Trafford Strategic
Safeguarding Partnership

SAR VM FINAL REPORT

NHS
Trafford
Clinical Commissioning Group

TRAFFORD
COUNCIL

Contents

1.0 Introduction

1.1 VM died in February 2020 from injuries sustained when she was hit by a lorry whilst crossing a road near her home. She was 84 years of age and had been diagnosed with a neurodegenerative disease in keeping with both Alzheimer's and Vascular Dementia six months before her death. During the month prior to her death agencies had become aware of concerns for her safety arising in part from walking about the streets near her home at night. As concerns escalated, agencies in contact with her made urgent efforts to safeguard her which were not successful.

1.2 Trafford Strategic Safeguarding Partnership decided to undertake a safeguarding adults review (SAR) on the grounds that neglect may have been a factor in her death and there were concerns that partner agencies could have worked together more effectively to protect her. A description of the process by which this SAR was conducted is shown at Appendix A.

1.3 David Mellor was appointed as lead reviewer for the SAR. He is a retired chief officer of police and has over eight years' experience of conducting statutory reviews. He has no connection to any agency in Trafford.

1.4 An inquest will be held in due course.

1.5 Trafford Strategic Safeguarding Partnership wishes to express sincere condolences to the family and friends of VM.

2.0 Terms of reference

2.1 The time period covered by the SAR is from 10th February 2019 until 6th February 2020. Significant events which took place prior to this time period were also considered.

2.2 The Key Lines of Enquiry for this review are as follows:

- When concerns arose that VM was walking about the streets at night and appeared to lack insight into the risks this exposed her to, how effective was the single and multi-agency response to these concerns?

- Were the risks to which VM was exposed assessed and appropriate action taken to address those risks? Was a multi-agency or single agency approach taken to risk management?

- How effective were systems for escalating urgent concerns about a person who appeared to be at risk of serious harm?

- Was admission to hospital under the Mental Health Act appropriately explored?

- When VM began to make decisions against professional advice, such as rejecting support and not taking her medication, were issues relating to her mental capacity appropriately considered?

- How effective were interventions to prevent a deterioration in VM's presentation?

- How effective were the efforts of agencies to engage with VM and her son?

- How effective was multi-agency working in this case?

3.0 Glossary

Best Interests - if a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

Care Programme Approach (CPA) - is a framework to assess the care and support needs of people with mental health problems, develop a care plan and provide the necessary support. A care coordinator monitors the care and support provided.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The presumption in the MCA is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability to understand the implications of their situation, to take action themselves to prevent abuse and to participate to the fullest extent possible in decision-making.

Section 42 Care Act 2014 Enquiry by local authority

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Self-Neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings, lack of self-care to an extent that it threatens personal health and safety, inability to avoid harm as a result of self-neglect, unwillingness to seek help or access services to meet health and social care needs and includes behaviour such as hoarding.

4.0 Synopsis of the case

4.1 VM has been described by her family as an independent person who led a very active life and particularly enjoyed travelling in the UK and abroad. She worked in canteen assistant and cleaner roles. After the death of her husband, she was primarily supported by her son who lives in Hampshire. At the time of her death she lived in her own property in a warden controlled development for retired people. She registered with her GP practice in April 2015 and had been diagnosed with Type 2 Diabetes, Asthma, Hypertension and Angina. She began experiencing mild memory loss in 2016 and was diagnosed with Dementia in Alzheimer's Disease in September 2019.

4.2 VM's daughter-in-law first raised concerns about her memory on 20th August 2015. VM was said to be experiencing some difficulty in taking her medication, which was provided to her in blister packs, because she had never been able to read or write and her family were worried that if her memory was beginning to be impaired this could further affect her ability to take her medication safely. Her GP carried out a Mini-Mental State Examination (MMSE) which resulted in a score of 21/30, suggesting mild impairment. She was referred to the Memory Clinic.

4.3 On 28th September 2015 VM was assessed by the Memory Assessment Team and found to have a mild cognitive impairment. There was no clinical evidence to support a diagnosis of dementia at that time and she was discharged to the care of her GP.

4.4 Over the next few years VM presented to her GP with various physical ailments but there were no further concerns raised about her memory until 2018.

2018

4.5 On 12th and 16th April 2018 the police attended VM's address after she mistakenly reported that her flat had been burgled. She appeared confused on both occasions. The property she reported as stolen was found in the flat. During the first visit the police noticed that she had switched off her fridge and the food inside had begun to smell. The police referred her to Trafford Adult Social Care initial assessment team (IAT) and her son was also contacted. The referral from the police was recorded by Adult Social Care and was subsumed into their response to the hospital admission which took place shortly thereafter (see next Paragraph).

4.6 VM was admitted to Wythenshawe Hospital on 20th April 2018 after her bank called an ambulance due to her confused behaviour and concerns about her memory. She was seen by the hospital's rapid assessment, interface and discharge (RAID) team who found no indication of an acute mental illness. VM was reported by the hospital discharge nurse to be independent and self-caring whilst on the ward with no risk behaviours noted and there were no concerns about her presentation or behaviours. She was able to eat and drink independently and take her medication as prescribed. However, the hospital social worker felt that VM lacked insight into her needs and was 'fixated/anxious' over people entering her property and stealing her belongings. The hospital social worker documented that she felt that VM lacked capacity regarding risks at home. Following a discussion with her son, VM was referred to SAMS (Stabilise And Make Safe) - a service which focuses on helping to build confidence, maintain or regain strength and ability after illness, an accident, a hospital stay or some other incident.

4.7 Just prior to her hospital admission it transpired that VM had left her bag containing her purse and keys in a local café which had been stolen. The locks were changed on her flat as a result.

4.8 VM was discharged from hospital on 4th May 2018. The SAMS support, which is intended to be short term, was provided by Olive Healthcare which it is documented that she declined.

4.9 VM had been discharged from hospital with two month's supply of medication. When this error was recognised she was re-admitted to Wythenshawe Hospital the following day (5th May 2018). An incident report was completed and a safeguarding referral made. It transpired that VM's medication had been put into a blister pack to assist her in managing the medication but that the same medication was also dispensed in non-blister pack format. The incident report established that the cause of the problem was human error. VM discharged herself from hospital on 10th May 2018.

4.10 On 23rd May 2018 VM was assessed by the CMHT duty team having apparently been referred by the GP. The outcome of the assessment was discussed in an MDT and it was decided to refer her to the Dementia Crisis Prevention Team (DCPT) – which provides multi-disciplinary assessment, treatment and care for people diagnosed with dementia who are at a high level of risk and without support may require hospital admission. The DCPT received the referral on 29th May 2019. The provider for the Dementia Crisis Prevention Team and the Community Mental Health Team is Greater Manchester Mental Health NHS Foundation Trust (GMMH).

4.11 On 25th May 2018 VM's daughter-in-law phoned Adult Social Care to express concern about VM's deteriorating mental health, her refusal to let carers into her flat, her paranoia in respect of an imaginary 'man from upstairs' who she believed was entering her flat and moving things around and VM's stated intention that she planned to carry a knife. There was contact between Wythenshawe Hospital and VM's GP to check whether there were any immediate health and safety concerns following her hospital discharge earlier that month. The Adult Social Care (ASC) emergency duty team (EDT) made a home visit that evening and established that VM was safe and well and receiving four care calls per day. It appears that by this time, Olive Healthcare, who had initially been commissioned to provide the SAMS support, had now been commissioned to provide longer term home care. Adult Social Care were under the impression that the community mental health team (CMHT) also planned to make a home visit but this was not the case.

4.12 On 31st May 2018 an ASC social worker visited VM who said that she didn't like the carers visiting and confirmed that she was not carrying a knife. VM's case was documented to be open to the CMHT who were considering appropriate medication. VM's case was closed to Adult Social Care at this point.

4.13 On the same date (31st May 2018) the DCPT assessed VM's needs and provided input for a period of time and conducted a medical review before she was transferred back to the CMHT on 19th June 2018. Her case was again discussed at MDT and it was decided that an assessment by a neuro-psychologist should be conducted to support a diagnosis.

4.14 On 22nd June 2018 Adult Social Care received a referral from the warden of the retirement housing complex in which VM resided. The warden's referral stated that VM was making untrue allegations against a male resident of entering her flat, stealing food, going through her underwear drawer and hiding her personal possessions. The male resident was said to be 'distraught' at the allegations. The warden stated that VM's locks had been changed three times in recent months. The warden also stated that he had discussed the issue with VM's son who was said to be of the opinion that the intruder did not actually exist. As CMHT were managing VM's case at the time, Adult Social Care passed the warden's referral onto them.

4.15 On 23rd October 2018 VM was reported to the police as a missing person by her neighbour who had dropped her off at Trafford General Hospital (TGH) earlier due to 'gastro/rectal bleeding' and had subsequently been informed by VM's son that she was returning home by taxi, but had not arrived. TGH confirmed that VM had been transferred to Manchester Royal Infirmary (MRI) for a CT scan to check for indications of cancer. When the police contacted the MRI they were initially unable to locate her but subsequently found her in the Surgical Assessment Unit during the

early hours of the following morning where she had been since 9pm the previous evening after telling staff that her son would be picking her up, which was not the case as he lived in Hampshire. VM was discharged from hospital.

4.16 VM was seen by the neuro-psychologist for an initial visit on the 8th November 2018 but would not engage in the assessment and refused any further input. The older adults CMHT consultant was informed that VM would not engage with the care coordinator or the psychology assessment and recommended discharge from CMHT.

4.17 Towards the end of 2018 and beginning of 2019 several concerns were raised with VM's GP practice about her memory, behaviour and concordance with medication. The GP practice has advised this review that despite several attempts to make further contact with the CMHT and establish a plan, there was no outcome from the CMHT and it is unclear to the GP practice whether VM was reviewed by them again or not. VM remained on the older adults CMHT case load until 15th January 2019 when she was discharged following discussion with the consultant psychiatrist, psychologist and care co-ordinator. VM had been reluctant to engage, was adamant that she did not want any further visits and her condition was considered to have been stable for some time. According to GP records VM was discharged from the CMHT much earlier – in October 2018. The CPA Care Plan shared with her GP practice documented that VM had paranoid thoughts which she found distressing.

2019

4.18 On 15th January 2019 Olive Healthcare raised a welfare concern in respect of VM with Adult Social Care, specifically that she continued to decline carer input - believing that she could look after herself, continued to believe that a 'man upstairs' was entering her home and stealing her property – although there was no evidence that this was the case – and may have taken a double dose of her medication leaving her feeling sleepy. VM was said to fear being moved to a care home or 'loony bin' or that her son might have her 'committed'. The care provider had been in touch with VM's son who said his longer term plan was for his mother to move closer to him. He was documented to feel that his mother's needs were 'minimal' at that time. Adult Social Care forwarded this information to the CMHT who the former service incorrectly believed the latter service to be supporting. This welfare concern would have been received by the CMHT around the date that they discharged VM from their service.

4.19 On 4th February 2019 the registered manager of Olive Healthcare re-contacted Adult Social Care to follow up on the welfare concern raised on 15th January 2019. He was advised that the concern had been passed to the CMHT but further enquiries established that the concern had been closed by the CMHT, apparently on the same date that they had discharged VM from their service. Adult Social Care then listed the Olive Healthcare welfare concern for allocation, although there is no record of any further action being taken by Adult Social Care.

4.20 On 15th February 2019 VM was admitted to Wythenshawe Hospital for treatment for constipation. A Deprivation of Liberty Safeguards (DoLS) was applied for during her admission. She was accepted by OPAL House* for a period of assessment but declined to stay. Her capacity was reassessed and she was felt to have capacity to make this decision. Her son was also consulted and is said to have agreed with the decision. She was discharged on 22nd February 2019, at which time her package of care was not in place which necessitated an urgent referral to Adult Social Care who arranged for her package of care to be re-started. Her GP was requested to refer her for a bladder scan due to 'slight thickening'.

*OPAL House is a 41 bedded unit located on the Wythenshawe Hospital site which provides care for patients who no longer need acute care, but who need to regain their strength and improve their independence prior to discharge. Many patients using the unit have dementia.

4.21 On 14th May 2019 VM attended Trafford General Hospital outpatients general surgery clinic, having been referred by her GP due to bleeding from her rectum. In clinic VM and the friend who was accompanying her were insistent that the bleeding was Per Vaginal (PV). Her history was reviewed and the plan was for a repeat sigmoidoscopy (examination of the lower colon) and her GP was requested to refer her to Gynaecology and Urology to rule out cervical or bladder bleeding.

4.22 On 15th May 2019 VM's GP referred her to Adult Social Care over concerns which were articulated by her neighbour who accompanied her to the GP appointment, that VM was knocking on her neighbour's doors early in the morning and that from observing her blister packs she was taking more medication than she should on some days and missing her medication on others. Adult Social Care contacted the CMHT but appear to have taken no further action. The GP also wrote to the Older Adults CMHT detailing concerns about her being confused, failing to take her medication correctly and being worried that people were coming into her flat and taking her belongings. The CMHT noted that they had discharged VM in January 2019 and wrote back to the GP to ask whether VM would be agreeable to a referral to the CMHT and to request further information about her physical health.

No information having been received from the GP by 30th May, the referral to the CMHT was rejected.

4.23 On 31st May 2019 VM's son contacted her GP to raise further concerns about her memory. A further referral was made to CMHT which gave a lengthy explanation of VM's mental health problems and confirmed that she had now consented to the referral. In response a CMHT duty worker made an entry in the electronic patient records to confirm that the original GP referral had been rejected (see previous paragraph) but unfortunately made no reference to the new GP referral received that day and so the new GP referral was overlooked.

4.24 On 6th June 2019 VM was seen in Trafford General Hospital's outpatients Urology clinic. The plan was for cystoscopy (procedure to examine the lining of the bladder) and cardio thoracic scan. Her capacity was assessed and it was felt she had capacity to consent to these procedures. On 21st June 2019 the cystoscopy was completed and no abnormalities were detected.

4.25 On 30th July 2019 VM's son phoned Adult Social Care to express concern about his mother because of a deterioration in her memory, that she was missing taking medication and 'her care file was not consistent in terms of medications' and that she was calling at her bank at 15 minute intervals to withdraw her pension. He requested a change of care agency and also said that VM's GP was arranging a memory assessment for his mother. (Her son may have been referring to the further CMHT referral the GP made on 31st May 2019 which was not received by the CMHT).

4.26 On 8th August 2019 the GP received a phone call from VM's son to say that his mother's behaviour was 'worsening' and she still had not had any input from the memory clinic or the CMHT.

4.27 On 12th August 2019 the older adults CMHT received VM's medical history from her GP and telephoned her son who raised concerns after hearing from his mother's neighbour that VM was confused, going to the bank and pharmacy several times a day to request money, was not taking medication and was very vulnerable. The son was documented to have 'stopped' her carers as they were not 'doing their jobs properly'. He said that VM's neighbour was very supportive and was making sure that she took her medication in the short term. The CMHT requested that VM's GP refer her to 'social services' urgently.

4.28 On 15th August 2019 the older adults CMHT made an initial screening visit to VM who initially engaged well in the assessment but became more irritable. VM's case was discussed at an MDT meeting on 20th August 2019 and it was decided to refer her to the Dementia Crisis Prevention Team and subsequently for an Occupational Therapy assessment.

4.29 On 18th August 2019 Trafford Commissioning documented that they had responded to VM's son's complaint about her care provider (Paragraph 4.25) - Olive Healthcare - who advised that VM and her son repeatedly refused care. On the same date Olive Healthcare raised a concern for welfare in respect of VM, specifically that she had been refusing care from her carers because she believed that she did not need them and could look after herself, that Olive Healthcare had been informed by VM's son that he had cancelled the care package that they provided as he was of the opinion that his mother could self-manage her medication with the assistance of her neighbour. Olive Healthcare doubted whether the neighbour was able to manage VM's medication.

4.30 On 22nd August 2019 the Dementia Crisis Prevention Team (DCPT) case manager to whom VM's case had been allocated made an initial visit. VM acknowledged no difficulties other than her memory not being as good as it used to be. The DCPT occupational therapist made initial contact by telephone on 10th September 2019 and spoke to VM's neighbour who told the therapist that VM was refusing some medication, misplacing items in the home, not attending appointments and not managing her finances. The occupational therapist shared these concerns with VM's case manager.

4.31 On 13th September 2019 a Doctor from the DCPT assessed VM at home and found her to have notable cognitive impairment suggesting a neurodegenerative disease in keeping with both Alzheimer's and Vascular Dementia. VM was keen to trial the anti-dementia drug memantine. Liaison with her case manager was needed to monitor the medication and 'to secure further support in the community'. (There was a delay in memantine being commenced as VM was admitted to hospital for two weeks with abdominal pain and constipation on 3rd October 2019 – see Paragraph 4.35).

4.32 On 18th September 2019 the DCPT case manager visited VM to discuss the memantine and the support she needed from carers. VM agreed that the case manager could contact 'social services' following their 'recent review' to establish what support was being considered. Two days later the DCPT occupational therapist visited VM to gather information for an assessment of her support needs (strengths, skills, abilities and needs). VM was noted to be irritable and resistive to this assessment as it would entail the occupational therapist observing her carrying out tasks in the home.

4.33 On 27th September 2019 VM was discussed at a DCPT morning meeting at which concerns were expressed about her memory and a pre-existing undiagnosed learning disability relating to her inability to read or write.

4.34 On 1st October 2019 Adult Social Care received a referral from VM's DCPT case manager requesting a package of care to assist her with her new medication regime.

4.35 On 3rd October 2019 VM was admitted to Wythenshawe Hospital due to abdominal distension. A DoLS application was submitted. During this admission VM's son raised concerns that his mother's memory was deteriorating and she was unable to care for herself at home. VM was said to be adamant that she didn't want home carers. There is mention that VM might require an EMI (Elderly Mentally Infirm) placement in the hospital records. She was not started on memantine during her hospital admission as the abdominal distension for which she was admitted was a side effect of the drug. She was discharged on 17th October 2019 and was to receive SAMS (Stabilise And Make Safe) support once more.

4.36 On 18th October 2019 VM was visited by her DCPT case manager who found her to be 'pleasant but confused and disoriented'. Care agency staff were to visit twice daily to assist with medication, although VM complained about the need for carers as she found them intrusive.

4.37 On 6th November 2019 the DCPT occupational therapist visited VM to continue the assessment of support needs and found that her fridge had been turned off and, as a result, high-risk foods needed to be removed. VM said she was unhappy that people were 'messing with her fridge'. The assessment was to continue.

4.38 The following day the DCPT case manager spoke with VM's son by phone. The son had a planned meeting with 'social services'. The case manager advised that a small cohort of carers – as VM found having many different carers stressful - supervise medication as part of their visits and check the fridge.

4.39 On 22nd November 2019 the DCPT case manager visited VM who he found to be 'brittle' as well as finding the input from her carers to be irritating. She had begun taking memantine. Her neighbour was present and said that VM continued to buy food which will often go out of date, but would not allow the out of date food to be thrown away. A SAMS review was concluded on the same date which documented that the new medication regime was in place and carers would support with this, monitor the fridge for perishable goods and provide gentle prompting to VM about personal care. iCare Solutions began providing VM with home care from this date.

4.40 On 23rd November 2019 the iCare carer was initially unable to gain access to VM's flat as VM was unable to find the key to let her in and appeared distressed. iCare contacted VM's son who advised them to contact the neighbour for a spare key.

4.41 On 25th November 2019 the DCPT case manager and the occupational therapist discussed VM's case, in particular the difficulty in completing the OT assessment due to VM not engaging or not being at home. It was decided that the care package would be used to monitor and intervene where needed.

4.42 On 1st December 2019 VM refused to allow the iCare carer into her flat and shouted at her to move away from her door.

4.43 On 13th December 2019 it was decided to discharge VM from the DCPT on the grounds that memantine was being administered, the OT assessment had been completed and she was supported by carer visits twice daily. (The OT assessment had not actually been completed although VM's case manager had monitored how she met daily living activities).

2020

4.44 On 3rd January 2020, the GP received concerns from iCare that she had been found walking the streets in the night. She was visited at home by a GP the same day and there were no clinical signs of any medical illness. iCare carers were advised to monitor the situation and contact the GP practice if there were any further issues. iCare spoke to VM's son who asked for his mother to be seen by the 'mental health team' who were said to be involved. iCare said they would speak to Adult Social Care to arrange this but there is no indication that this was raised with Adult Social Care or the GP.

4.45 On 10th January 2020 VM's son contacted Adult Social Care to express concern that his mother had recently been found walking the streets at night on two occasions and been returned home by strangers. She had apparently become lost in the dark although she was able to remember her address details. He said that she was also neglecting her personal hygiene, banging on neighbour's windows saying that she could not find her keys (which she was wearing around her neck) and that she believed that he (her son) was trying to get her 'committed'. The case was allocated to a social worker for review.

4.46 On Wednesday 29th January 2020 VM's GP contacted Adult Social Care to pass on concerns from VM's son about her walking the streets during the hours of darkness, locking herself in her flat, knocking on neighbour's windows, becoming quite verbally aggressive with people and buying meat in bulk which she did not need. The son had added that the neighbour was struggling to cope. The GP arranged for bloods to be taken, a physical review and a referral to the DCPT the following day. The visit by the social worker to whom VM's case had been allocated on 10th January was scheduled for 7th February 2020.

4.47 On Thursday 30th January 2020 the GP made a home visit. VM was initially very upset because she hadn't been told about the visit. She was upset that people kept coming into her flat and 'messing things up'. The GP observed that it was apparent that she had no insight into her condition and recent events. She agreed to a physical examination which found cloudy offensive urine, protein and leucocytes on dipstick. The GP thought she may have a UTI, but the GP's main concern was the progressive nature of her dementia. The GP spoke to VM's iCare carers and prescribed a trial of antibiotics for a possible UTI. Contact with the DCPT established that VM was no longer open to their team and it would be necessary to re-refer which was done the same day.

Friday 31st January 2020

4.48 On the morning of Friday 31st January 2020 iCare contacted VM's GP to say that her presentation had worsened in that she was refusing medication and being verbally abusive. She had told the carer to leave and also the nurses, who had presumably attended to take bloods. During the morning iCare submitted a concern for welfare to Adult Social Care stating that VM had been declining her medication, been verbally abusive to carers and asked them to leave her flat, declined to take antibiotics prescribed for a UTI and had been disposing of her MAR sheets. iCare felt that she was unsafe living on her own.

4.49 The GP phoned the DCPT to advise that VM had refused medication from her carers that day and was at risk of walking the streets. The DCPT documented that the GP said she had completed a safeguarding referral to 'social services'. (No safeguarding referral was made). It was agreed that her previous DCPT case manager would visit her to complete an urgent review which they had scheduled for Monday 3rd February 2020. The GP sought advice on what could be done to support VM in the interim and was advised to contact 'social services' or send her to A+E. The GP did not feel that sending VM to A+E was the most appropriate course of action and so she contacted Adult Social Care and was advised to make a referral. Following the referral the GP practice was contacted by Adult Social Care and advised that a social worker was due to see VM in February 2020, that they did not feel that an urgent assessment was justified as there might be a medical issue as she had a UTI and VM was being visited by carers twice daily. Adult Social Care also suggested a referral to the MFT Enhanced Care Service* which the GP did not feel was appropriate. Adult Social Care documented that the GP felt that a placement may be beneficial.

(*This urgent service is for patients immediately at risk of admission to hospital (they are either in their own home or A+E). These patients will be seen within 6 hours of the referral and a health and social care package will be put in place to support them to stay at home for 72 hours).

4.50 The GP phoned VM's son who reported that her carers had told him that VM had been carrying a knife and screwdriver. The GP spoke to VM's carers who were unable to corroborate this information. The GP felt that given VM's paranoid behaviour, the carrying of the knife and screwdriver, if confirmed, could put professionals at risk, including ambulance crew if it was decided to send her to A+E. The option of a Mental Health Act assessment was then considered by the GP. The GP contacted VM's neighbour who advised that VM was with a social worker, Adult Social Care having decided that VM required a more urgent visit by the social worker to whom her case had been allocated. The social worker spoke with the GP by phone and advised that VM had declined hospital admission. The social worker documented that VM had allowed him access, but was hostile, and denied she required any support, stating she was meeting all of her personal needs independently. She had told him that her son wanted her sectioned as he thought she was 'wacko'.

4.51 The GP and the social worker discussed the option of arranging a Mental Health Act assessment and it was agreed that the GP would contact the Adult Social Care EDT (it was after 4.30pm). It is understood that the EDT – which is composed of approved mental health professionals (AMPH) - declined to conduct a Mental Health Act assessment on the grounds that VM had a UTI. The EDT later contacted the GP practice to explain the position. A message was left for the GP to contact the EDT but the GP was unable to get through and no further contact between the EDT and the GP practice was achieved that evening and no Mental Health Act assessment took place.

4.52 The social worker remained with VM until the early evening and was under the impression that an ambulance had been summoned to take her to hospital for treatment of the UTI in the first instance. When the social worker left, it was agreed that the neighbour would wait with VM for the ambulance to attend, although she (the neighbour) was also feeling unwell. No ambulance had in fact been arranged and VM was not taken to hospital that evening.

4.53 On Monday 3rd February 2020 VM was visited by the DCPT case manager who documented that VM's son had phoned her GP to express concern about reports of his mother being out of her flat at midnight on two occasions and once at 9pm and needing assistance from strangers to find her way home. Additionally, her carers had reported that she was carrying a knife in her bag, had been verbally abusive to them on visits, had locked herself out of her flat and had been buying 'vast amounts' of food despite not cooking. VM's GP said that when she visited her, she was very angry and wanted to be left alone. The case manager found VM to be disoriented to time and demonstrated no insight into her care needs. Whilst she accepted that her memory was not good on occasion, she could recite her address which she regarded as 'proof' that she could not get lost. She complained that things were being moved around her flat but vehemently denied that she may have moved these items herself. VM did not want to consider any other accommodation or other support.

4.54 The plan devised by the DCPT case manager was that there was no obvious value in a medication review as memantine had been initiated relatively recently, there was little value in repeating the recent intensive DCPT support, she would be referred back to 'social services' to review her care package and be referred for care co-ordination by the older adults CMHT to enable longer term monitoring and the possibility of introducing a support worker.

4.55 Also on 3rd February 2020 iCare raised further concerns about VM in that she was said to be accusing staff of stealing her money and a screwdriver and sharp knives had been found in her handbag. It was also believed that she had been putting washing powder in her tea mistaking it for sugar. The social worker liaised with the GP and with the CMHT and made a telephone call to VM who was unable to hold a coherent conversation. The CMHT confirmed that VM would be discussed at their daily meeting the following day. The social worker also made a home visit to VM.

4.56 On Tuesday 4th February 2020 the older adults CMHT considered the referral from the DCPT case manager and decided to allocate a Care Co-ordinator to VM. The social worker left a message for iCare to contact him but they were unable to obtain a reply from his phone number.

4.57 At 2.35pm on the same day VM was hit by a lorry whilst crossing the road a short distance from her home address. She was taken to hospital but died from her injuries on 6th February 2020.

5.0 Views of VM's son

5.1 VM's son decided to contribute to the review and did so via a telephone conversation with the lead reviewer.

5.2 He said his mother had been an independent person and a very confident solo traveller in the UK and abroad. She had led a very active life. She worked in canteen assistant and cleaner roles. She was unable to read or write. After the death of her husband, her son helped her deal with any issues which required forms to be filled in or documents to be read.

5.3 The son felt that early signs of Dementia became apparent around three years prior to her death. He said that his mother tended to frequently ask questions in order to confirm information and so when she began asking questions because she had forgotten something, he didn't initially realise that she was experiencing memory problems. He recalled that she he began to forget her bank PIN but as her bank knew her well, they were able to help her access her account.

5.4 From around two years prior to her death, her son felt that she needed help in taking her medication. He became worried that she was forgetting to take her medication after a hospital admission (believed to be the May 2018 admission described in paragraphs 4.8 and 4.9), when 'loads' of medication she had not been taking were found in her flat. He added that she referred to her diabetes tablets as 'poison'. Home carers were 'employed' but the son felt that they were not effective and so these carers were replaced by a new provider (Paragraph 4.29). He added that his mother 'hated' carers coming into her home.

5.5 The son said he began to feel that his mother lacked the capability to care for herself, but he said that professionals disagreed with him. When a professional asked about her about her ability to take care of herself, the son felt that his mother was able to give the 'right' answers i.e. saying that she cooked and cleaned for herself when this was not actually the case. He felt that his mother could 'talk the talk' but struggled to 'walk the walk', in that she could give the impression that she was able to look after herself during a conversation with a professional, but was often unable to put this into practice when she was in her home environment. He went on to say that he felt that she should have been assessed for residential care. If she had been assessed locally as needing residential care and been placed in a local care home, his plan was to try and arrange her transfer to a nursing home in which his wife worked and which was situated near their home in Hampshire.

5.6 He said that his mother began to get lost and also began losing her keys. After this necessitated changing the locks on her flat, his mother began wearing the flat keys around her neck but he said that she began forgetting that they were there.

5.7 He said that his mother became very paranoid and believed that a 'guy from upstairs' was going into her flat and so she put a knife in her pocket with which she said she would use to stab him. He said that when this happened, he rang 'social services' who told him to ring '999'.

5.8 During one hospital admission her son asked that his mother 'not be allowed to go home' because he felt that she could no longer care for herself. The son said that it was difficult discussing a placement in residential care with his mother as she would become upset at this prospect. He said his mother felt that she would 'lose herself' or 'disappear' if she was placed in a care home. After conversations with his mother about residential care, he said that his mother would to speak to him or take advice from him for a time. However, because of her short term memory loss, she would usually forget about the conversation after a short while and their relationship would continue as before.

5.9 Overall, he felt that his mother was well supported by her GP but accessing other services, particularly mental health services, always seemed to require a referral from the GP, and in his view everything seemed to 'peter out' after his initial contact with the GP. He said that he kept asking for his mother to be reassessed by mental health services but this didn't happen in his view.

5.10 He said he had become very concerned about his mother walking off and getting lost and it was only 'sheer luck' that 'good Samaritans' brought her home and prevented her from being exposed to greater harm. On Friday 31st January 2020, he had understood that his mother was to be admitted to hospital and said that he was told that an ambulance was 'coming in two hours'. He said that his mother's neighbour waited with her for the ambulance for four hours, but it never came.

5.11 The son said that when he and his wife cleared her flat following her death, all of his mother's clothing was missing. He believed that she had been cutting her clothes up or giving them away.

5.12 VM's son was given the opportunity to read and comment on a late draft of this report and expressed himself satisfied with the report including the findings and recommendations.

5.13 Attempts have been made to contact VM's neighbour to offer her the opportunity to contribute to this review, but at the time of writing contact with her had not been achieved.

6.0 Analysis

6.1 In this section of the report each of the terms of reference questions will be addressed in turn.

When concerns arose that VM was walking about the streets at night and appeared to lack insight into the risks this exposed her to, how effective was the single and multi-agency response to these concerns?

6.2 Agencies became aware that VM had begun walking about at night on 3rd January 2020, a little over a month prior to her death (Paragraph 4.44). At this initial stage only iCare, her GP and VM's son were aware of the problem. The GP asked iCare to monitor the situation and contact the GP practice if there were any further issues. It is unclear what the GP practice's specific expectations of iCare were at this point. iCare were commissioned to visit VM twice during the day and so any monitoring they did would probably be limited to finding out that VM had been walking about at night only after the event. iCare documented that, after speaking to VM's son by phone, they would speak to Adult Social Care to arrange for the 'mental health team' to be involved, but there is no indication that this was done. In any event, the route to mental health services would have been via primary care. There appears to have been no consideration of approaching Trafford Council as commissioners of iCare to consider adjusting the times or frequency of their visits to include an evening visit.

6.3 Concerns about VM walking about were raised again a week later (on 10th January 2020) when her son phoned Adult Social Care to report that his mother had recently been found walking about the streets at night on two occasions and been returned home by strangers. The case was allocated to a social worker for review and after making telephone contact with VM a home visit was arranged for 7th February 2020.

6.4 Concerns about VM walking about were again raised by her son in a telephone call to VM's GP on 29th January 2020.

6.5 There is no indication that any formal or informal assessment of the risks VM was exposed to by walking the streets during the night was carried out at this point or subsequently. This behaviour represented a significant change in behaviour which needed an assessment. Additionally no safeguarding referrals were considered.

Were the risks to which VM was exposed assessed and appropriate action taken to address those risks? Was a multi-agency or single agency approach taken to risk management?

6.6 As previously stated, there is no indication that any formal or informal assessment of the risks VM was exposed to by walking about the streets during the night was carried out. Had a risk assessment been carried out the risks that one might have been expected to be identified are as follows:

- She may get lost and be unable to find her way home. People with dementia often have problems with orientation and memory which can make it hard for them to find their way home. This risk materialised on at least two occasions and was mitigated by the fact that VM appeared able to recite her home address. This enabled passers-by to escort her safely home.

- She was at risk of exploitation of her vulnerability by someone harming her, stealing her possessions or escorting her home and stealing from her home, and knowing her address, continuing to target her.

- She was at risk from people affected by drink who were more likely to be on the street during the late evenings.

- She was at risk of slipping or falling in the dark.

- She was at risk whilst crossing the roads. VM may have experienced difficulty in processing information about vehicles travelling towards the point at which she was attempting to cross the road and drivers or riders may have had difficulty in observing her clearly, particularly during the hours of darkness.

- In January she was likely to be exposed to very cold and wet weather and become ill.

6.7 Had these risks been explicitly considered, it could have been possible to think of ways in which the risks could be mitigated. The Alzheimer's Society provides helpful guidance on addressing the concerns arising from a person with dementia 'walking about' (1). The Alzheimer's Society suggests the following:

6.8 Try and understand why someone is walking about; avoid the term 'wandering' because this is an unhelpful term because it suggests that the person is walking without a purpose, whereas they will often have a reason for it. The reason why a person with dementia walks about may not be obvious and they may not remember or be able to explain why they walk about. The Alzheimer's Society suggests the

carer/supporter keeps a journal for a couple of weeks, including notes about the person's behaviour and any reasons they give for walking about.

6.9 The Alzheimer's Society suggest the following reasons why people with dementia may walk about:

- Memory loss – they might begin a journey with a particular goal in mind and then forget where they were going. They might be searching for an item that they have misplaced or think that someone else has taken.

- Confusion about the time – people with dementia often become confused about the time. This confusion may be particularly prevalent during the winter when it is common to go to sleep, and wake up, when it is dark. They may walk a lot at night because they have difficulty sleeping which is common in older people and particularly common in people with dementia. Assistive technology can help including placing a large clock showing a.m. and p.m. by the person's bed. Additionally, there are many simple things which can help a person sleep including avoiding daytime naps although it is noted that one possible side effect of the memantine taken by VM is drowsiness.

- Relieving pain - a person with dementia may walk about more when they are feeling unwell, feeling uncomfortable or constipated although VM's was examined by her GP for signs of physical illness on 3rd January 2020. One of the possible side effects of memantine is constipation. The person may walk about because they are responding to an uncomfortable environment, possibly too hot or too cold, poor lighting or bad smells. It is known that VM's tendency to leave her fridge door open sometimes caused food to be spoiled creating a bad smell.

- Restlessness, agitation and anxiety - restlessness may be a symptom of the physical changes in the brain caused by dementia. It can also arise from 'restless leg syndrome' which gives people an overwhelming, irresistible urge to move their legs to stop unpleasant sensations – mostly at night. Some people walk about because they feel anxious. They might also be responding to hallucinations.

- Boredom and a lack of activity - people with dementia may walk about because they don't do as much as they used to do, or they feel they have energy to spare. VM had enjoyed travelling independently and she was no longer able to do this. Regular exercise can help.

- Continuing a habit and staying independent - people with dementia often want to continue with habits or interests they had before their diagnosis and walking may be one example of this. Dementia-friendly walking groups are available in some areas where people with dementia continue walking in a safe environment with other people.

- Feeling lost or looking for someone - as dementia progresses, the person may try to find someone or something from their past. Additionally they begin to feel lost in their own home (2).

6.10 The Alzheimer's society also suggests tips for limiting the risks arising from walking about such as providing safer alternatives such as creating a path in their garden for them to walk about, installing a door sensor which plays a pre-recorded message asking the person not to leave the house, switching off outside lights at night to minimise what the person can see through their window, making sure they carry identification, ensuring 'in case of emergency' numbers are saved and easily accessible on their mobile phone, considering a specialist tracking device which uses GPS to locate where they are although this would require consent and advising local neighbours and shopkeepers (3).

6.11 Whilst the risks to which VM was exposed to by walking about the streets at night engendered a high level of concern, there is no indication that they were articulated in a structured way, assessed and mitigating actions put in place. A specific link between walking about and road safety was never articulated.

6.12 Although VM's walking about may have been affected by memantine, when she was seen by the DCPT case manager on 3rd February 2020, it was decided that 'there was no obvious value' in a medication review as memantine had been initiated relatively recently (since 22nd November 2019 at the latest). Additionally, the possibility that she had not been taking memantine regularly, which may also have contributed to her confusion does not appear to have been considered.

6.13 A safeguarding referral could have been considered by iCare or the GP when concerns about VM's walking about the street at night were first raised on 3rd January 2020 (Paragraph 4.44), by Adult Social Care when concerns were raised again on 10th January 2020 (Paragraph 4.45) by the GP when further concerns were raised on 29th January 2020 (Paragraph 4.46) and by the DCPT when the case manager assessed the risks to which VM was exposed on 3rd February 2020 (Paragraph 4.53).

6.14 DCPT documented that the GP had, or was intending to submit a safeguarding referral in respect of VM on 31st January 2020 (Paragraph 4.49) but no safeguarding referral was made.

6.15 Had a safeguarding referral been made it seems likely that VM would have been deemed to have passed the three stage test necessary for the referral to progress to a Section 42 Safeguarding Enquiry. The three stages are as follows:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or at risk of, abuse or neglect and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

6.16 Had a safeguarding referral been made on 3rd or 10th January 2020 this could have prevented the crisis situation developing on Friday 31st January 2020. Had a safeguarding referral been made on Friday 31st January 2020 it could have provided a statutory framework to facilitate multi-agency working and clearly identified Adult Social Care as the lead agency co-ordinating the Section 42 Enquiry.

6.17 It should be noted that walking about at night was not the only risk that professionals were worried about as concerns escalated over the period 29th – 31st January 2020. Other risks included carrying weapons, being verbally abusive, declining her medication, neglecting her personal hygiene, buying food in bulk which she didn't need, appearing confused in that she had been banging on neighbour's windows saying that she couldn't find her keys -which she was wearing around her neck - and her neighbour - who had become a significant protective factor in VM's life – was struggling to cope with supporting her. Taken together, these risks indicated to professionals that VM may no longer be safe at home. This had become quite a complex situation and professionals may have had difficulty in weighing up the risks VM faced and how the various risks may interact with each other.

6.18 In their contribution to this review, GMMH state that the assessment carried out by the DCPT case manager on 3rd February 2020 was thorough despite the difficulties in engaging with VM. The assessment included a STAR (Standard Tool for Assessment of Risk) V2 risk assessment. This appears to be a thorough approach to risk management although the GMMH guidance (4) could give greater emphasis to risks related to accidents which in the guidance is limited to 'falls'. However, a road safety assessment could have been completed as part of an occupational therapy assessment, although it had proved difficult to fully engage VM in the occupational therapy assessment in late 2019 (Paragraph 4.41).

6.19 The plan arrived at was to refer VM to 'social services' for a review of her care package – which could have led to increased home care visits, particularly during the evening – and a referral for care co-ordination to enable longer term monitoring and possibly the introduction of a support worker. Care co-ordination was agreed by the older adults CMHT and, over time, this was an approach which appeared to have a good chance of succeeding in addressing VM's needs and reducing the risks to which she was exposed. Tragically, she was knocked over by the lorry later in the day on which the decision to allocate a care co-ordinator was taken.

How effective were systems for escalating urgent concerns about a person who appeared to be at risk of serious harm?
Was admission to hospital under the Mental Health Act appropriately explored?

6.20 Systems for escalating urgent concerns were tested by VM's case. Whilst it is acknowledged that there were opportunities to intervene earlier to safeguard VM, professional concerns escalated markedly from Wednesday 29th January 2020.

6.21 The GP who became involved in VM's care from Thursday 30th January and attempted to access appropriate support for VM throughout the day on Friday 31st January 2020 contributed to the practitioner learning event arranged to inform this review. The GP could have considered an assessment of VM's mental capacity on Thursday 30th January 2020 given that the primary concern at that point was the progressive nature of VM's dementia and she was noted to lack insight into her condition and recent events. An adult safeguarding referral could also have been considered on Thursday 30th or Friday 31st January 2020.

6.22 The urgent re-referral to DCPT on Thursday 30th January 2020 was entirely appropriate. DCPT could have considered re-prioritising patient appointments in order to see VM prior to instead of immediately after the weekend of 1st/2nd February 2020 although it seems very unlikely that any DCPT assessment would have been considered by the older adults CMHT until after the weekend. Additionally, GMMH has advised this review that the CMHT and DCPT are not commissioned or enabled to provide a crisis response.

6.23 Adult Social Care brought forward the visit by a social worker from the scheduled date of 7th February 2020 and he visited VM on Friday 31st January 2020. Whilst there was direct telephone communication between the social worker and the GP, unfortunately confusion arose over whether VM was to be admitted to hospital A+E that day. The social worker, who remained with VM until the early evening, VM herself, her neighbour who waited with her and VM's son were all under the impression that an ambulance had been summoned and would be coming to

transport VM to hospital that evening. This was an unfortunate state of affairs, may have caused VM, her son and her neighbour anxiety and distress and did not reflect a professional response to the concerns about VM.

6.24 The GP had considered arranging for VM to be conveyed to Hospital A+E by ambulance, as suggested by DCPT, but ultimately decided that this was an inappropriate course of action for VM. Whilst this would have enabled VM to have been referred for a mental health assessment at hospital, the GP was concerned for the safety of the ambulance crew given the possibility that VM may be unwilling to attend hospital and may have been carrying a knife and a screwdriver. Other factors which may have made Hospital A+E unattractive as an option may have been the likelihood that it could be quite busy on a Friday evening leading to delays in being triaged and referred for a mental health assessment and that VM could find the experience upsetting and disorientating. Additionally, VM may have declined assessment by the hospital mental health team. As previously stated, the question of whether VM may lack capacity to make decisions such as this does not appear to have been a factor in decision making on Friday 31st January 2020. Adult Social Care suggested that the GP refer VM to the MFT Enhanced Care Service which is an urgent service for patients immediately at risk of admission to hospital. These patients will be seen within 6 hours of the referral and a health and social care package will be put in place to support them to stay at home for 72 hours. This could have been an appropriate option for VM as it could have addressed the growing concern that she was no longer safe in her own home although VM had often not been comfortable being supported by carers in her own home.

6.25 Ultimately, the GP's preferred option, after consulting with the GP practice's duty doctor, was for VM to be assessed under the Mental Health Act 'with a view to being sectioned for her own safety'. However, VM's UTI diagnosis appears to have been a barrier to an AMHP considering co-ordinating a Mental Health Act assessment of VM. By the time a Mental Health Act assessment was being actively considered, it was after 4.30pm on the afternoon of Friday 31st January 2020 and any referral for a Mental Health Act assessment would need to be considered by the Adult Social Care EDT, the members of which are all AMHP trained. The GP then had a telephone conversation with the duty social worker and provided details of the case and was advised that the EDT would ring her back. The EDT had not rung back before she finished work for the day. The GP handed the case over to the GP practice's duty doctor. The GP practice later received a message from the EDT requesting the doctor call them back but when the duty doctor attempted to recontact the EDT, she was unable to get through to them and no further discussion of a Mental Health Act assessment took place. Nor was a formal referral for a Mental Health Act assessment made. The AMHP service has no record of the GP's informal request for a Mental Health Act assessment but as the option was not under active discussion until after

4.30pm, it was the EDT, rather than the regular AMHP service who became involved. Whilst it seems likely that the EDT would have declined a Mental Health Act assessment on the grounds of VM's UTI, it is regrettable that it was not possible for the GP to have direct contact with an AMHP in the EDT.

6.26 The GP felt that the UTI should not have prevented the consideration of a Mental Health Act assessment as the UTI diagnosis was not a confirmed diagnosis, although antibiotic treatment had commenced, and the GP's primary concern was the progressive nature of VM's dementia and the risks she was exposed to as a result. The Panel established to oversee this review supports the likely AMHP view that the UTI diagnosis precluded the Mental Health Act assessment as the UTI may have been a factor in VM's presentation and therefore needed to be treated prior to an informed assessment under the Mental Health Act. However, the GP believed that the process by which a Mental Health Act assessment could take place had been set in train when she left work on Friday evening having worked many more hours than she was scheduled to do.

6.27 The GP felt that the unwillingness of agencies – DCPT and Adult Social Care – to discuss patients prior to a referral being formally submitted hampered efforts to arrange appropriate support urgently. It is regretable that it did not prove possible for the GP, who had detailed knowledge of VM's presentation and access to her medical history to have a direct conversation with an AMHP in the EDT during the later afternoon/early evening of Friday 31st January 2020 in order that an informed conversation could have taken place which would either have led to a Mental Health Act assessment or ruled it out. And if ruled out, alternatives could have been considered rather than leaving VM in 'limbo' over that weekend when, thankfully, she came to no harm.

6.28 Friday afternoon is frequently a pressurised time in the week when the range of services available during the working week suddenly diminish and when there is a risk that service users whose needs are escalating may struggle to access the support they need. This review has been advised that an EDT handover meeting held each Friday at 4.30pm could help to address similar occurrences in the future as the handover aims to enables a clear handover of information and improved lines of communication.

6.29 The Panel which oversaw this review noted the absence of any individual or agency with a lead role in co-ordinating the response as the concerns about VM escalated in late January 2020. This could well have been addressed had the care co-ordinator allocated to VM by the CMHT MDT on 4th February 2020 had time to work with partner agencies to support her. In advance of the appointment of a care co-ordinator it was noted that the GP fulfilled a leadership role and was supported in

this by the duty doctor from her GP practice. In this case, fulfilling the lead role was very challenging, frustrating and emotionally draining and so it is important that colleagues who fulfil such roles can readily draw upon support, at the time and subsequently.

When VM began to make decisions against professional advice, such as rejecting support and not taking her medication, were issues relating to her mental capacity appropriately considered?

6.29 There had been indications that VM may lack capacity in respect of some decisions or that her capacity may fluctuate from 2018. Prior to her discharge from hospital on 5th May 2018, the hospital social worker documented that she felt that VM lacked capacity regarding 'risks at home' (Paragraph 4.6). VM then declined the short term SAMS support which had been put in place to support her following her discharge home and was re-admitted to hospital just three days after her discharge. This second hospital admission in quick succession lasted for two days prior to her self-discharging (Paragraph 4.9). There is no indication that the concerns about VM's capacity were shared or further considered during this period or that apparently unwise decisions such as declining the SAMS support and self-discharging from hospital were enquired into.

6.30 Mental capacity assessments appear to have taken place during hospital admissions when Deprivation of Liberty Safeguards were considered justified on two occasions (Paragraph 4.20 and 4.35), although on the first of those two hospital admissions she was subsequently assessed as having capacity to decline support from OPAL House.

6.31 It is quite possible that VM's capacity was fluctuating or that she had capacity to make some decisions but not others. However, her decision to decline the support of OPAL House, which she was assessed as having the capacity to make, could have been considered as one of a series of unwise decisions. There appeared to be no exploration of the mounting number of decisions VM was taking to decline support such as repeatedly declining home care from both Olive Healthcare and iCare, declining post- acute hospital discharge support in OPAL House, refusing to fully participate in the DCPT occupational health assessment and declining the neuro psychological assessment.

6.32 The Mental Capacity Act (MCA) sets out five statutory principles which underpin the legal requirements of the Act, one of which is that a person is not to be treated as unable to make a decision merely because they make an unwise decision. However, the MCA Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of

harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character'. The Code of Practice adds that 'these things do not necessarily mean that somebody lacks capacity...but there might be need for further investigation, taking into account the person's past decisions and choices' (5).

6.33 VM's apparent confusion did not always prompt enquiry about capacity such as when she waited in the MRI for several hours for her son to pick her up which was not a feasible option because he lived in Hampshire (Paragraph 4.15), despite appropriate information sharing about this incident by Adult Social Care with CMHT.

6.34 VM was frequently perceived to lack insight into her needs. The Panel which oversaw this review commented that lacking insight did not necessarily mean that she lacked mental capacity, however her lack of insight into her needs placed her at risk because her lack of insight resulted in a lack of awareness of the risks she was exposed to around her home which was compounded by her reluctance to accept support from carers.

6.35 In his contribution to the review, VM's son felt that his mother was capable of giving what he described as the 'right' answers when professionals asked her ability to take care of herself. He felt that his mother could 'talk the talk' but struggled to 'walk the walk', in that she could give the impression that she was able to look after herself during a conversation with a professional, but was often unable to put this into practice when she was in her home environment. 'Walking the walk' can also be described as 'executive capacity' or the ability to execute the plan in every day life situations by applying information in practice at a time when the person needs to make a decision.

6.36 In the final days of her life, VM presented as having no insight into her condition or recent events (Paragraph 4.47), becoming verbally abusive when agitated, displaying increasing paranoia (Paragraph 4.50), felt she was able to meet all her personal needs independently (Paragraph 4.50) and disoriented to time, demonstrating no insight into her care needs and the risks she was exposed to when walking the streets (Paragraph 4.53). However, no capacity assessment was carried out or apparently considered during this period.

6.37 Had a capacity assessment been carried out at that time or earlier and VM found to lack capacity then decisions she lacked the capacity to make could have been taken within a formal best interests framework which would have enabled her son to be involved in a more structured way than had previously been the case. (Agency contact with him had been largely reactive in seeking to respond to concerns he raised from afar). It would also have been possible to consider whether VM was eligible for and would benefit from advocacy support.

How effective were interventions to prevent a deterioration in VM's presentation?

6.38 VM was under the care of mental health services from May 2018 until January 2019. When she did not engage with the neuro-psychologist, an appointment which had been arranged to support a diagnosis, and then declined further input, she was discharged by the CMHT (Para 4.16). Whilst VM had the right not to engage with mental health services, the possibility of diagnosing and treating her needs was lost at that time. There was an opportunity to have considered a multi-agency discussion at that point in order to discuss how VM and her family could be further supported given the concerns raised at that time with VM's GP practice about her memory, behaviour and concordance with medication (Para 4.17). At the time that the CMHT discharged VM they documented her to have been stable for some time, which may have been an over-optimistic view.

6.39 She was under the care of mental health services again from August until December 2019. With hindsight it may have been preferable for her to have been referred back to the older adults CMHT when the short term involvement of the DCPT ended. During this period of care she had been diagnosed with notable cognitive impairment suggesting a neurodegenerative disease in keeping with both Alzheimer's and Vascular Dementia and started on memantine. Additionally, it became clear that VM was struggling to manage her medication, risking food poisoning by turning off her fridge, required prompting with her personal care and was resistive to being observed carrying out tasks in the home which led to the occupational therapy assessment not being fully completed. However the DCPT did refer VM to Adult Social Care which led to the care package which had been cancelled by her son being reinstated, albeit with the different provider.

How effective were the efforts of agencies to engage with VM and her son?

6.40 Agencies consistently experienced challenges in engaging with VM. The reasons why she frequently resisted interventions and assessments did not appear to be explored with her or her son. Professionals often appeared to adopt a respectful, sympathetic yet persistent approach to VM, but when faced with irritation or resistance they often left things there. Had a conversation taken place in which VM's resistance to support was explored, it seems likely that she may have expressed her fears of a placement in residential care (see Paragraph 5.8) and the value she placed on maintaining her independence. This could have led to a greater appreciation on VM's part that accepting home care could help her to be supported to live relatively independently in her home for as long as possible.

6.41 Generally agencies engaged positively with VM's son, although he expressed frustrations with services other than VM's GP (Paragraph 5.9). However, as stated, the engagement with VM's son tended to be reactive in that agencies responded to concerns he raised on behalf of his mother or they contacted him when problems arose. The son has advised this review that he obtained lasting power of attorney in respect of his mother in December 2019. He was providing care to his mother from a considerable distance which created difficulties for both the son and the agencies in contact with his mother. In his contribution to the review he outlined his plan of moving his mother to a nursing home near his home in Hampshire in which his wife worked but there is little indication that he and Trafford based services ever had a discussion about how this might be accomplished when it was no longer possible to support her to live independently.

6.42 When VM's son complained about the support provided by Olive Healthcare, Trafford Commissioning investigated his complaint. However, the complaint generated some concerns about VM's welfare and there is no indication that any action was taken to address these issues (Paragraph 4.29) and VM was left without home care support until her diagnosis of Alzheimer's and vascular dementia led to the prescription of memantine and home care was reinstated in October 2019, just two months after it had been cancelled. Her son has advised this review that when the package of care provided by Olive Healthcare was cancelled he said he pressed for a new provider to be put in place and only intended that his mother should be supported by her neighbour for a short interval whilst a new home care provider was commissioned.

6.43 VM's neighbour played an increasingly important role in supporting her from May 2019 and there were times when too much may have been expected of her, particularly during the two month interval between home care providers when she assumed complete responsibility for ensuring VM's medication was administered. The demands of supporting VM gradually increased yet there appears to have been no consideration of offering her a Carer's Assessment or other support.

How effective was multi-agency working in this case?

6.44 During the period from May 2018 until January 2019 when VM was under the care of mental health services, her GP practice did not appear to have a clear understanding of the care she was receiving and the extent to which she was engaging and appeared confused as to when VM was discharged from mental health services.

6.45 Adult Social Care tended to pass on concerns about VM to the CMHT during the time that VM was under the CMHT, when they might have considered a more collaborative approach or at least a discussion with CMHT (Paragraphs 4.14 and 4.18). Adult Social Care also passed concerns about VM to CMHT when VM was no longer under their care (Paragraph 4.22), which appeared to indicate that forwarding concerns about VM to CMHT may have become a default position once it was noted that she was, or had been under the care of the CMHT. Whilst this was appropriate given GMMH's responsibility for health *and* social care, it was necessary for Adult Social care to check that the CMHT was still actively working with VM. Additionally, VM's discharge from mental health services in January 2019 appeared to coincide with Adult Social Care sending the CMHT a concern for welfare referral they received from Olive Healthcare (Paragraphs 4.18 and 4.19). The CMHT do not appear to have advised Adult Social Care that they had discharged VM from their care. This review has been advised that CMHT do not routinely advise Adult Social Care of decisions to discharge patients but would generally do so if Adult Social Care were involved in providing support.

6.46 The CMHT appear to have incorrectly advised the GP that VM's consent would be necessary for them to accept the referral the GP wished to make (Paragraph 4.22). GMMH have advised this review that the older adults CMHT does not require confirmation from the GP that consent has been given by the client as the service then contacts the client/relatives/carers to arrange the initial assessment and should the client be clear that they do not wish to be seen at that point the CMHT would risk assess and then liaise further with the GP and consider any need or indication for a Mental Health Act assessment or consider a 'cold call' visit to further assess risks and inform the next steps and decision making.

6.47 Additionally the CMHT overlooked the further GP referral in respect of VM (Paragraph 4.23) and at the time of writing GMMH were continuing to look into the matter to establish how the mistake was made. Additionally, there is no indication that VM's GP practice followed up on the lack of response from the CMHT to their two unsuccessful attempts to refer VM in May 2019 (Paragraphs 4.22 and 4.23), until VM's son re-contacted them to say that his mother was still waiting for input from CMHT (Paragraph 4.26) which led to a further GP referral (Para 4.26). Overall it took three GP referrals to prompt a response from CMHT on this occasion, which explains the frustration which the son expressed in his contribution to this review (Paragraph 5.9).

6.48 VM's refusal of services and assessments could have been viewed as self-neglecting behaviour although the Trafford Strategic Safeguarding Partnership guidance on self-neglect appears to place much greater emphasis on lack of self-care or care for one's home environment, which was a less prominent feature of

VM's case. Had VM been perceived to be self-neglecting by refusing services and assessments and a safeguarding referral considered this could have generated a multi-agency approach.

Good Practice

6.49 The DCPT case manager advised that a small cohort of carers – as VM found having many different carers stressful – should supervise medication as part of their visits and check the fridge (Paragraph 4.38).

7.0 Findings and Recommendations

The response to concerns arising from VM 'walking about'.

7.1 When concerns arose about VM leaving her address during the hours of darkness, walking the streets and becoming lost, the response of the agencies who became aware could have been more considered. The impression gained is that agencies appreciated that walking about the streets during the hours of darkness exposed VM to risks but were less sure about how to respond effectively. The risks arising from VM's 'walking about' were not fully explored and were not specifically included in the DCPT risk assessment carried out on 3rd February 2020. The option of carrying out a road safety assessment as part of an occupational therapy assessment does not appear to have been considered at that time. A safeguarding referral appears to have been under consideration as concerns escalated from 29th January 2020 but no safeguarding referral was eventually made. Safeguarding referrals could also have been considered when concerns first began to arise about VM 'walking about'.

7.2 The Alzheimer's Society guidance on understanding 'walking about' behaviours and responding sensitively and thoughtfully to them could have been of particular value in this case. This Alzheimer's Society guidance should be used to enhance professional practice and strengthen risk assessments locally and also widely shared to inform policy and the assessment of risk nationally.

Recommendation 1

That Trafford Strategic Safeguarding Partnership makes use of the learning from this case, in particular the Alzheimer's Society guidance on understanding and responding to 'walking about' behaviours, to inform professional practice by means of a practice direction and by strengthening risk assessments.

Recommendation 2

That Trafford Strategic Safeguarding Partnership disseminates the learning from this case more widely in order that Safeguarding Adults Boards in England are able to review policy and risks assessments as necessary.

Responding to crises

7.3 Systems for escalating and addressing urgent concerns were tested by VM's case although it is acknowledged that there were opportunities to intervene earlier

to safeguard VM. Reflecting on how the escalating concerns about VM were managed on Friday 31st January 2020 it is unfortunate that, at that stage, VM did not have a care co-ordinator to navigate systems, make urgent referrals and help VM access the support she required.

7.4 What this case demonstrates is that many services are neither commissioned or resourced to provide a crisis response and professional awareness of those that are crisis response enabled and those that are not, may need to be enhanced. It would be helpful if a concise multi-agency guide to crisis enabled service provision in Trafford was prepared and disseminated.

7.5 Additionally Friday afternoon is frequently a pressurised time in the week when the range of services available during the working week suddenly diminish and when there is a risk that service users whose needs are escalating may struggle to access the support they need. This review has been advised that an EDT handover meeting held each Friday at 4.30pm could help to address similar occurrences in the future as the handover aims to enables a clear handover of information and improved lines of communication. The Strategic Safeguarding Partnership may wish to seek assurance on how effectively these arrangements address the challenges which not infrequently arise on Friday afternoon/evening.

Recommendation 3

That Trafford Strategic Safeguarding Partnership arranges for a concise multi-agency guide to crisis enabled service provision in Trafford to be prepared and widely disseminated to professionals.

Recommendation 4

That Trafford Strategic Safeguarding Partnership seeks assurance on the effectiveness of handover arrangements to emergency and out of hours services on Friday afternoons.

Multi-Agency Working

7.6 The response of primary care, Adult Social Care and the Community Mental Health Team to VM's needs was far from seamless. VM's GP experienced difficulties in making referrals to the CMHT but did not always follow up on this lack of responsiveness until prompted to do so by VM's son. Additionally, there appeared to be a lack of clarity between the CMHT and the GP practice over whether VM was under their care or whether she had been discharged.

7.7 Once VM had been accepted by the CMHT, Adult Social Care's default position appeared to be to pass on to the CMHT any concerns they received about VM, even when VM was no longer under the care of the CMHT. Adult Social Care needed to check that the CMHT was still actively working with VM, and often they did not do so.

7.8 No multi-agency meeting or discussion took place as concerns about VM began to escalate. There would have been clear benefits in such a discussion taking place between primary care, Adult Social Care and the home care provider. This type of discussion seems to be much rarer in the adult safeguarding sphere than it is in the child safeguarding sphere. However, had any safeguarding referrals been made and progressed to a safeguarding enquiry this could have provided a framework for multi-agency collaboration.

Recommendation 5

That Trafford Strategic Safeguarding Partnership obtains assurance that the local system includes multi-agency discussions in the planning and co-ordination of cases in which concerns are beginning to escalate.

7.9 The Panel also explored how primary care, Adult Social Care and Community Mental Health services could operate in a more seamless manner than was evident in this case. The Panel felt that no specific recommendation was merited but that this may be an issue that Trafford Strategic Safeguarding Partnership wishes to keep under review.

Safeguarding referrals

7.10 No safeguarding referral was made in respect of VM. Paragraph 6.13 sets out some of the numerous opportunities when a safeguarding referral could have been considered. Additionally, there is no indication that professionals such as the GP or the DCPT case manager considered seeking specialist safeguarding advice from within their own organisations.

7.11 It is recommended that when the learning from this review is disseminated, professionals are reminded of the criteria for making a safeguarding referral and the sources of specialist safeguarding advice available to them.

Recommendation 6

That when Trafford Strategic Safeguarding Partnership disseminates the learning from this review, professionals are reminded of the criteria for making a

safeguarding referral and the sources of specialist safeguarding advice available to them.

Self-Neglect

7.12 VM's refusal of services and assessments could have been viewed as self-neglecting behaviour although the Trafford Strategic Safeguarding Partnership guidance on self-neglect appears to place much greater emphasis on lack of self-care or care for one's home environment, which was a less prominent feature of VM's case.

7.13 The Safeguarding Partnership may wish to review their guidance on self-neglect to ensure that refusal of services is a more prominent example of possible self-neglecting behaviour.

Recommendation 7

That Trafford Strategic Safeguarding Partnership reviews their guidance on self-neglect to ensure that refusal of services is a more prominent example of possible self-neglecting behaviour.

Mental Capacity

7.14 One might have expected VM's impaired memory, lack of insight into her needs and her subsequent diagnosis of Alzheimer's and vascular dementia to have led to a greater professional focus on her mental capacity thereafter but this does not appear to have been the case as clear opportunities to assess VM's mental capacity to make specific decisions appear to have been missed. Professionals could also have given greater consideration to VM's 'executive capacity' or ability to apply information at the time she actually made decisions. Additionally there appears to have been no exploration of the mounting number of 'unwise' decisions VM was taking to decline services - which prevented her from receiving the support she needed.

7.15 The Mental Capacity Act has proved a challenging piece of legislation for professionals to come to terms with and invariably appears as a learning theme in Safeguarding Adults Reviews. This review is no exception. It is therefore recommended that the Strategic Safeguarding Partnership requests each agency involved in VM's case to state what specific actions they plan to take in the light of this SAR to improve the response of their staff to mental capacity issues including the issue of someone persistently making unwise decisions.

Recommendation 8

That Trafford Strategic Safeguarding Partnership requests each agency involved in VM's case to state the specific actions they plan to take in the light of this SAR to improve the response of their staff to mental capacity issues including the issue of someone persistently making unwise decisions.

References

(1) Retrieved from Alzheimers.org

(2) ibid

(3) ibid

(4) Retrieved from Greater Manchester Mental Health NHS Foundation Trust's website

(5) Retrieved from Gov.uk - Mental Capacity Act

Appendix A

Process by which safeguarding adults review (SAR) conducted

It was decided to adopt a systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Chronologies which described and analysed relevant contacts with VM were completed by the following agencies:

- iCare Solutions
- Greater Manchester Mental Health NHS Foundation Trust.
- Greater Manchester Police
- Manchester University NHS Foundation Trust
- Trafford Council Adult Social Care
- Washway Road Medical Centre, Sale

The chronologies were analysed and issues were identified to explore with practitioners at a learning event facilitated by the lead reviewer.

VM's son contributed to the SAR via a telephone discussion with the lead reviewer and also had the opportunity to read and comment on a late draft of the SAR report.

The lead reviewer then developed a draft report which reflected the chronologies, the contributions of practitioners and the contributions of VM's family.

The report was further developed into a final version and presented to Trafford Safeguarding Strategic Partnership.