paid back it was in arrears: "SB was advised that this was a civil matter, that she needed to seek legal action about getting her money back and that it was a civil matter…This incident was treated and finalised as a civil dispute. GB was never spoken to by West Yorkshire Police in relation to this matter. It is not recorded if any consideration was given to signposting SB and GB to Action Fraud as potential victims of a fraud offence (abuse of position)." As police concede: "It is recorded on the West Yorkshire Police systems that the Safeguarding Unit were made aware of this incident, but it is not recorded if consideration was made to make a safeguarding referral to Adult Social Care."

6.89 Previous to the second fraud investigation, on 11 March 2015, GB's personal assistant raises concerns about SB's drinking over the previous months. This was not raised as a safeguarding alert and there is no evidence of support being offered around this. In response, the social worker sought legal advice and requests capacity and Best Interests assessments from advocate.

6.90 West Yorkshire police receive a call on 4 April 2015 "concerned for the welfare of SB's son, GB" and request an officer to conduct a welfare check. Officers are unable to contact SB or GB as they were absent from their home (presumably at the holiday lodge). An officer finally sees GB and SB at home on 10 April 2015 but reports: "there are no issues with neglect and all in order at the address." Nonetheless, Police admit "it is not recorded if the Safeguarding Unit were notified of this call" – had they enquired with Adult Social Care they may have discovered the address of the lodge in Lancashire. *And had visited the home a few days before.*

6.91 On 15 June 2015, the home care agency report that "SB was verbally abusive towards care staff at the weekend following alcohol use" and that SB would "not allow carers to make GB anything to eat". The agency follows this up on 26 June 2015 with concerns that "SB was drinking earlier in the week. Carers informed that they feel that the drinking may be due to the lack of support which GB and SB have when at the lodge." There is no evidence to show how this was responded to or whether it was raised as safeguarding alert.

6.92 On 3 December 2015, Lancashire Social Services contact Bradford Adult Social Care about a safeguarding concern following an "incident" at the holiday lodge on 28 November 2015 resulting in GB being admitted into Blackpool Victoria Hospital with a urinary tract infection. Any safeguarding work will have been carried out by Lancashire, but there is no evidence that Lancashire sought to involve Bradford, nor of Bradford seeking participation. The record notes that "SB was intoxicated, agitated, abusive, laughing, at one point held a knife to her own throat." SB is also admitted into hospital, and GB later discharged into a care home for respite. While there, Bradford agreed for Lancashire to carry out a Care Act assessment of GB and a Mental Capacity Act assessment. These assessments conclude that GB did have

capacity to decide on what care and support he needed while his mother was in hospital – and he made the decision to accept respite care at a local care home.

6.93 Further, on 21 May 2015, a West Yorkshire police record includes a report from Lancashire Constabulary: "Officers were called to [the holiday lodge] where the informant's disabled son had allegedly attacked her. The male, GB was in an unclean state, dressed in just a bath robe and nothing underneath, he did not appear to have washed that day, his hair was greasy and he appeared dirty." The property is also described as "dirty" and smelling of faecal matter. However, this incident also turned up a Vulnerable Adult Referral from 13 August 1999 "which states that SB was arrested and interviewed on suspicion of attempted murder by administering an overdose of drugs on GB. CPS advise insufficient evidence."

6.94 This is particularly troubling. Admittedly, it was 16 years ago – but had this information been shared, it might have cast a different shadow over the care and support provided, and the manner and the urgency, in which that would or could be provided. As, commendably, West Yorkshire Police concede:

> "It is not recorded if West Yorkshire Police made contact with colleagues in Lancashire Police. Certainly the information provided within the referral cast doubt on whether SB was physically and mentally capable of caring for her elderly disabled son. Sharing the information known would have highlighted the safeguarding issues and all the agency involvement, both current and past including the apparent deliberate overdose of GB by SB in August 1999, whilst at their holiday home in Lancashire."

6.95 Similarly, West Yorkshire Police accepts that its actions "were minimal in this case". At the very least this should have prompted a safeguarding alert and strategy meeting. As police concede: "In hindsight there was a missed opportunity to instigate a formal safeguarding adult concern. Had such a meeting been convened, this may have provided the opportunity to identify that GB was a victim of domestic abuse with regard to SB's controlling and coercive behaviour, isolating him from friends, family members and other potential sources of support."

7 The lessons learnt

7.1 Although there are a number of troubling moments in this case, there are also several positives that emerge. For instance, there are good examples of interagency working: police and Adult Social Care while investigating the potential fraud case; Airedale Hospital, Adult Social Care and the care home on GB's respite placement; good communication between Adult Social Care and the various home care agencies; and the community matron and social worker agreeing joint visits following a health integration meeting.

7.2 Similarly, the evidence shows that the Yorkshire Ambulance Service, the Fire Service, the hospital trusts and the GP practice – all interacted with GB in line with guidance and expected professional standards. The GP practice is particularly commended for being the one service which, over time, consistently sought to seek GB's views on matters, and, on all but one occasion (a delay caused by absence), responded in a timely, effective manner. Airedale Hospital also made its safeguarding referral in a timely and appropriate manner (although despite concerns about SB coping at home, seemingly did not question the plan to return GB home with SB).

7.3 It also pleasing that since the time of GB's death, agencies have not waited to be told how to progress but have taken on initiatives themselves. For example, West Yorkshire Police have provided database training to safeguarding staff. They have, since October 2017, been part of a Bradford multi-agency safeguarding hub (MASH). The team currently comprises an acting sergeant, one detective constable and three vulnerable victims' co-ordinators and is based in the same building with a local authority safeguarding co-ordinator and advanced practitioner.

7.4 As police explained to the review: "with the introduction of the Adult MASH, there is an opportunity for the Police to research and review Vulnerable Adult referrals received from the Local Authority online referral system or internally to West Yorkshire Police through a form 263 risk assessment. The referrals average at 11 per day. A multi-agency discussion is held twice daily and the results and actions are documented on Niche (*a police electronic record system*). Sharing information with our Partners and discussing each referral with Social Care should ensure that proportionate and effective safeguarding measures are implemented in respect of each referral. This should include the completion of PND (*police national database*) checks at the point of referral."

7.5 Following this, the West Yorkshire Police Strategic Safeguarding Board (20 October 2017) were informed that the National Steering Group have asked that PND be pushed within Forces, particularly highlighting what it can do for Safeguarding. In response (7 November 2017) a PND Masterclass was organised for managers and staff (a version of which may be filmed for on-line training purposes). The PND Manager has also attended divisional training days. Further PND training has also been delivered to the Safeguarding staff in January 2018.

7.6 Since April 2017, the district nursing and community matron services now have a standardised safeguarding adults template – to help record and share safeguarding concerns. Their "no access" policy has also been updated as has the safeguarding

training provided by the trust to include more centrally the principles of *Making Safeguarding Personal.*

7.7 All the above is to be commended.

7.8 In order to improve services and practice even more across all agencies, the review considers that more consistency is required in recognising or reacting to safeguarding concerns and potential issues of neglect – and more urgency or certainly more timeliness in doing so.

7.9 There also needs to be a greater understanding of safeguarding, the regional procedures and the principles of "Making Safeguarding Personal" across all agencies – but in particular Adult Social Care and West Yorkshire Police (although, as said, commendably, this has been and is being addressed). It is equally important to recognise the need to hold face-to-face multi-agency meetings where there are ongoing or unresolved safeguarding risks; and the need to consider how best to include sensitive historical information around safeguarding and how to best include this into current risk assessments or safeguarding enquiries.

7.10 There also needs to be a clearer, more consistent and evidenced-based understanding of mental capacity and best interests across all agencies. Workers should look to adopt a more analytical approach. This is of particular importance when trying to establish a person 's views, wishes and feelings when they have no capacity or their capacity is in doubt. Where mental capacity to make a particular decision is in doubt, a capacity assessment must take place, in line with the Mental Capacity Act (2015) Code of Practice. Equally, all reasonable efforts should be made to support individuals to achieve capacity and make their own decisions, before Best Interests decisions are made

7.11 While recognising the presumption of capacity, efforts should be made to confirm that capacity where doubt might exist and not be reliant on seemingly caring family members or advocates. Staff also need to have the confidence to record any doubts over capacity.

7.12 Therefore, there also needs to be a sharper awareness by staff of potential coercion and control by carers (even when this is perhaps unintentional) and a stronger professional curiosity. For example, exploring a person's aggression as a potential form of communication.

7.13 In light of this it is important for professionals to not readily accept carers' decisions to refuse care and support to a service user – however well-intentioned it may seem, without appropriate challenge. This should be particularly so where there are or have been concerns around coercion and control or carer stress or ability to care.

7.14 Recording clearly needs to be improved. All records should be relevant and meaningful – using a facts-analysis-judgement approach. When concerns are raised – it should be recorded clearly what was done (even if "no further action") in response to these and the rationale behind that response should be clear.

7.15 The Safeguarding Adult Review panel for GB agreed that the following were the areas of learning. They recognised the importance of:

- having up-to-date assessments and day-to-day involvement as part of the health and social care record;

- making all reasonable efforts to explore the person's wishes whether or not they have mental capacity to make that particular decision;

- staff understanding the need to explore the causes of a person's aggression as a potential form of communication;

- "presumption of capacity" - unless a capacity assessment can show the person lacks capacity to make that decision at that time;

- the need to improve confidence among some professionals to carry out and record a capacity assessment where it is in doubt;

- the need to make sure professionals, of all agencies, are meeting their duty under the Mental Capacity Act to make all reasonable efforts to support the person to achieve mental capacity, before making a Best Interests decision;

- the need to improve agencies understanding of Independent Mental Capacity Advocate (IMCA) role in Best Interests decisions (for example, not being asked to make decisions);

- not confusing the duty to "consult" and work collaboratively with deferring Best Interests decisions to carers without lawful authority;

- not assuming that carers can always act as advocates for the person in their care;

- considering aggressive, controlling and coercive behaviour towards care agency staff or other professional staff, and whether this is also experienced by the adult at risk;

- remaining focused on the adult at risk, while trying to work collaboratively with carers and families;

- recognising and considering the warning signs (and implications on the adult at risk) of carers or families refusing care or support and wanting to reduce care packages;

- the benefit of calling face-to-face multi-agency meetings where there are ongoing and unresolved concerns about safeguarding risk;

- considering the combined risks associated with domestic abuse (for example, coercion and control) when present with, for example, carer stress, mental ill-health and alcohol misuse;

- the need to consider how sensitive historical safeguarding information (for example, previous serious criminal allegations, even if unproven) may be incorporated into current risk assessments and safeguarding enquiries; and

- the most appropriate professional seeking the views and wishes of the adult at risk in a "safe space" before closing safeguarding enquiries.

7.16 Finally, as covered earlier, the process for this Safeguarding Adults Review (SAR) has simply taken too long. I recognise there have been changes in key personnel in the local authority (as the co-ordinating agency) which clearly has not helped. I also recognise the pressures in the everyday working lives of practitioners and agencies. But this is cold comfort to those outside of the professions (especially the family of GB) – and we need to understand and acknowledge this. And, crucially, we need to start thinking about what message this sends to families and the public. The local authority now has a policy and procedure for SARs – which is a good start but even this appears lengthy and process-driven. In my view, these type of reviews need to cover all the relevant issues, but should do so in a sharper, outcome-focused and solution-focused way.

8 Family's views

8.1 As GB's daughters we welcome the report. We think it covers well the events leading up to the death of our dad. However, for us, it does raise some questions.

8.2 Although we were estranged from GB, we were aware growing up there that we were part of unconventional family dynamic. SB purposely excluded all family contact and input with GB. We were also aware – and this was confirmed in the coroner's report as well as the SAR – of SB's erratic behaviour, not least through her drinking. SB was a strong woman and who had the personality to change - and would seem perfectly fine when people called to the house. She would be sober and everything would undoubtedly be in its place. The house was big and nice – so who would suspect anything? We are also further concerned that she seemed to keep money in her account that was supposed to have been used to pay for more care for GB.

8.3 For us, the evidence also points towards SB's often low mood and the many references to SB's seemingly struggling to cope.

8.4 We have these questions:

- Why was it accepted that SB was the only family member that could care for or cared about GB? Why wasn't an effort made to contact the other family members? We would have been willing to help if we could.

- It seemed that the social workers accepted SB's "public face" and that everything was fine. Why did they always book their visits so SB could be ready for them? If they had called unannounced they may have found the situation very different. Why did they not scratch below the surface?

- Care packages repeatedly failed. How many times must things fall apart before it flags up concerns about how SB was managing GB's care? Also carers, at times, were unable to get in (this also happened the day before the fire). What is the reporting procedure about this? Who should be following this up?

- Given the SAR, it does seem there were strong signs that things were not right – why did workers and carers not spot what seemed very obvious?

- If SB did have money in her account that should have been used for care for GB why wasn't this monitored? How is this checked?

- It is unclear whether GB had capacity – some say he did, others he did not. Even where capacity was accepted, how could GB know he was being looked after well by SB – he had nothing to compare it with?

9 Recommendations

9.1 I believe this review has drawn together and highlighted some broad themes that should improve safeguarding practice in the Bradford area, focusing on:

- having a powerful understanding of *Making Safeguarding Personal*;
- approaching consistently issues of mental capacity and Best Interests awareness and decisions;
- finding a safe place for adults at risk to talk to find out their wishes and feelings, even where capacity is doubted or conflicted;
- promoting consistent professional curiosity even where things have always been or have always seemed to be fine;
- encouraging managers to challenge practice and positively use reflective supervision to get the best awareness, analysis and judgement out of their staff; and
- sharpening up recording skills.

9.2 This review respectfully requests the Bradford Safeguarding Adults Board and its partner agencies consider the following recommendations. In doing so, the Board and each agency might consider a variety of methods to achieve these recommendations. For example, holding a learning event where the good practice highlighted and suggestions for improving practice can be shared with managers and practitioners alike. Naturally, other methods, such as training and raising awareness through targeted publicity, procedures, guidance, leaflets and so on could be included. It is also crucial that whatever actions *are* taken that the impact of those actions is monitored to assess their effectiveness – and that the results of that monitoring process are shared widely to all relevant agencies and staff.

9.3 In the spirit of learning lessons, it is recommended that The Board and its partner agencies consider:

- through its multi-agency procedures and practice how to encourage a more consistent approach to safeguarding concerns and potential issues of neglect, and to better raise understanding of the principles of *Making Safeguarding Personal* and embed this in everyday practice;
- introducing a standard practice initiative to make sure that multi-agency face-to-face meetings are suggested (by any agency) where there are ongoing or unresolved safeguarding issues or concerns;
- improving the consistency of practice in providing evidence-based capacity and Best Interests decisions that include the wishes and feelings of the adult at risk, especially where they lack capacity or their capacity is doubted or fluctuating;

- promoting professional curiosity as central to practice, even in cases where there have been no apparent concerns around neglect, abuse, coercion or control – and consider if carers are speaking and acting to divert workers away from a potential abusive reality; particularly in instances where carers or family members might refuse or amend proposed care or treatment, or where there might be an indication of carer stress; agencies may also wish to consider how management through quality assurance, audits and, specifically, reflective supervision can play a key role in this;

- improving the quality of recording in safeguarding (and generally) to make sure all records are relevant and meaningful following a facts-analysis-judgement approach;

- looking at current practice for cross-border arrangements to improve responses for Bradford's citizens who may be subject to safeguarding concerns while staying in other local authorities (and other local authorities' citizens who may be staying in Bradford), and improving information sharing across authorities; and

- improving the process for Safeguarding Adult Reviews, making them more efficient, effective and timely; and having a mechanism in place that holds all agencies and all those involved to account while carrying out a review, with a particular emphasis on understanding what involved families are going through, and for those families' actual (and I would add – perceived) experience of a review.

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