Safeguarding Adults Review
for City of York Safeguarding Adults Board

Mr. A

Prepared by

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Executive summary

MR. A was a patient at The Retreat independent hospital in York continuously for 45 years between 1973 and 2018. He moved to Billingham Grange independent hospital in Stockton on Tees and remained there until his death in September 2020. Mr. A was detained under the Mental Health Act (MHA) for almost the entirety of his time in hospital, apart from a brief period between 2014 and 2016 when he was subject to the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS). MR. A's care was funded throughout this time by a private trust fund administered in South Africa.

As a result of these arrangements, the state (local authority and NHS) had very little knowledge of Mr. A's care or contact with him until approximately 2014, when the first DoLS referral was made. There had been one-off involvements through MHA assessments in the 1970s and again in 2008.

It is evident from the notes that Mr. A's family, who were closely involved in his financial arrangements, although not trustees of the trust fund, were keen to prevent state involvement in his care, in order to ensure that Mr. A remained at The Retreat and to minimise any possibility of him being moved to an NHS (or any other) facility.

This created a considerable tension regarding the ongoing assessment of the suitability of his placement on George Jepson Ward at The Retreat, and the possibility of further assessments, specifically to explore the possibility of an autistic spectrum (ASD) diagnosis. Mr. A was diagnosed with paranoid schizophrenia in 1971, which remained his diagnosis until at least his transfer to Billingham Grange. However, for at least the last 15 years of his life, the care teams were referring to possible, probable, likely and actual ASD diagnosis. He was never formally assessed for ASD or diagnosed as such, although after his move to Billingham Grange, an NHS team concluded that a working diagnosis of ASD should be given.

Throughout Mr. A's time at The Retreat his treatment was primarily for schizophrenia, with psychopharmacological treatment being by far the main response to his symptomatology.

Local authority involvement was most intense between 2014 and 2016, during which time Mr. A was assessed under the DoLS scheme four times and three DoLS authorisations were granted. It continued in 2017 following a safeguarding alert in relation to self-neglect.

Whilst the outcome of the DoLS assessments has not been challenged in this review, the assessments themselves exhibited some significant deficits. There is no doubt that Mr. A's symptoms made communication with him very difficult, but there was almost no evidence of direct communication with him during any of the assessments, and no attempts at more creative means of communication, as required by the MCA Codes of Practice, for people with specific communication needs.

None of the assessors had alternatives to realistically consider, but when they were considering other theoretical options, they appeared only to look at the two extremes of remaining on George Jepson Ward at The Retreat, or discharge to the community, which was patently unrealistic. None explored the fact that Mr. A was placed on a dementia ward with increasing numbers of patients with behavioural and psychological symptoms of dementia, while he himself had a diagnosis of schizophrenia, and likely additional ASD.

Mr. A had a paid representative (RPR) as required under the DoLS scheme who visited him six times in total. Her reports are criticised for repetition and apparent copying and pasting

across multiple visits. On each visit she noted Mr. A's neglected appearance. The words "unkempt", "dishevelled" and "grubby" are repeatedly used. However, these descriptions did not find their way into the field headed "Concerns", and although all the reports were sent to York CC DoLS team, she did not raise them directly. Equally, the DoLS team received these reports and, if they were read, no one picked up on this pattern of neglect.

The final DoLS assessment in 2016 did not result in a further DoLS authorisation due to the findings of the mental health assessor, who reported that Mr. A was exhibiting "gross neglect" and that "he looks like a vagrant". A MHA assessment was initiated, Mr. A was re-detained on s3 MHA but there was no response to these powerful comments by the doctor.

This failure to respond to apparent neglect (or self-neglect) is compounded during an adult safeguarding investigation initiated in early 2017 by staff at The Retreat. A major investigation took place over approximately four months in spring 2017. However, it appears that the investigation covered two wards, numerous patients and focussed more on the organisational changes on the ward than Mr. A as an adult at risk.

Statements were made by professionals from The Retreat and from other agencies which contrast to the observations by the paid RPR, the latest DoLS mental health assessor and the staff who initiated the safeguarding alert. There was a view that Mr. A's needs were generally being adequately met, that he was generally clean and the incident which prompted the alert was a "one-off". There is no evidence that the investigation read or explored the notes which referred to the previous "unkempt", "grubby" and "dishevelled" presentation throughout 2015, or "gross neglect" just six months prior to this alert.

This reviewer is in no doubt that Mr. A presented a considerable challenge to the care team who were looking after him. However, it is suggested that his ASD (which now appears to be uncontentious) will have at best not been helped, and at worst been severely aggravated by being on a ward with patients with dementia and associated behavioural symptoms.

The Retreat staff showed at times a clear understanding that Mr. A was not suitably placed on George Jepson Ward, but for a variety of reasons chose not to act on this concern. It has been established in case law that family, even when funding the care, cannot force a clinician to continue to provide care which the professional concludes is not appropriate.

The local authority had opportunities to intervene during the mid 2010's and there was adequate evidence of significant neglect. While it was described as 'self-neglect' it is important to consider the context of Mr. A's detention on a highly staffed hospital ward and whether the possibility of institutional neglect could have been considered.

Finally it important to consider the reports from Billingham Grange in the 18 months following his transfer from The Retreat. There is evidence of a significant reduction in aggression, reduction in the need for physical restraint and improved socialisation. The Mental Health Tribunal which sat to consider Mr. A's case in August 2020 (seven weeks before his death) asked the team to consider discharge planning and requested a referral be made to the local authority social services team.

This indicates the potential for rehabilitation with a different programme of care and treatment. Sadly, it is impossible to know how much more progress Mr. A could or would have made in the next 18 months.

Terms of reference

Case Overview:

For many years, Mr. A's notes recorded his year of birth as 1946, and much documentation continued to reference that year. All his Mental Health Act and Deprivation of Liberty documentation give his date of birth as 15th April 1946. However, Mr. A's family confirmed to The Retreat in 2011 that his correct date of birth was 15th April 1948. The Retreat records subsequently recorded this date, but the amendment was not made on records, including legal detention documents, completed by other agencies. The latest example found was the First Tier Tribunal decision of 28th June 2017.

This report will therefore use the date of birth confirmed by his family, as 15th April 1948.

Mr. A was admitted to an independent mental health hospital in 1973 following a serious suicide attempt at the age of 25 years. His care and continued detention in hospital has been funded privately by a Trust fund set up by his parents. His family members have continued the parents' wishes which has resulted in Mr. A being detained for the majority of his life. He has a diagnosis of paranoid schizophrenia; but is also noted to have behaviours which would support a diagnosis of Autistic Spectrum Disorder (although this has not been formally assessed).

For the majority of his life in care facilities he has been detained under the Mental Health Act. In more recent years there was a period where the Mental Capacity Act was applied and Deprivation of Liberty Safeguards authorised. Mr. A's care was transferred in 2018 to another independent hospital outside the locality following the planned closure of the hospital where he had 'lived' for 45 years.

PURPOSE OF THE REVIEW:

- To establish the facts
- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies (or any other person involved in the care of an adult) work together to safeguard adults at risk
- Review the effectiveness of procedures (both multi agency and those of individual organisations)
- Inform and improve local interagency practice and commissioning arrangements
- The author will work closely with the family in helping to shape and inform the review.
- Where evident identify good practice
- Improve practice by acting on learning and developing best practice
- Bring together and analyse the findings of reports from agencies to make recommendations for future action

The Care Act 2014 provides a legal framework to protect adults at risk of abuse or neglect. Roles, responsibilities and accountability are set out and include guidance on the principles which should underpin all work in adult safeguarding.

Specific areas for the SAR to focus on and key areas to be analysed:

- Application of the Mental Health Act and Mental Capacity Act/Deprivation of Liberty Safeguards for people whose care is outside the NHS
- Application of the Human Rights Act
- Responsibilities of regulatory bodies and public bodies in maintaining oversight of independent providers and individual cases
- Missed opportunities to bring about the potential of improved outcomes for Mr. A

The SAR is asked to consider:

- The background to Mr. A's admission to The Retreat, including an overview of his mental health difficulties and the rationale (and hopes) for his admission.
- The oversight and independent scrutiny of Mr. A's inpatient admission, including that provided by any relevant legislation that he may have been subject to at the time.
- How was Mr. A's progress during the inpatient admission scrutinised by those responsible for funding.
- The role and involvement of Mr. A's family in relation to his hospital admission and ongoing treatment.
- The involvement of any independent advocate
- What role, if any, did the Hospital Managers at The Retreat Hospital have in regard to Mr. A's long-term admission.
- What involvement, if any, did statutory services have with Mr. A's case and were they coordinated and effective in changing the outcome.
- What evidence was there of communication and information sharing between the hospital and any relevant statutory service?
- The timeliness of interventions for Mr. A and his family.
- Risk assessment and risk management, particularly in relation to how Mr. A's future care needs were being addressed.

Period of time the Safeguarding Adult Review is to consider

September 2008-June 2020 (please note, that the Sept. date is the first contact that the City of York Council had from The Retreat regarding Mr. A).

Methodology

1. Chronologies (to be combined) to be undertaken by the following agencies:
    a. **City of York Council-Adult Social Care**
    b. **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)**
    c. **The Retreat Hospital**
    d. **Mr. A's registered GP**
    e. **Vale of York CCG**
    f. **Advocacy**
    g. **The Billingham Grange Independent Hospital (Barchester Care) - this is new placement and they may not do a chronology but will need to be consulted, i.e. current/future outcomes.**
2. The agencies above to be also asked to make recommendations as to what actions they need to undertake to improve practice.

3. Learning events. Practitioners and Managers will be invited to events to establish the local context and inform the SAR.
4. Family Involvement. The family will be invited to take part in the SAR in the following ways:
    - Invited to meet with the author to give their view of the events surrounding Mr. A's long-term hospital admission.
    - Invited to parts of the SAR process as determined by the SAR Panel
    - Invited to contribute to a final draft prior to publication
    - Informed about publication stages, dates and processes

Postscript

Mr. A sadly passed away at Billingham Grange independent hospital on 27th September 2020. As a result of this further information, a decision was made by the SAB not to involve Mr. A's family in the process, and to complete the review from the papers already provided.

Family involvement

Due to Mr. A's sad death in September 2020, it was determined that the review would continue using the documentation provided.

An email was sent to Mr. A's brother informing him of the review, but although he acknowledged the correspondence, he did not respond to a further or a letter setting out the details of the review.

This report therefore has not been able to incorporate the views of Mr. A's family into his care and treatment.

Safeguarding adult reviews

Section 44 Care Act 2014 places a statutory requirement on Safeguarding Adults Boards (SABs) to commission and learn from Safeguarding Adult Reviews (SARs) in specific circumstances, as laid out below, and confers on SABs the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

> a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
>
> b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or
>
> c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

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

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

> a) identifying the lessons to be learnt from the adult's case, and
>
> b) applying those lessons to future cases.

Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures: London Multi-Agency Adult Safeguarding Policy & Procedures - April 2019

All LSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

Documents examined

Date	Document title
04/09/08	ASW assessment report
04/09/08	Letter from ASW to nearest relative
19/09/11	Letter correcting Mr. A's date of birth
13/02/14	Capacity assessment and best interests decision (MHT representation)
16/05/14	Safeguarding alert
May/June 2014	DoLS documentation (request, urgent authorisation, extension request, extension granted, eligibility, mental health, best interests, capacity, no refusals, authorisation granted)
28/05/14	Safeguarding planning meeting notes
Sept/Oct 2014	DoLS documentation (eligibility, mental health, best interests, capacity, no refusals, authorisation granted)
03/11/14	Appointment of DoLS RPR
15/12/14	Appointment of DoLS paid RPR
19/12/14	DoLS paid RPR report
29/12/14	Dietician assessment
12/01/15	Dietician review
28/01/15	Dietician review
25/02/15	OT report
07/05/15	DoLS paid RPR report
07/07/15	DoLS paid RPR report
24/08/15	DoLS paid RPR report
Sept/Oct 2015	DoLS documentation (renewal request, DoLS form 4, DoLS form 3, authorisation granted)
20/09/15	Best interests meeting (placement at George Jepson Ward)
08/10/15	DoLS paid RPR report
17/11/15	DoLS paid RPR report
01/01/16	Mental capacity assessment (personal care)
27/01/16	Best interests meeting (personal care)
29/01/16	Risk profile
09/02/16	Best interests meeting (personal care)
19/02/16	Letter requesting external psychiatric review
15/03/16	Letter from Tees, Esk and Wear Valley consultant psychiatrist in LD to The Retreat medical director
15/03/16	Best interests review (personal care)
24/05/16	Case summary by medical director

Date	Document title
May 16	Various correspondence (letter and emails) between The Retreat and trustees
31/05/16	Best interests review (personal care)
12/07/16	Best interests review (personal care)
24/07/16	Safeguarding alert
Sept/Oct 2016	DoLS documentation (renewal request, DoLS form 4, DoLS form 6 – authorisation not granted)
14/10/16	AMHP referral
18/10/16	AMHP assessment report
25/10/16	DoLS notification authorisation not granted
25/10/16	Letter to nearest relative
07/02/17	Safeguarding alert
09/02/17	Safeguarding enquiry
10/03/17	Safeguarding enquiry plan
26/05/17	Mental capacity assessment (safeguarding processes)
06/06/17	Safeguarding outcome review
07/07/17	Safeguarding enquiry report
12/07/17	Safeguarding outcome review
01/01/18	Safeguarding summary
Feb 18	Psychologist review of notes
01/03/18	Speech and language therapist guidelines to support communication
20/04/18	Mental capacity assessment (future care decisions)
24/07/18	Best interests meeting (information sharing)
20/08/18	Letter from The Retreat to Mr. A's brother
20/08/18	Delegation of functions of nearest relative
22/08/18	Discharge planning meeting
03/09/18	Discharge planning meeting
25/10/18	IMCA referral (change of accommodation)
15/11/18	IMCA pre-decision report
04/12/18	IMCA post-decision report
26/11/18	Manual handling assessment
27/11/18	MHA transfer form H4
27/11/18	Discharge summary
30/01/19	CPA minutes (Billingham Grange Hospital)
17/07/19	CPA report (Billingham Grange Hospital)

Date	Document title
03/01/20	CPA minutes and report (Billingham Grange Hospital)
17/06/20	CPA minutes and report (Billingham Grange Hospital)

Miscellaneous records from The Retreat:

Title	Number	Date range
Activity record	87	Nov 10 – Sept 18
Associate managers hearings documentation	11	Mar 09; Aug 10; Sep 11; Apr 17; Oct 17; Oct 18
Care plan	37	Aug 08 – Aug 10; Jun 16 – Nov 18
CPA review	15	Nov 10 – Sept 18
FACE core assessment	13	Jan 09 – Apr 15
Formulation record	7	Feb 13 – Jun 18
HoNoS	57	Mar 13 – Aug 18
MHA s132 patients rights form	10	Jul 11 – Oct 18
Multi-disciplinary discussion	15	Aug 17 – Sept 18
Multi-disciplinary review	79	Jun 10 – Nov 18
Neuropsychiatry inventory	6	Jun 12 – Oct 17
Quality of life assessment	7	Jan 15 – May 17
Observation arrangement	60	Mar 15 – Oct 18
Recovery plan	21	Jul 13 – Jan 16
Risk profile	38	Aug 09 – May 18
Significant event document	75	Nov 10 – Nov 18

Brief summary of early history

Mr. A was born in South Africa in 1948 (please see reference in the overview above that his year of birth was recorded as 1946 until confirmed as 1948 with his family in 2011). It is recorded in a clinical report to a First Tier Tribunal in 2013 that he experienced developmental delay, particularly with regard to his language. In addition he had problems with aggression and temper tantrums, was unable to mix or make friends and isolated himself.

He moved to Sydney, Australia in or around 1962 and it is reported that he saw a psychiatrist there. He returned to South Africa in 1965 and attended Johannesburg University to study mathematics, chemistry and physics, but it is reported that he did not complete his degree course.

Mr. A's first acute episode of mental ill health occurred in 1968 when he was visiting the United States as a student. He was diagnosed with paranoid schizophrenia and it is reported that he was stabilized on medication.

In 1968, Mr. A moved to live in Israel on his own. His parents moved to England. It is reported that Mr. A stopped taking his medication while in Israel, and he returned to live with his parents in England the same year.

Both of Mr. A's parents died in 1970. His father died of chronic bronchitis and his mother of a coronary thrombosis.

During 1970 it is reported that Mr. A worked for a while as a laboratory technician in a school. He has not worked since that time.

Mr. A was admitted to the Maudsley Hospital in 1971 following an acute episode of his mental illness in which he attempted to hang himself. He was treated with a range of anti-psychotic medication including depot medication. He was moved to The Retreat in York in 1973. This placement was funded privately through a trust fund, which it is reported was set up by his parents before their death, and he remained there until his move to Billingham Grange independent hospital in 2018.

> **Comment: It is noted that Mr. A's parents set up a trust fund for him before their deaths in 1970. This was before his first major acute episode of mental illness but after his initial diagnosis. Their actions suggest an awareness by Mr. A's parents at that time of his vulnerability and the possible (or likely) eventuality that he would need support at least in relation to his financial circumstances, and possibly more widely.**

He was given approximately 80 treatments with Electro-Convulsive Therapy (ECT) during 1976, 1977 and 1978. There is no further record of the use of ECT after 1978, and he was prescribed a range of intra-muscular depot anti-psychotic medication from that time.

While at The Retreat, Mr. A was initially detained under section 26 of the Mental Health Act 1959[1]. He was subsequently detained in 1984 on section 3 Mental Health Act 1983 (MHA), which was renewed on a number of occasions[2].

[1] S26 MHA 1959 was a detention for treatment, and was broadly replaced by s3 MHA 1983.

[2] Section 3 MHA can be renewed after the first six months, then after a further six months, then annually. The renewal can be completed by the Responsible Clinician (Responsible Medical Officer until 2008) without the

However, in 2008 it was discovered by the MHA Administrator at The Retreat in preparing for a Managers' Hearing that there had been an error in Mr. A's section 3 renewal in 1996 and he had been unlawfully detained for the ensuing 12 years. The author has no information about the outcome of this unlawful detention and whether Mr. A was given any advice regarding his legal rights as it is outside the terms of reference of this review.

involvement of an Approved Mental Health Professional (ASW until 2008). The RMO needed to write a report to the hospital managers and consult with one or more persons professionally involved in the patient's care.

Chronology from September 2008

The discovery that Mr. A's section 3 had not been effectively renewed in 1996 meant that he was an informal patient and there was no lawful authority to continue to detain him. It is evident that the care team at The Retreat believed that Mr. A needed continued treatment in hospital for his mental disorder, and that the treatment could only be given if he was detained under the MHA.

A referral was made to the City of York Approved Social Work (ASW) service and Mr. A was reassessed by an ASW on 4th September. Mr. A was further detained on section 3 MHA following this assessment.

The ASW (Approved Mental Health Professional since November 2008 – AMHP) was required by the MHA Code of Practice to submit an outline report to the hospital following the assessment[3]. The local authority additionally expects the ASW to complete a full social report which remains within the local authority notes.

The ASW at that time completed both a brief report and a longer social report as required. He noted the "technical error" in the renewal of the section 3 in 1996 and the resulting unlawful detention. He noted in the short report that Mr. A remains "floridly psychotic" and at risk of self-neglect without staff intervention. He noted that staff "commonly use restraint in order to administer his depot medication." He added in the longer social report that Mr. A refuses oral medication, could be "volatile and prone to lash" and was considered an absconding risk. "More than benign force is necessary to administer his medication."

The ASW also noted in the longer social report that Mr. A had been informed that he was no longer subject to s3 MHA. However, the report suggests he remained severely mentally disordered and that the care team were continuing to detain him pending the outcome of the MHA assessment.

The ASW noted in his report that he had consulted with Mr. A's nearest relative, as required by law, and had provided her with the details of her statutory rights. He also wrote a letter to her dated the same day as the assessment confirming the outcome of the assessment and her rights as nearest relative.

> **Comments:**
>
> **The ASW followed the legal requirements of the assessment and the expectations set out in the MHA Code of Practice. He noted that Mr. A needed to be informed of his rights and that the nursing staff would be doing this as soon as his mental state permitted it.**
>
> **The administration of medication using "more than benign restraint" is permitted under Part IV of the MHA for patients who are detained under section 3. While the nature of this treatment appears concerning, and there is no exploration of how long this had been continuing, there is no reason to find that the ASW should have raised this as a concern.**
>
> **There is no mention of the independent nature of the hospital and the fact that Mr. A was a private patient. This does not appear to have been explored or identified. However, this is not explicitly within the legislative remit of the ASW**

[3] MHA Code of Practice (2008 edition) 4.94

when undertaking a MHA assessment. If there was no concern raised regarding Mr. A's continued care at The Retreat, and the fact that he had been a patient there for a considerable time, it would not have raised an alert for the ASW in relation to the need for continued detention and treatment.

Whilst the error in renewing Mr. A's detention in 1996 led to an unlawful detention lasting 12 years, the reviewer believes that this would have been considered a procedural (or technical) breach rather than a substantive breach, as the evidence is that Mr. A needed detention throughout that time and there is no evidence that the lack of lawful authority had any impact on the care he received. It appears clear that he needed continuing detention throughout that time.

Safeguarding alert May 2014

A safeguarding alert was raised by staff at The Retreat on 16th May 2014 following an incident involving Mr. A and another patient on the ward in which Mr. A kicked the other patient and was in turn grabbed by the throat by that patient. Ward staff intervened and it was reported that Mr. A was "visibly distressed and voicing his distress" by the incident.

This led to a "safety planning meeting" on 28th May, held at The Retreat. This was a multi-disciplinary meeting involving staff from The Retreat. The minutes indicate that the alert was forwarded to the local authority and CQC, but there was no one present from the local authority, nor did they give apologies.

It is reported that staff attempted to involve Mr. A in the safeguarding process but he did not cooperate with this. The multi-disciplinary team considered involving an advocate but did not proceed with this due to Mr. A's reluctance to engage with new people.

Much of the planning meeting focused on the other patient involved with the incident, who it is reported had advanced dementia and had been aggressive to other patients on the ward.

Comments:

The safeguarding alert and process took place before the changes in legislation brought by the Care Act 2014. The process remained fully within the remit of The Retreat, although it is noted that the local authority and CQC were informed about the alert.

Following the Care Act 2014, the local authority has had a clear role in overseeing the process and signing off the investigation and any actions needed.

It is notable that Mr. A was nursed on a ward with patients with advanced dementia, including a patient who was exhibiting significant behavioural symptoms including aggression to several other patients. Mr. A had diagnoses of a functional mental illness and possible autistic spectrum disorder. He did not have dementia. It must be questioned whether this ward was most appropriately suited to his care and treatment.

Deprivation of Liberty Safeguards: 1st authorisation

Shortly after this incident, The City of York Deprivation of Liberty Safeguards (DoLS) service received a request for an assessment under the DoLS scheme. The referral was made on 22nd May 2014 and was accompanied by an urgent authorisation as required by the DoLS legislation.

The referral referenced the recent Supreme Court judgement[4] redefining deprivation of liberty and requiring formal authorisation of Mr. A's placement. The Retreat granted themselves an urgent authorisation to ensure Mr. A's lawful care and treatment during the period of the DoLS assessment, and an extension was granted on the grounds that the local authority was experiencing a high volume of requests.

The referral notes that Mr. A was not receiving any medication and no restraint was required for any aspects of his care and treatment. It continued to state that Mr. A was compliant with the treatment provided, which was described as a "highly supportive environment cognizant of his mental health needs."

Comments:

This DoLS referral was made shortly after the Supreme Court judgement which significantly lowered the threshold for identification of deprivation of liberty and dramatically increased the number of requests for DoLS authorisations across the country.

The Retreat followed the requirements of the legislation in granting itself an urgent authorisation while awaiting the completion of the DoLS assessment. It also requested an extension which was approved by the local authority. The reason given for the extension was that the City of York was experiencing a high volume of requests. This was explicitly excluded from the grounds in the DoLS Code of Practice for granting extensions, but the sudden increase in referrals following the Supreme Court judgement caused large backlogs across the country. There were no legal challenges raised about the use of extensions in this way, and subsequent long delays in completion of assessments, considerably outside the legal time limits.

The DoLS assessment involved individual assessments by a consultant psychiatrist (the mental health and eligibility assessments) and a best interests assessor (BIA 1) who was a social worker (the age, no refusals, capacity and best interests assessments). It is suggested that the age, mental health and capacity assessments are uncontentious. There was no doubt that Mr. A was over 18 years of age; he had a well-established and chronic mental illness. Although the social worker who undertook the mental capacity assessment found it almost impossible to engage with Mr. A, all the supporting evidence supports the fact that he lacked capacity to make decisions regarding his accommodation.

Although Mr. A had previously been detained under the MHA, the section had been discharged early in 2014 following a decision to discontinue the depot medication. The care team felt that the regular restraint needed was traumatic to Mr. A and he did not show

[4] P v Cheshire West and Chester Council, P & Q v Surrey County Council [2014] UKSC 19. Widely known as "The Cheshire West case"

signs of relapse as they reduced the dose. As the medication was discontinued, it was reported that Mr. A was compliant with the supportive care being offered and was not showing any objection to remaining at The Retreat, therefore a decision was made that he no longer required detention under the MHA.

The Supreme Court judgement in March 2014 established the principle that a lack of objection to the placement was not relevant to whether or not a person was deprived of their liberty. However, the existence or otherwise of objection to being a mental health patient is highly relevant in determining whether the MHA or the MCA DoLS is the appropriate route for authorising the person's detention[5]. The psychiatrist (Med 1) determined that Mr. A was objecting to neither his accommodation in hospital nor any part of his treatment. Therefore the MHA was not indicated and the most appropriate form of authority for his care would be under the DoLS.

BIA 1 notes in her assessment the considerable length of time Mr. A had been at The Retreat and that he has needed detention and treatment under the MHA. She goes on to state that "his therapeutic regime has been so successful that his psychiatrist has decided that he no longer needs to be sectioned under the Mental Health Act and is now a voluntary patient." She consulted with Mr. A's brother and reported she had attempted to contact his sister but failed to make contact. Mr. A's brother supported him remaining at the placement.

BIA 1 undertook a 'balance sheet' exercise when completing the best interests determination. She looked at the respective benefits and risks of remaining at The Retreat and returning to live in the community. She concluded that the benefits of remaining in the current environment far outweighed the risks, and also, unsurprisingly, that the risks of returning to the community outweighed the benefits. She also noted that Mr. A was becoming more trusting of staff and speculated that this could be due to the discontinuation of regular restraint to administer the depot medication.

The BIA has the option of recommending conditions which can be attached to the authorisation. Such conditions are set by the Supervisory Body (the local authority) which signs off the documentation and grants the authorisation and are binding on the Managing Authority (The Retreat). In this case BIA 1 recommended the condition that "the managing authority should take all reasonable steps to work with the relative person's representative in exploring whether [Mr. A] could live in a less restrictive environment".

The BIA specifies the maximum duration for which the authorisation can be granted (up to a statutory maximum of one year) and the Supervisory Body can grant an authorisation for up to the time specified by the BIA, but no longer. BIA 1 specified a maximum duration of four months but did not explain why she did not give a longer duration. The DoLS forms in use at that time did not require a reason to be given.

The authorisation was granted on 4th June, the day the extended urgent authorisation expired, and was granted for four months, which was the maximum duration given by the BIA. The condition recommended by the BIA was attached to the authorisation.

Comments:

[5] Mental Capacity Act 2005 schedule 1A (the eligibility test)

The assessments followed the legislative requirements and broadly contained the necessary evidence to support a standard authorisation under DoLS. The evidence of consultation with individuals who were interested in Mr. A's welfare was very limited, with reference to them supporting the placement but no record of a consultation with Mr. A's brother. The assessment was completed within the statutory timescales, which was unusual in relation to the considerable delays that many areas were experiencing in the aftermath of the Supreme Court judgement.

There is no reference to the appointment of a Relevant Person's Representative (RPR), who is required to ensure that Mr. A's statutory rights under DoLS are protected[6]. The supervisory body must appoint someone into this role as soon as practicable following the granting of the authorisation[7]. This could be a family member or if no one is willing or able to take on the role, would most likely be a paid person from an advocacy organisation.

The BIA made reference to the need to consider a less restrictive environment for Mr. A, and this was written into the authorisation as a condition. However, it has been long established that while conditions are binding on managing authorities (in this case, The Retreat), there are no legal mechanisms to ensure they are actioned and no sanctions against managing authorities who do not follow them.

It is difficult to see what further action the BIA could have taken in this assessment. The evidence provided showed that the restrictions on Mr. A had significantly reduced during the past six months, with a discontinuation of depot anti-psychotic medication and the ending of regular, traumatic restraints in order to administer it. Mr. A was discharged from the section 3 detention although he remained an inpatient. He was showing no signs of objection to the care and treatment being provided and his family supported the placement.

The BIA did not explore the financial nature of the placement and the fact that there were no state bodies reviewing the placement. This mirrors self-funders in registered care homes where there is no oversight of the placement other than the DoLS process, in the event of the person lacking capacity to consent to their accommodation.

Deprivation of Liberty Safeguards: 2nd authorisation

The first DoLS authorisation was scheduled to end on 2nd October 2014. A further assessment was arranged and undertaken during September. The mental health and eligibility assessments were undertaken by the same consultant psychiatrist as in May (Med 1) and confirmed Mr. A's mental disorder and eligibility for DoLS.

A different BIA (BIA 2) undertook the other assessments. The capacity assessment concluded that Mr. A lacked the relevant capacity and while this view is shared by all professionals and family, there is in the author's opinion insufficient evidence on the form to support the conclusion. The assessor fails to give reasons why Mr. A fails to meet the required elements of the test.

[6] Mental Capacity Act 2005 Schedule A1 para 140
[7] Mental Capacity Act 2005 Schedule A1 para 139

It must be noted, however, that there are elements within the best interests assessment which address Mr. A's capacity and BIA 2 does provide some evidence of lack of capacity in that assessment. BIA 2 noted that he was unable to undertake a proper interview due to Mr. A's hostile response to him when he visited. The care staff provided information regarding alternative methods of communicating with Mr. A (use of a whiteboard) and BIA 2 considered returning on another occasion but decided not to.

The MCA Code of Practice provides guidance on the importance of alternative communication methods when assessing a person's capacity[8], particularly when it is established that verbal communication will pose specific difficulties.

BIA 2 does address the issue of Mr. A's considerable period of time in institutional care. He references the first BIA's comment that Mr. A had become institutionalised and agreed with this view. He reinforced the observation that Mr. A was expressing no desire to leave and "one imagines that the possibility of a move elsewhere would be an abhorrent prospect for him." The BIA noted that the care staff had found it increasingly difficult to persuade him to leave the ward.

BIA 2 referenced the conditions attached to the first authorisation and commented that "there is evidence that the hospital has [worked with the RPR to explore whether Mr. A could live in a less restrictive environment] but both parties are of the view that [Mr. A] is appropriately placed and…are proportionate and necessary…" BIA 2 did not propose any conditions to attach to this authorisation.

BIA 2 considered three alternatives in his determination of Mr. A's best interests

- To remain in hospital for the purpose of residence, care and treatment
- Possible detention under the Mental Health Act (not eligible at present)
- Discharge to the community with a care plan of support (not in his best interests)

BIA 2 confirmed that the current placement was in Mr. A's best interests and recommended a maximum duration of one year. The was granted by the supervisory body, commencing on 3rd October 2014 and expiring on 2nd October 2015.

Comments:

Again, the documentation broadly fulfils the statutory criteria, with the exception of the evidence to support the conclusion of lack of capacity in the capacity assessment. As mentioned above, BIA 2 includes some of that detail within the best interests assessment form. However, it is suggested that BIA 2 should have made further attempts to communicate with Mr. A given the information available regarding non-verbal communication strategies that may be more effective. There is no dispute that Mr. A lacked capacity so it is suggested that at worst in this case, it is a procedural failure.

BIA 2 recognised and noted the unusual nature of the funding, that Mr. A's inpatient stay was financed by a private trust fund. There is no requirement on the BIA to consider the funding of the placement, other than to determine in what manner the deprivation of liberty is "imputable to the state". BIA 2 did not raise

[8] Mental Capacity Act 2005 Code of Practice 4.49, 4.52

any issues about this arrangement, and in fact the arrangement was stable with no likelihood of Mr. A's placement being put at risk.

Both BIAs 1 and 2 considered in their assessments alternatives to remaining at The Retreat, but both only considered discharge to the community. They both concluded that it would not be in Mr. A's best interests to be discharged from a 24-hour care setting. They did not explicitly consider the option of a less restrictive institutional setting, although BIA 1 had included that consideration in her condition.

Both BIA 1 and 2 noted the support of Mr. A's family for the placement and the lack of any evidence of objection or distress by Mr. A to the care and treatment being provided at The Retreat.

Mr. A's brother was appointed RPR following the granting of the second standard authorisation. This was confirmed on 29th October 2014 when Mr. A's brother signed the form to consent to this appointment. However, a further form was completed on 26th November which states that the BIA had not been able to identify a RPR and a request was made to appoint a paid RPR from a local advocacy organisation. This referral was accepted on 15th December 2014. There is no explanation given why the consent signed by Mr. A's brother just one month earlier was not actioned, and a paid RPR was appointed instead.

A paid RPR was appointed from Cloverleaf Advocacy organisation and visited Mr. A four times during this authorisation. She completed a report for the local authority DoLS service following each visit. Comments on the role of the RPR and the reports are contained later in the report within the 'themes' section.

Comment:

It is very unusual and outside the remit of the legislation for an individual to be appointed RPR and to consent in writing to that appointment, and for a different RPR to be appointed without any evidence of the termination of the original RPR's appointment. Regulations set out clear grounds for terminating a RPR's appointment[9] and there is no evidence of any of those grounds being met.

Deprivation of Liberty Safeguards: 3rd authorisation

The second Deprivation of Liberty Safeguards authorisation was due to expire on 2nd October 2015. A renewal request was sent to York DoLS service from The Retreat in early September and the relevant assessments were commissioned and completed later that month. The mental health and eligibility assessments were undertaken by a different psychiatrist to the previous two (Med 2) but came to the same conclusion.

The other assessments were undertaken by another different BIA (BIA 3). The capacity assessment was again completed without any meaningful communication with Mr. A. BIA 3 reported that Mr. A had waved his hand at him and the ward staff indicated that this was a sign that Mr. A did not want to speak. There was no reference to the information provided at the previous assessment that staff find a more effective method of communication by

[9] The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008. SI 2008 no. 1315. Regulation 13.

writing on the white board in his room. BIA 3 concluded that Mr. A lacked capacity based on consultation with others and reference to previous documentation.

The best interests assessment tells a story of a patient who is becoming increasingly isolated in his own room and rarely spending any time in the common areas. It was reported that "he finds any form of human contact unbearable". It is notable that BIA 3 reports that the staff at The Retreat have considered "whether it would ultimately be in [Mr. A's] best interests to remain there." However that discussion had not progressed due to the inability to engage with Mr. A.

Not only was the capacity assessment completed without any engagement with Mr. A, but neither the mental health assessor nor BIA 3 were able to involve him at all in any of their assessments. This was acknowledged as a significant problem by BIA 3 and Mr. A's voice was not being heard, even with the involvement of a paid RPR.

BIA 3 expressed the dilemma of Mr. A's situation clearly in his summing up. The current placement is a restrictive environment, but there was no guarantee that another environment would be able to manage Mr. A's needs with a less restrictive regime. After 40 years, The Retreat was Mr. A's 'home' and he knew no different environment. The staff at The Retreat had spent years building trust, although it appears that the improvement was mainly due to the discontinuation of forced medication, and there was a risk that another setting would not be able to manage him any better.

Similarly to the previous assessors, BIA 3 also included a balance sheet in his report. He considered the respective benefits and burdens of remaining at The Retreat under the same restrictions, or to move to an environment that is less restrictive.

BIA 3's conclusion that the current placement continued to be in Mr. A's best interests was couched in a negative way "At present, and the foreseeable future, I cannot see similar care or treatment that can be provided effectively in a way that is less restrictive of his rights and freedom of action."

Mr. A's paid RPR had been visiting him regularly during the period of the authorisation and expressed similar ambivalent feelings about Mr. A's placement. She expressed concerns that attempting to engage with him or consider a less restrictive environment may be "pushing him too far [which] would actually cause further disruptions in his life."

BIA 3 recommended a maximum duration for the authorisation of one year and did not recommend that any conditions be attached. The Supervisory Body accepted these recommendations and the 3rd authorisation commenced on 25th September 2015, to expire on 24th September 2016.

The paid RPR from Cloverleaf Advocacy continued to act in this role during the 3rd authorisation. She visited Mr. A two times during this authorisation and completed a report for the local authority DoLS service following each visit. Comments on the role of the RPR and the reports are contained later in the report within the 'themes' section.

Comment:

It is concerning that at consecutive DoLS assessments, assessors have failed to communicate with Mr. A, either as part of the assessment of his capacity or as part of attempting to involve him in the process of the assessment, and to try to elicit his wishes and feelings. It had previously been established that Mr. A does not

respond well to people with whom he is unfamiliar, and also isolates himself from the regular staff. However, records show that staff have attempted to use alternative methods of communication with some success. No attempt was made to explore these methods as part of the DoLS assessment process.

Self-neglect: 2016

During the course of the 3rd authorisation, concerns increased regarding Mr. A's well-being. Mr. A was increasingly neglecting his personal hygiene and resisting attempts to assist him with his personal care. A best interests meeting was held at The Retreat on 27th January 2016, involving hospital staff, the paid RPR and an Independent Mental Capacity Advocate (IMCA) to consider whether it would be in Mr. A's best interests for staff to apply restraint in administering care against his expressed wishes.

A balance sheet approach was followed, which indicated a strong balance against the use of restraint. All at the meeting agreed that restraint in order to provide personal care to Mr. A was not in his best interests and that the care team was not at a stage where they felt that such intervention was required.

In the section entitled 'beliefs, values and/or cultural or religious requirements', it is noted that Mr. A was Jewish but the team does not know how much he identifies with his faith. There is discussion that his beard is important to him and this could stem from his religious beliefs as very orthodox Jews would rarely trim the beard. This issue was raised repeatedly at reviews throughout the first half of 2016.

At a subsequent best interests review meeting in May 2016, a decision was made to contact a local rabbi to obtain advice to improve the teams understanding of Mr. A's spiritual needs. At the review meeting in July 2016, it is recorded that the social worker had contacted a rabbi but he had not visited. The meeting agreed that this action was no longer relevant, though there is no explanation for this change of view.

There were limited discussions about further strategies, other than monitoring skin integrity, trying different communication methods and "taking a firmer approach".

Mr. A's brother was consulted as part of the process and he expressed opposition to any interventions which would distress his brother and believed "that the issue would pass and resolve itself".

At the end of the meeting, it was agreed the mental health law manager seek a legal view to determine whether treatment for personal care could be considered a treatment for mental disorder, in which case it could be administered against his wishes under the MHA. The meeting agreed to reconvene in six weeks.

Comments:

It is noted that this meeting took place in January 2016, after the enactment of the Care Act 2014. The meeting was a best interests meeting and not held under the safeguarding remit, although the hospital social worker for safeguarding was present. The Care Act includes self-neglect within the categories of abuse and neglect which could initiate investigations under section 42. The hospital staff could have initiated safeguarding procedures which would have required local authority involvement, as per new Care Act requirements.

The process followed the requirements of the MCA and the best interests checklist by attempting to involve Mr. A, involving his RPR and consulting his brother. While his brother expressed his opposition to the use of restraint, it was clear that the meeting came to their own decision and correctly did not give the brother decision-making authority over this issue.

The Retreat also involved an IMCA, which while providing additional support to Mr. A in the process, was outside the remit of the MCA, unless the meeting was being held under safeguarding procedures[10]. IMCAs are only required for changes of accommodation or serious medical treatment[11], neither of which were relevant in this situation. For these decisions, they are only required where there is no one else to consult, and in this case, consultation took place with both the paid RPR and Mr. A's brother.

The meeting correctly considered Mr. A's beliefs, values and any cultural and religious issues which may impact on the decision. In considering Mr. A's self-neglect, including refusal to cut his hair and beard, the meeting considered whether it was linked to his Jewish faith, as very orthodox Jews rarely trim the beard. It is suggested that this is an unhelpful observation and could easily have been discounted by considering Mr. A's past history, or by consulting his family members. A CPA report in 2010 recorded "[Mr. A] is of Jewish origin but is non-practicing and has never been interested in this aspect of his life (confirmed by family)". To possibly conflate severe self-neglect with a cultural choice was an inappropriate consideration of cultural and religious beliefs.

It is noted that while the meeting unanimously decided that it would not be in Mr. A's best interests to restrain him using the authority of sections 5 and 6 of the MCA, they did decide to explore the use of the MHA. It is not clear whether the members of the meeting believed that the MHA (if it was felt to be a legal use) would give clearer authority to act against Mr. A's wishes. Use of either form of authority would carry equal risk of trauma and distress to Mr. A.

A recovery plan (care plan) was completed and dated two days after the best interests meeting. It covers all the main elements of Mr. A's daily routine and his needs. It recognizes the complexity of his situation and has many elements where staff are advised to encourage Mr. A to comply with the care being offered and to give him the opportunity to accept interventions. There are no proactive strategies proposed to increase the likelihood of Mr. A complying with the care being offered.

The medical director of The Retreat wrote on 10th February to the consultant psychiatrist in the learning disabilities team of the NHS trust. This letter clearly sets out the doubts held by the medical director regarding the continued suitability of The Retreat for his placement. The letter confirms that the ward on which Mr. A had been staying for many years, which was designated an older person's ward, had over the years become increasingly oriented to dementia care.

[10] The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006. SI 2006 No. 2883

[11] MCA ss37, 38 and 39

A chronology of involvement with Mr. A provided by Tees, Esk and Wear Valley NHS Foundation Trust (TEVW) records the receipt of a referral on 10th February 2016 on "PARIS" [the local recording system]. The chronology states:

> *"Referral recorded on PARIS to ALD YS CMHT CLDT, however rejected as had already been discharged before transfer to TEWV services from LYPFT".*

A reply was received on 16th March from a consultant psychiatrist in learning disabilities rejecting the referral, stating that the community learning disability team are not commissioned to undertake the work requested and suggesting the case be taken to the Court of Protection. The TEWV chronology submitted for the purpose of this review states that the referral was declined because Mr. A had already been discharged before the transfer of TEWV services from the Leeds and York Partnership NHS Foundation Trust.

There is no further contact with Mr. A until a further referral (which was accepted) in November 2018.

> **Comment:**
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> **It is disappointing that this detailed request from the medical director to a consultant psychiatrist was dealt with summarily as a referral and advice was given that it should best be dealt with by the Court of Protection. It appears that the response is driven by the final paragraph of the referral letter, which questions Mr. A's most appropriate placement in the context of his family's desire to prevent a move, rather than advice on his diagnosis, best options for his accommodation and possible impact on his mental well-being as a result of a move.**

Further best interests meetings were held in March, May and July 2016. Mr. A's condition remained broadly unchanged, with a slight improvement reported in March followed by a deterioration in May and little further change reported in July. None of these meetings changed the conclusion that it was not in Mr. A's best interests to provide personal care by use of restraint.

A further safeguarding alert was made in July 2016 following another assault by another patient on Mr. A. There is no record of whether Mr. A was injured or his reaction to the incident.

> **Comment:**
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> **This is the second recorded incident on this ward in which Mr. A has been assaulted by another patient. It was established that the first patient had dementia with associated behavioural and psychological symptoms, but there was no information regarding the other patient in this alert. However, the alert notes that the other patient was 95 years old and as he was on a psychiatric ward it appears that there were certainly behavioural elements to that patient's presentation. Mr. A did not have dementia and it appears the reason he was on the ward was due to his age and frailty. There is a further question regarding whether this ward was suited to Mr. A's care, particularly given the particular nature of his needs and the challenges the staff were faced with in providing him with the care and support he needed.**

Deprivation of Liberty Safeguards: 4th assessment

The third DoLS standard authorisation was due to expire on 24th September 2016 and a 'Form 2' request for a renewal DoLS assessment was completed and sent to City of York DoLS service on 6th September. The request stated that there had not been any significant changes since the last authorisation was granted.

The medical assessor was the same consultant psychiatrist who assessed Mr. A for the first and second DoLS authorisations (Med 1) and therefore was familiar with his case. He visited Mr. A at The Retreat and completed his report on 10th October. Med 1 noted in his report that "There is gross neglect. [Mr. A] has not had a bath or a wash for at least a year, possibly two. He is malodorous. His hair and beard are uncut and matted. He looks like a vagrant. He has not changed his underwear for months. Indeed, he rarely changes his clothes."

Med 1 concluded that Mr. A was not eligible for a further DoLS authorisation because of his mental disorder and his objection to basic care interventions, causing his gross self-neglect. The DoLS assessment ended at this point as an authorisation could not be granted[12]. Med 1 recommended that a MHA assessment be arranged.

The DoLS 'Form 4' medical assessment notes that a referral was made by The Retreat for a MHA assessment on 10th October, although the AMHP duty record gives the referral date as 14th October. The assessment took place on 18th October and Mr. A was detained on section 3 MHA. Med 1 was one of the examining doctors and provided a medical recommendation.

> **Comment:**
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> **The description by Med 1 of Mr. A's self-neglect when he was examined for the purpose of the DoLS assessment is stark. There is an argument that the degree of self-neglect exhibited by Mr. A in the context of containment in a care facility should have necessitated a formal safeguarding referral. This could have been initiated by the doctor (Med 1), the assessing AMHP or by the Supervisory Body which will have had access to Med 1's 'Form 4' report.**

Further detention on s3 MHA and safeguarding alert

There is no further involvement of the local authority until February 2017, when a further safeguarding alert was raised by two members of staff at The Retreat. One member of staff noted that Mr. A had faeces up his back when he was standing at the bathroom. She also noted that his nails had not been cut in years and there was no plan to intervene. A second member of staff stated she felt that Mr. A was being neglected in many ways. She added several further concerns regarding the poor care provided to both Mr. A and other patients on the ward.

Several meetings were held during the following four months in the context of this safeguarding enquiry, but they became entangled with a broader investigation into the care and treatment of all patients on George Jepson Ward and another ward at The Retreat, during some building and renovation works. This investigation involved a total of 20 patients and the meeting notes were not always fully focused on this particular individual.

[12] Mental Capacity Act schedule A1 para 50(2)

A number of statements are made in the notes which can be called into question when consideration is given to the previous records

- "[Mr. A's] family are extremely involved in his care", although it appeared that they visited rarely.
- A member of staff from The Retreat stated that "up to this point, [Mr. A's] needs had been adequately met over the years".
- Another member of The Retreat staff commented that "Mr. A had independently washed the faeces off and generally always appeared clean"
- The CCG representative stated that "the incident sounded like a one-off for [Mr. A] and added that it was important to say that this is not about inadequate care by any stretch of the imagination…"

The City of York safeguarding officer completed her summary report in July 2017 and a review meeting was held the following week. A variety of concerns were raised in the course of the investigation, the main ones concerning a failure to support Mr. A's personal care and poor support for his nutrition and hydration. The care plan for Mr. A detailed a variety of tasks which were specified to encourage and support Mr. A to undertake personal care, and there was a requirement to record the interventions, but there were considerable gaps in the recording. A number of staff were unaware of specific elements of the care plan.

Equally, the recording of Mr. A's nutritional and fluid intake was sporadic at best. Staff intermittently recorded when food and drink were left for Mr. A but there was no recording of what was actually consumed. It was noted that Mr. A was less likely to eat meals in the dining room if other patients were there and it was noisy. There was a note that Mr. A's favourite food was fish and chips, but there was no suggestion that this should be provided for him more frequently.

In the review meeting, one professional from The Retreat stated that "a great deal of Mr. A's symptoms relate to schizophrenia rather than autism." Another professional commented that Mr. A "resides on the unit for people with dementia and that there was a possibility that this does not suit his needs and may have to move." The outcomes meeting included a variety of items relating to Mr. A's care at The Retreat, such as the quality of care plans, mental capacity assessment, audit of recording and monitoring charts. The outcomes meeting concluded with the chair informing the group that there was no need for an ongoing safety plan and further safeguarding meetings.

Comments:

The concerns regarding the general ward environment and the impact of the general building and works appears to have impeded the focus on Mr. A as an individual at risk. The minutes of the meeting were not solely focused on the possible neglect of Mr. A's care, and repeatedly referred to the ward issues and the wider issues affecting the patients more generally.

In contrast to the powerful description of Mr. A's condition provided by Med 1 in his DoLS report, and the increasing concern expressed over the past year by the staff over the ability to provide adequate care for Mr. A, the meetings suggest a one-off issue contrasting with a generally well looked-after patient. This is also in contrast to the risk profile dated 29/01/16 which stated that Mr. A was at severe risk of self-neglect.

The safeguarding review meeting focused on the existing placement and the quality of care and made no comment in relation to the possibility of a move to a more suitable placement.

The safeguarding process focused specifically on the allegation of neglect by the staff, and once that had been addressed, there was arguably no further role for the safeguarding procedures. However, the issue of the suitability of Mr. A's placement remained, but there was no structure in which to progress this discussion.

During the course of this safeguarding investigation, there is a record in the "significant events" documentation of a visit by a 'best interest assessor' who visited the unit on 20th June 2017 to complete "an independent placement review" for Mr. A. This person spoke to the social worker from The Retreat and looked at Mr. A's notes. She questioned why he was paying for his placement privately but no one could give her an answer. There is no record of the reasons for this assessment, who arranged or paid for it or the results. There is no record of a report by this person. The record ends "Staff to await her best interest decision regarding the possibility of moving [Mr. A] to a different placement.

The only clue to this placement review is held in the discharge planning notes dated 22nd August 2018, which refers to an approach to the local authority the previous year to provide an independent view on the suitability of his placement. It is recorded here that a social worker from the local authority safeguarding team attended and assessed Mr. A, but was not willing to make any recommendations until a referral was made to a speech and language therapist to try to enhance communication with Mr. A.

Discharge planning

There was no further contact with City of York Council or the local NHS until summer 2018. A decision was made in March 2018 that The Retreat would cease to provide inpatient services and Mr. A's brother was contacted informing him that Mr. A would need to move to a new placement. The Retreat wrote to Mr. A's brother in March, April, May and June 2018 informing him of the forthcoming organizational changes. Mr. A's brother responded to an email in August when it was made clear that these changes would necessarily result in Mr. A's move from The Retreat due to its ending of hospital status and no longer being able to accommodate inpatients.

Two planning meetings were convened, in August and September 2018. The first meeting set out the key issues and challenges in relation to discharging Mr. A to another resource, given the considerable length of time he had spent at The Retreat. A number of other issues were raised in this meeting

- Mr. A's immigration status and his ability to access statutory funding streams. Following investigations, it was established that Mr. A had indefinite right to remain in the UK.
- Mr. A's family involvement, including the nearest relative role. Also the family's views regarding future plans. Mr. A's sister agreed to delegate her nearest relative role to her brother. The historic opposition to a move from The Retreat was now irrelevant as The Retreat would no longer be providing inpatient care.
- The implications for Mr. A as a self-funder and whether this would impact on decisions regarding future provision. It was noted that Mr. A's family had always resisted any NHS involvement as they were concerned that this may lead to a recommendation to move

him from The Retreat. Following the decision to end inpatient provision at The Retreat, necessitating a move for Mr. A, his family continued to insist that any further provision be funded by the trust fund set up to pay for his care.

- Mr. A's human rights in relation to the decision to discharge him from The Retreat to another resource. There was some concern whether the closure of The Retreat as an inpatient facility may breach Mr. A's Article 8 rights to private and family life, due to the length of time he had been living there. However, this was not considered a risk and the meeting noted that there could be a counter argument in relation to his current care being provided on a dementia unit. It was noted that this concern had been raised at the last Mental Health Tribunal hearing. In addition, it notes the approach to the local authority in 2017 for an independent assessment of whether George Jepson Ward was the most suitable placement (discussed above). However, a decision was made to withdraw inpatient services from The Retreat before this was taken forward and the local authority had no further involvement.

  Comment:

  This further evidences concerns about George Jepson Ward as a suitable placement for Mr. A. Although it was reported that concerns regarding Mr. A's placement on a dementia ward had been raised at the last Tribunal hearing, the previous First Tier Tribunal on 28th July 2017 did not make any mention of this in their decision or findings.

Several alternative resources in Yorkshire and the northeast of England had been identified as a potential placements. This was being discussed at both planning meetings but was not Mr. A's eventual discharge destination.

Billingham Grange Hospital

Mr. A moved to Billingham Grange independent hospital on 27th November 2018. This hospital is located in Billingham in the Borough of Stockton on Tees. Four CPA reports have been provided, following six monthly reviews in January and June 2019, January and June 2020. Key elements of the reports are included below:

- Mr. A was recommenced on depot anti-psychotic medication in April 2019
- A decision was made in May 2019 by the TEWV Trust-wide Autism Team that a diagnostic assessment would not be appropriate. This decision was based on the existence of significant mental ill health and limited ability to gain childhood history. A working diagnosis of ASD was recommended.
- Mr. A had been visited by a psychologist from the autism service in June 2019. The psychologist did not advise any immediate changes to his care. It was felt that the priority should be management of Mr. A's psychotic symptoms before carrying out a full assessment.
- The CPA reports include Positive Behaviour Support Plans, including a traffic light system of behaviours and suggested responses.
- The reports also include comprehensive incident charts recording all episodes where restraint was used. Restraint was used for bathing, the administration of depot medication and once to permit the podiatrist to cut Mr. A's toenails.

While the first CPA meeting consists of relatively brief minutes without a full report, this meeting was mainly concerned with identifying the main issues in relation to his care and treatment. The reports following the subsequent 6-monthly CPA reviews provided more information regarding Mr. A's progress at Billingham Grange.

The first CPA report in January 2019 states that The Retreat were arranging for the National Autistic Service to see Mr. A. This was followed up by one of the meeting attendees. The minutes refer to possible sensory inputs to improve Mr. A's well-being. By May 2019 the trust-wide Autism team had reviewed Mr. A's notes and decided a full assessment was not appropriate but had advised on the records that a working diagnosis of ASD should be given. The autism service agreed to remain involved, although they felt that before they could undertake any further work, Mr. A's mental state and psychosis needed to be stabilised to the point that he was not distressed.

The CPA reports show a gradual increase in Mr. A's cooperation with the care team and his treatment plan. However, the analysis of any progress during the first year of Mr. A's placement at Billingham Grange is severely limited by the fact that the January 2020 report of his support and enablement plan, as well as the reports of his contact with other disciplines is almost identical to the wording of the report compiled in July 2019. The only change in text relates to the results of a blood test for prostate and kidney function. It would appear that the bulk of the January 2020 report is copied and pasted from the previous document. There is significant overlap in the June 2020 report but there is also new analysis.

Perhaps the best information regarding Mr. A's progress at Billingham Grange comes from the chronology of incidents and also from the psychiatric and occupational therapy reports in the documents.

Incidents involving restraint[13] decreased significantly from the first half of 2019, when there were five or six per month, to six in total during the first five months of 2020. Use of restraint increased significantly in April 2019 when Mr. A was prescribed depot anti-psychotic medication. Restraint was regularly used to administer the depot from April to August 2019 but was used for that purpose only twice from September 2019 to May 2020. Most episodes of restraint occurred at times of personal care when staff took action to ensure Mr. A had a bath or shower. However, this also reduced from weekly in early 2019 to a total of five incidences during the six months to June 2020.

The psychiatric report noted that Mr. A was engaging more effectively with staff, his distress had reduced, particularly following the reintroduction of the medication, he was allowing staff to administer the depot medication from November 2019 (although occasional episodes of resistance continued), he was sitting in the communal area more frequently and accepting some physical touch. The report in May 2020 stated that he is pleasant and cheerful and now says 'thank you' to staff.

The occupational therapy reports tell of increased engagement in therapeutic activities. He exhibited increased tolerance of social and physical contact. He was spending the majority of his day in communal areas. He was walking around the ward and was escorted off the ward to visit the reception on the ground floor of the hospital. The possibility of section 17

[13] Billingham Grange staff use MAPA techniques (Management of Actual or Potential Aggression) and these are recorded in the document.

leave was being discussed but this had not occurred. The restrictions imposed as a result of the Covid-19 pandemic had also impeded further consideration of this development.

The TEWV chronology notes that a Mental Health Tribunal was convened on 7th August 2020 to consider Mr. A's ongoing section 3 detention. The notes state that the section 3 was upheld. However, the notes also state:

> *"Panel asked about discharge planning and social services contact and requested a referral to be made to York Social Services so that planning can begin for Mr A's discharge from Billingham Grange as he had made great progress with no incidents for almost 3 months."*

Mr. A sadly passed away on 27th September 2020, and therefore the June 2020 CPA report is the final documentation regarding his care and treatment at Billingham Grange.

Comments:

While there are criticisms of these reports, particularly in relation to the apparent copying and pasting information from one report to another, there is clear evidence of significant and sustained improvement in Mr. A's engagement and responses to the care staff and the treatment regime.

A clear Positive Behaviour Support Plan was put in place at an early stage and a decision was made to reintroduce anti-psychotic medication after five months of his placement. Proactive strategies were introduced first to ensure Mr. A's personal hygiene was maintained, and later to administer the depot medication. The records show that the strategies employed by the care team enabled the required care and treatment to be given, and Mr. A's resistance to these interventions reduced significantly over the course of the six to nine months of their use. There is also clear and consistent recording of restraint which enables a pattern to be identified and reviewed effectively.

The reports during 2020 identify a significant change in Mr. A's socialisation, with increasing time spent outside his room, more exploration of the ward environment and beyond, and improved social and physical engagement with staff.

This improvement was also recognised by the Mental Health Tribunal which encouraged Billingham Grange to start to consider discharge from hospital, due to the reduction in the frequency of incidents of behaviours which challenge by Mr. A, such that no incidents had been recorded in the previous three months. This is particularly notable, given Mr. A's continuous hospitalisation throughout the previous 47 years.

It must be noted that this change occurred during the first 18 months of Mr. A's placement at Billingham Grange, and all agreed that his 47 years at The Retreat had caused considerable institutionalisation. Sadly, due to Mr. A's death in September 2020, it is impossible to know how he would have further progressed in his new placement.

Themes identified

Who were the decision-makers in relation to Mr. A's care?

The financial circumstances of Mr. A's psychiatric care appear to be highly unusual, in that he was detained in hospital for many years and throughout that time his care was paid for privately through a trust fund, set up by his family and administered in South Africa. Various reports name an attorney based in Johannesburg as trustee. This attorney also visited The Retreat with Mr. A's brother on at least one occasion to discuss Mr. A's placement.

The NHS had no responsibility for or oversight of Mr. A's care from the date of his transfer from The Maudsley Hospital to The Retreat in York in 1973 until his death at Billingham Grange in 2020.

This funding arrangement remained in place despite Mr. A being potentially subject to section 117 aftercare arrangements as a result of his detention on section 3 MHA throughout this time.

Mr. A was not continuously detained under the MHA from 1973, as he was discharged from section 3 in spring 2014 and subsequently made subject to the Deprivation of Liberty Safeguards until 18th October 2016, when he was again detained on section 3 MHA.

In addition, Mr. A was unlawfully detained for approximately 12 years due to an error in the renewal of the section. This unlawful detention started some time in 1996 and continued until it was discovered and a further MHA assessment was undertaken on 4th September 2008.

Mr. A remained in hospital throughout this period, including the time he was not detained under the MHA, so the section 117 aftercare duties, which commence on discharge from hospital, did not come into play.

The effect of the financial arrangements for his care appear to have created a considerable inertia in relation to thinking about whether The Retreat, and the particular ward at The Retreat, was meeting Mr. A's needs.

The Retreat first expressed doubts about Mr. A's suitability on this particular ward during 2014, but these concerns, while interspersed with statements that he was suitably placed[14], increased in intensity during the next two to three years.

In May 2016, The Retreat emailed Mr. A's brother and attorney (trustee) stating that the ward was now a dementia unit for men with severe and challenging behaviours. It went on to say that he was "ill-placed on this unit in terms of suitability and model of care".

Throughout this period Mr. A's brother was consistent in his opposition to any suggestion that Mr. A be moved to another unit. There are several statements that Mr. A's family insisted on continuing to pay for his care privately in order to avoid the risk of a decision being made to move him from The Retreat.

In June 2017, RK and his cousin visited Mr. A. There was some discussion regarding Lasting Power of Attorney for health and wellbeing (sic), although this would not have been feasible

[14] The latest example of the statement that Mr. A was appropriately placed on George Jepson Ward was in a MD Review on 17th April 2018.

due to the requirement of Mr. A to have capacity to create that instrument. The report of that meeting includes the following;

> "[the family] have been informed that Mr. A's funding should fall under the local authority whilst he is under section, the reasons for this have been explored by them. The family raised some concern that this would mean they would loose (sic) their "voice" and [Mr. A] would potentially be moved. The team reassured them that this would not be the case but that we want to ensure [Mr. A's] care remains safe and appropriate for his needs."

The family exerted considerable authority over decisions regarding Mr. A's care and assessment. The Retreat proposed a formal autism assessment during 2016 but this did not proceed while Mr. A's brother and solicitor were considering it. It was recorded in April 2017 that they were "not willing to fund an autism assessment". This statement was repeated in a social circumstances report to the First Tier Tribunal in June 2017.

It is noted that following his transfer to Billingham Grange in early 2019 an autism assessment was set up through the NHS. The autism team made a clinical decision not to proceed with a full assessment due to Mr. A's history and current presentation, but there were no concerns regarding whether or not his brother would 'consent' to this assessment.

While the only recorded trustee to Mr. A's trust fund is the attorney from Johannesburg, Mr. A's brother (RK) was treated as the defacto decision-maker for his placement throughout the period of the review. RK did not have lasting power of attorney or deputyship either for health and welfare or for property and financial affairs. The existence of a trust fund certainly complicates the decision-making in relation to funding Mr. A's care, but does not provide RK (or anyone else) with the authority to make decisions regarding his health and welfare.

This was acknowledged regarding some of the decisions such as the use of restraint to deliver personal care. The Retreat care team appropriately consulted RK in the best interests process as someone interested in Mr. A's welfare, and did not treat him as the decision-maker, but it appears that RK's resistance to any change of placement undermined any discussion regarding the suitability of George Jepson Ward for Mr. A's care.

It is acknowledged that at the time, there was genuine concern that a move from George Jepson unit, where Mr. A had been placed for several years, or The Retreat more generally, where he had been placed since 1973, would lead to a significant risk to his psychological and mental health. The statements that the ward was his home, and that he knew no other environment held some force.

However, there was considerable evidence that the unit was not meeting his needs, and the nature of the funding created an inevitable conflict of interest for The Retreat, which had received ongoing financial remuneration for his care for the past 45 years.

Caselaw has confirmed that while it is perfectly legal for a person to be detained under the MHA while receiving private care, the Court of Appeal judgement confirms that "it will not be possible for care or treatment which is in conflict with the recommendations of the responsible clinician"[15]. Therefore, while Mr. A was detained under the MHA, it would have been possible for his responsible clinician to conclude that he should no longer be cared for

[15] North Dorset NHS PCT v Coombs [2013] EWCA Civ 471 para 34

on George Jepson Ward, or even within The Retreat, even if his family and trustees disagreed with this decision.

While this funding arrangement may appear very strange in the context of long-term psychiatric inpatients, it is more common in relation to care home residents who may be funded through private means. Lessons may be learnt in relation to the oversight of self-funders when they come to the notice of the local authority or the CCG. This is most likely to be through the Deprivation of Liberty Safeguards process, or in future the Liberty Protection Safeguards scheme. Alternatively, they may become subject to a safeguarding enquiry.

In these circumstances it is important that a thorough assessment or investigation is undertaken, as this may be one of the only opportunities to examine the care and treatment being provided to the individual.

Possibilities of change through the DoLS process

The change from detention under the MHA to deprivation of liberty under the MCA Deprivation of Liberty Safeguards provided an opportunity for the local authority to undertake an assessment of Mr. A's circumstances at The Retreat. This was perhaps the first opportunity for such an assessment since his arrival in 1973.

The only previous assessments had been undertaken through the lens of the MHA, which is an extremely narrow assessment, determining whether Mr. A needed to be detained for the purpose of treatment for mental disorder.

The DoLS assessment is designed to be much broader than a MHA assessment, incorporating consideration of whether the care and treatment provided to the individual, which amounts to a deprivation of their liberty, is in their best interests.

The DoLS process has been roundly criticised since its introduction, due to its bureaucracy and complexity in both legislative drafting and documentation[16]. However, the best interests assessment requires the BIA to examine the care and treatment provided to the individual, involve the individual as far as is possible in the process, consult with all those who have an interest in the person's welfare (paid and unpaid) and consider whether any conditions should be imposed by the Supervisory Body (the local authority which signs off the DoLS authorisation).

Mr. A was subject to three best interests assessments as part of the four requests for DoLS authorisations. The fourth request was ended before a best interests assessment was completed due to the conclusion of the mental health assessor that Mr. A was not eligible for DoLS and should be reassessed for detention under the MHA. This was a legally robust decision as it is set out in the DoLS schedule that all assessments must stop if the person fails to meet one the qualifying requirements[17].

The reviewer has commented on the limitations in the assessments, particularly in relation to attempts to communicate with Mr. A. It could be argued that the capacity assessments failed to contain sufficient evidence of lack of capacity to satisfy the requirements of the Act. There is little evidence of any attempts to use alternative means of communication, particularly considering the well-documented attempts of the care team to use a white board and written communication with Mr. A. BIA 2 considered the use of the whiteboard, but commented that "this seemed an unsatisfactory method of communicating with [Mr. A] about Deprivation of Liberty and his views, wishes and feeling on residence, care and treatments". It is suggested that attempts at using alternative methods of communication would be significantly less unsatisfactory than the complete failure to communicate verbally with him.

Notwithstanding these issues, it is suggested that a more comprehensive attempt at communicating with Mr. A, both for the capacity assessments and in relation to the best interests assessment (as required in the best interests statutory checklist), is unlikely to have made a substantive difference to the outcome. It appears uncontentious that Mr. A lacked capacity in relation to decisions about his accommodation throughout his placement at The Retreat.

[16] Lady Hale in the "Cheshire West" Supreme Court judgement referred to their "bewildering complexity"
[17] MCA Schedule A1 para 133

The first assessment was undertaken soon after the care team had stopped administering depot medication to Mr. A (which resulted in his discharge from section and the DoLS application). The BIA focused on this as evidence for the success of the therapeutic regime. It was reported that he had a great deal of freedom in his care plan and is able to choose whether or not to engage in activities, and that he could spend as much time on his own as he would like.

It is notable that the BIA 1 included a condition which specified that "[The Retreat] should take all reasonable steps to work with the relative person's representative in exploring whether [Mr. A] could live in a less restrictive environment". It is well-known that conditions have limited authority, and unless the local authority (as supervisory body) or Relevant Person's Representative actively pursue the conditions, they are unlikely to be acted upon.

The second DoLS assessment took place just four months later. BIA 2 recorded that "the nature of [Mr. A's] care needs cannot be delivered in a less restrictive environment at this time since he requires a level of monitoring and supervision which is not tenable in a non-institutional setting."

The three choices considered by BIA 2 were

1. To remain in hospital for the purpose of residence, care and treatment;
2. Possible detention under the Mental Health Act;
3. Discharge to the community with a care plan of support.

There was no consideration as to whether an institutional setting other than The Retreat may be able to meet his needs more effectively and be less restrictive of his freedoms.

BIA 2 added that Mr. A "does appear settled in this care setting" which is further evidence not to recommend explorations of alternative resources.

BIA 3 referenced a comment from the RPR in his consultation "There are no ideal solutions to what has been a situation which has been engrained for such a long time, and the need to explore the 'least restrictive option'".

BIA 3 considered two options in his 'benefits and burdens' analysis at the end of the best interests assesment document:

1. Remain at The Retreat under the same restrictions
2. To move to an environment that is less restrictive.

BIA 3 therefore appears to consider the possibility of another environment which may also be an institutional setting, but which would be less restrictive. BIA 3, however, rules this out as although the benefits would be "less patients around" and "a more 'normal' home environment", the burdens were

- "likely to disengage;
- cannot elicit assistance;
- would not settle in new environment;
- no one to monitor 24/7;
- family will be worried over risk to self and others;
- mental and physical health would deteriorate"

On reading this list of 'burdens', it appears that BIA 3 is not after all considering another institutional environment, but one where Mr. A would be left much more to his own devices.

All assessors understandably focused on Mr. A's considerable length of stay at The Retreat, and the risks to his emotional and psychological well-being if he was moved from what was explicitly referred to as his 'home'. This was reinforced by the care team who, while considering whether George Jepson Ward was appropriate for him, came to the consistent conclusion that it was in his best interests to remain there. Also, the strong and consistent view of Mr. A's brother that he should not move from The Retreat, or that ward.

No conditions were attached to either the 2nd or 3rd DoLS authorisations granted in October 2014 and 2015.

It is acknowledged that the role of the BIA in the DoLS process is limited and focussed specifically on whether the care and treatment being provided to the person is in their best interests. The BIA is not required or expected to comment on the care planning process[18]. However, the BIA is required to consider whether less restrictive options are available to the person, or whether the commissioners of care should be exploring alternatives which involve a lower level of restriction.

BIAs 2 and 3 both considered less restrictive options, but on each occasion the alternative considered was a move back into the community, which was clearly an unrealistic option.

BIA 1 included a condition that the managing authority (The Retreat) explore the option of a less restrictive environment. It is clear that The Retreat did at times consider whether George Jepson Ward was the most appropriate environment, but there were multiple factors militating against this. One has been discussed above (the nature of the funding and the decision-makers in relation to the placement). At no time was there any record of detailed consideration of alternative resources, and whether such alternatives may better meet Mr. A's needs.

Finally, at the time of the assessment for a fourth DoLS authorisation, the psychiatrist acting as medical assessor made powerful statements about the degree of Mr. A's self-neglect following his examination. He recorded the existence of "gross neglect", suggesting that he had not bathed for at least a year. He looked like "a vagrant". This was a description of a patient in a unit providing regulated care. A Mental Health Assessment was initiated which led to Mr. A being re-detained under the MHA, but no safeguarding alert was raised. This will be discussed further below in the section on safeguarding issues.

[18] MCA DoLS Code of Practice 4.75

The role of the paid RPR within the DoLS process and the Supervisory Body's consideration of the RPR reports

The DoLS schedule requires that everyone subject to a standard authorisation must have a relevant person's representative (RPR). The responsibility of appointing the RPR lies with the supervisory body (the local authority), and the appointment must be made as soon as practicable after the authorisation is granted[19].

The role and expectations of the RPR are set out in the DoLS schedule and also the relevant person's representative regulations[20]. In many circumstances, the RPR will be a member of the person's informal network. However, if there is no one willing or able to undertake this role, the law expects the supervisory body to appoint a professional person to undertake the role. Advocacy organisations are frequently contracted to provide people to undertake this role, and they are referred to as Paid RPRs.

Following the granting of the first authorisation in June 2014 there is no evidence of the appointment of an RPR. There is no clear reason why this did not happen.

Following the granting of the second authorisation in October 2014, Mr. A's brother signed to confirm his consent to be Mr. A's RPR. This appointment was confirmed within four weeks following the granting of the authorisation. There is no evidence from the best interests assessment whether any discussions took place with Mr. A's brother in relation to the RPR role, but it is noted that the original DoLS forms were in use at that time. There was no expectation on the BIA to record the discussions with the potential RPR.

Less than one month after Mr. A's brother confirmed his agreement to being appointed RPR, the supervisory body appointed a paid RPR employed by a local advocacy organisation. There is no record of Mr. A's brother relinquishing the role, or any reason why the supervisory body appointed a different RPR. From the records available to the reviewer, it would appear that the appointment of a paid RPR in November 2014 was outside the legal processes.

Notwithstanding the unusual nature of the appointment of the paid RPR, it would appear that this was the most appropriate appointment, and Mr. A's brother is unlikely to have been able to satisfy the requirements of the RPR as set out in the legislation.

The RPR is required to maintain contact with the person subject to DoLS and also to support and represent them in relation to the authorisation[21]. Case law has established that this means the RPR should be willing to request a review or take the case to the Court of Protection if necessary[22].

Mr. A's brother visited him at most annually, so it is suggested that this is not sufficiently regular to satisfy the definition of "maintaining contact". In addition, Mr. A's brother has repeatedly indicated through his actions that he supported Mr. A's placement at The Retreat and did not want any consideration given to a move. It was reported that Mr. A's

[19] MCA Schedule A1 para 139
[20] MCA Schedule A1 para 140, The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008 (SI 2009 No 1315)
[21] MCA Schedule A! para 140(1)
[22] AJ v A local authority [2015] EWCOP 5

brother had resisted NHS involvement in fear that consideration may be given to moving him.

It is therefore concluded that the appointment of a paid RPR potentially provided more regular monitoring of the authorisation, more regular contact with Mr. A during the period of the DoLS authorisation and greater opportunity to support him in relation to the authorisation.

One person acted as paid RPR to Mr. A throughout his authorisations. The paid RPR visited Mr. A four times during the second authorisation and twice during the third authorisation. On each occasion she completed a report and returned it to City of York as the supervisory body. The last report submitted to the supervisory body was in November 2015. There are no further reports in the ensuing ten months until the expiry of that authorisation in September 2016.

The reports of the paid RPR following her visits followed a repeating pattern, which reflects the nature of Mr. A's responses to staff throughout his time at The Retreat. The RPR was unable to engage with Mr. A in any of her visits.

The RPR's recording of her visits to Mr. A describe a consistently poor level of self-care and significant self-neglect is apparent in all her reports.

- 19/12/14: "From my brief meeting with [Mr. A] I could see that he was extremely unkempt."
- 30/04/15: "[Mr. A] looked unkempt and dishevelled." "I noticed [Mr. A's] shoes had a big hole in them"
- 06/07/15: "[Mr. A's] room was very untidy with pieces of newspaper everywhere and used food plates and bowls strewn around."
- 24/08/15: [Mr. A] was dishevelled and unkempt, his hair was matted and unruly."
- 30/09/15: [Mr. A] was sat in a chair, he looked grubby and dishevelled."
- 16/11/15: [Mr. A] looked grubby and unkempt although he looked alert and did give me occasional eye contact."

In the context of Mr. A being deprived of his liberty in a care environment, it is concerning that the RPR did not raise any concerns in relation to Mr. A's consistent level of apparent neglect. The RPR could have alerted the supervisory body to her comments, or she could have raised a safeguarding alert, if she felt sufficiently concerned.

The section of her report entitled "Observations" were identically worded in all six reports. Her first observation for each report states "At the present time from the information I have received it would appear that Mr A's level of supervision is both in his best interest and the least restrictive option to ensure his safety and wellbeing."

There is also a section in the RPR report form entitled "Concerns". The documentation in each of the reports is also identical, with the concern relating to Mr. A's length of time at The Retreat. There is no mention of his physical condition in any of the forms.

Although the RPR did not formally alert the supervisory body to her observations regarding Mr. A's physical condition. Each of her reports was sent to the City of York DoLS service as the Supervisory Body, which has responsibility for ensuring the deprivation of liberty remains in the person's best interests. Therefore, it is also clear that either the supervisory

body did not read the reports, or if they were read, the chronic level of neglect was not picked up.

It is suggested that this consistent picture of neglect in relation to a person who is being cared for in conditions of intense control and deprivation of liberty should have warranted further exploration.

As mentioned above, the RPR performs an important role in the DoLS process. Their duty is to the person subject to the DoLS authorisation, they are required to keep in contact with the individual, to ensure that their statutory rights (to appeal) are protected, and also to ensure that their deprivation of liberty continues to be in their best interests. They have the authority to request the Supervisory Body reviews the authorisation if they have any concerns regarding the individual or their care.

The role of adult safeguarding

There were many safeguarding alerts within the timescale of this review. Until April 2015 when the Care Act 2014 was enacted, safeguarding was not enshrined in legislation and there was no requirement for the local authority to be involved in decision-making in adult safeguarding investigations. There were several incidents from 2011 onwards where Mr. A either hit another patient or was hit by another patient. There are also several reports of times when Mr. A hit or kicked staff members, often during the provision of personal care, but this section will only address the issues of violence between Mr. A and other patients.

One such meeting was held in May 2014 which was designated a 'safety planning meeting'. The minutes indicate that the alert was forwarded to the local authority and CQC but no professionals from outside The Retreat appear to have been present at the meeting.

The first time following the enactment of the Care Act 2014 that the local authority was involved in relation to a safeguarding matter was in February 2017 when two members of staff raised an alert in relation to possible neglect of Mr. A. As discussed in the chronology above, a full safeguarding process was undertaken, including several meetings over the following five months. The local authority and CCG were involved in the process.

With the understanding that considerable caution needs to be exercised when looking at the process in retrospect, some of the comments made during the investigation appear to be dramatically at odds with the records of Mr. A's care.

The paid RPR under the DoLS process had consistently recorded that Mr. A had looked "grubby", "dishevelled" and "unkempt" over the course of six visits in 11 months between December 2014 and November 2015.

In September 2016, just four months before the safeguarding alert, the psychiatrist who undertook the DoLS medical assessment had commented that Mr. A was showing evidence of "gross neglect", matted hair and beard and that he "looks like a vagrant".

However, it appeared to be accepted with little challenge that Mr. A's needs had been "adequately met over the years"; that Mr. A "generally always appeared clean" and that the incident which prompted the safeguarding alert "sounded like a one-off" and "is not about inadequate care by any stretch of the imagination".

There is no doubt that Mr. A presented considerable challenges in relation to his care at The Retreat. However, the stark contrast between the comments made by the limited number of external professionals who were seeing Mr. A, and those made by the members of the investigating team is deeply concerning. The previous descriptions of Mr. A's level of self-neglect appear not to have been referenced at any point during the investigation, even to discount them as no longer relevant. If they had been actively considered, it is the opinion of the reviewer that serious consideration would have to have been given to whether The Retreat (or this ward) was able to meet Mr. A's needs.

It is suggested that the investigation, for whatever reason, was not sufficiently challenging of the picture painted by The Retreat. It appears to have been diverted, partially at least, into broader issues of the building works on the ward and lost a focus on Mr. A as a vulnerable individual.

The question of Mr. A's autism/Asperger's Syndrome and associated responses and treatment

Mr. A's notes are clear that he was diagnosed with paranoid schizophrenia from a very early age. There is no reference to the possibility of a diagnosis of autistic spectrum disorder (ASD) or Asperger's Syndrome until a psychiatrist at a Mental Health Review Tribunal (now First Tier Tribunal) suggested the possibility in 2003. This is before the remit of this review, but it appears that over the following five years the possibility of ASD was more frequently raised.

The ASW in 2008 wrote in his report that Mr. A had "a long-standing diagnosis of schizophrenia and Asperger's Syndrome". While several reports stated Mr. A had received diagnoses, it appears clear from numerous clinical reports that he has never been formally diagnosed with either ASD or Asperger's Syndrome.

Billingham Grange was the first service to request a formal assessment in 2019, and the Autism assessment service determined in June 2019 that "due to significant mental ill health and limited ability to gather childhood history, decision made that diagnostic assessment would not be appropriate. Will offer recommendations using ASD as a working diagnosis following face-to-face appointment."

It appears from the records that while there was an increasing awareness of the possibility of Mr. A having an ASD, the treatment and care was focused on the schizophrenia diagnosis throughout his time at The Retreat.

- 06/06/17: Safeguarding outcomes review. [The Retreat] "Mr. A's documentation was being reviewed and had an autism assessment which has never been undertaken with him before in the 42 years he has been a resident with us."
- 12/07/17: Safeguarding outcomes meeting. "…although Mr. A does not have a diagnosis of autism, he may be assessed at some point in the future. [The Retreat] noted that a great deal of Mr. A's symptoms relate to schizophrenia rather than autism."

It is suggested that Mr. A's early history, which was available to clinicians at least from 2009 when it was described in a medical report for a Mental Health Review Tribunal, shows strong evidence of ASD

- "[Mr. A's] language development was delayed. From an early age he poorly tolerated frustration and displayed aggressive temper tantrums. He did not make friends in nursery, isolating himself and not talking to others. He had difficulties mixing during his school years." (medical report to MHRT 4th June 2009)
- "[Mr. A] tends to isolate himself, not tolerating noise or high stimulus environments. He rarely uses verbal language, choosing to communicate through gestures and body language, which staff who know him well can understand." (Clinician's report to FTT 20th August 2013)

From early 2014, Mr. A's recovery plans included a section relating to his possible ASD. "It has been suggested that [Mr. A] presents as someone who has an Autistic Spectrum Disorder. As such, [Mr. A] may display certain behaviours or character traits that may be perceived as unusual or challenging." The long term goal was for staff to have awareness of ASDs and how they relate to Mr. A's care, and for them to develop approaches in working with Mr. A in relation to this.

However, despite considerable further evidence of ASD traits and their impact on his mental and psychological state, the focus was on treating him pharmacologically for schizophrenia with little or no consideration of interventions focused on his ASD.

- 19/05/14: [Mr. A] has remained very well in his mental state since the depot antipsychotic was stopped some months ago now. However this weekend has been difficult as he seems stressed by a fellow patient who is highly disturbed.

  [Mr. A] is agitated and distressed, especially so when this patient is near him. He has been aggressive this weekend in response. On review I noted fixed eye contact with me, and it was very difficult to reassure him. He kept clapping at me suggesting he wanted me away. He voiced that the baby had been cut out of him and that we were up to tricks. Thought disorder was evident.

  I take this as evidence of a relapse in psychosis. It may be that he settles back down again in a few days but this depends on the ward remaining calm. Stress does seem to be precipitating a relapse. It may be that he will have to be redetained and given a depot should he not improve quickly." (consultant psychiatrist)

- 02/02/15: "[Mr. A's] mental state has declined over the past few weeks. This does seem to correlate with changes on the unit especially around work being done to renovate rooms and work on the roof."

  "His mental state is known to be very closely linked to his environment. Without a depot it is possible his resilience to environmental change has diminished." (consultant psychiatrist)

- 12/02/15 (recorded on 18/02/15): Noted he is neglecting himself and less sociable, less able to tolerate others around him. Becomes more easily agitated and will start to clap his hands and tell them to go away. His mental state started to decline some weeks ago when workmen were on the unit. During this time there were new people present on the unit and it was noisier.

  "It is unclear why [Mr. A's] presentation has changed so much other than it roughly correlates with the workmen being present on the unit. It is entirely possible that he could have any underlying physical pathology at this point. It is also possible he may be psychotic again, or depressed or have a rapid onset dementia progress." (consultant psychiatrist)

- 19/11/18 (telephone conversation between consultant psychiatrist and Mr. A's sister): The psychiatrist commented "In short it is my impression that his presentation is largely due to ongoing psychosis."

It is noted in various points that Mr. A's family were consulted with regards to undertaking a formal assessment for autism but were at best reluctant and at times resistant to this proposal.

For at least the final eight years of his placement at The Retreat, Mr. A was cared for on a ward which was increasingly used to care for individuals with dementia, many with behavioural and psychological symptoms (BPSD) which can be extremely challenging. The incidents of aggression which led to several safeguarding alerts strongly indicates the level of behaviour which challenges exhibited by many of those patients.

Reports started to consider whether Mr. A was appropriately placed on George Jepson Ward at The Retreat in 2014. However at that point the conclusion was clearly that he was best placed there, despite the fact that he "continues to find the challenging behaviour of his peers difficult"[23]

A further CPA review in 2015 spoke of the pros and cons of Mr. A remaining on the ward "when it becomes a dementia unit", although it reported "the cons appeared to outweigh the pros"

[23] CPA review 15/09/14

Conclusion

The circumstances of Mr. A's care and treatment appear to be extremely unusual in that his continuous 47 years in psychiatric care, nearly all of which detained under the MHA, were funded privately. It is likely that these circumstances are extremely rare. However, mirror arrangements are significantly more common in care home placements, although they are unlikely to last for this length of time.

The possibility of questionable care in an environment which is arguably not suited to the individual's needs, could be repeated where the decision-maker is a family member or attorney instructed by the person's family.

It is impossible for the local authority or NHS to be able to monitor all private, self-funding arrangements, both because of the limited resources available to the state, and also due to the limitations on the powers of the local authority to make prospective investigations without a statutory duty.

However, the DoLS process provides a statutory duty to investigate the circumstances of individuals who lack capacity to make decisions regarding their accommodation, including self-funders. There is indeed a positive obligation on the state to investigate to protect the rights of individuals who may be deprived of their liberty within private arrangements[24].

The state became involved with Mr. A through both the DoLS and safeguarding processes. There is no doubt that the fact that Mr. A had been living continuously at The Retreat for over 40 years led to considerable and understandable reluctance to 'rock the boat'. Any decision to move him would inevitably bring significant risks that he would react negatively and would be worse off in a different placement.

However, there was considerable evidence that his needs were not being met, and it is argued, numerous occasions where safeguarding procedures could and should have been initiated due to institutional neglect. The Retreat staff themselves appear to have come to the conclusion that the placement was inappropriate but felt unable to act on this due to the opposition of Mr. A's brother.

A greater sensitivity to the impact of ASD on the individual should have initiated a more thorough discussion of the relative importance of psychiatric treatment and autism-sensitive responses in relation to Mr. A's care. It is arguable that the focus was for too long on pharmaceutical responses to his psychiatric diagnosis at the expense of exploration of his autism-related needs. This is not to say that psychiatric medication was unnecessary, but it could have informed the issues around his responses to patients with behavioural symptoms of dementia, building works on the ward and changes of staff.

Mr. A's response to his move to Billingham Grange appears remarkable. He was sadly only there for 18 months before his death, but perhaps the most striking indication of his progress comes from the Tribunal which recommended a referral to Social Services to start planning for his discharge. This reflects positive work undertaken by Billingham Grange staff and Mr. A's potential for recovery, given the appropriate care and treatment.

[24] This is set out in Re A Re C [2020] EWHC 978 (Fam) para 95

Recommendations

1. The local authority DoLS team should ensure paid RPR reports are properly scrutinised for any elements which may indicate cause for concern regarding an individual's care and treatment
2. DoLS practitioners (LPS in the future), including BIA's, doctors and advocates, should be reminded of the importance of raising issues of concern during DoLS assessments and visits, and the potential of using safeguarding alerts where issues of abuse or neglect may be relevant
3. The local authority DoLS service should be aware of the importance of assessments of self-funders (almost exclusively in care home environments) and the fact that this is likely to be the only independent oversight into that person's care and treatment.
4. Safeguarding investigators must ensure they have full access to all documentation regarding a person's care and treatment, including DoLS documentation, when undertaking enquiries
5. Professionals within mental health services have an awareness of the needs of people with autistic spectrum disorders, particularly those with behaviours which challenge and co-morbid mental disorder. They should know how to escalate to specialist services.