My aims for the presentation

To discuss

• the legal basis for safeguarding vulnerable adults with mental health problems – an overview – applying s42 and other Care Act functions to mental health patients

• a legal update for safeguarding leads: implications of the Care Act 2014 - brief highlights

• safeguarding vulnerable adults from restrictive practices

• ensuring the legal use of control and restraint

• record keeping and confidentiality
A quick Care Act overview for those for whom it is brand new!

• Changes to the *substance* and *concept* of *eligibility* and the *pathway*: assessment, support planning, resource allocation and review...

• **Advocacy** Rights for those facing substantial difficulty in engaging with the process – including safeguarding;

• Carers’ rights to have their eligible needs met and the consequential changing *relationship* with carers, service users and advocates;

• **Statutory safeguarding** and information sharing, and enhanced co-operation duties as between agencies;

• No more ‘significant’ harm threshold - and a free-wheeling *discretion* around *proportionate* enquiries....
Safeguarding – a brief history

• In the UK the Government introduced the formal recognition of adult abuse with the introduction of a document called ‘Elder Abuse’ (DOH Guidance 1993).

• The tone of terminology at that time suggested that “protection” was done to the adult by an organisation or organisations.

• Some 10 years later, 2000 “No Secrets” was issued with the intention of developing and implementing multi-agency policies and procedures within the adult protection framework. No Secrets required all local authorities to have a multi-agency policy by 2001.

• no actual statutory powers to do anything, and Las only had assessment and care planning functions under social care law.
Scope of Safeguarding policies

• The definition of a “vulnerable adult” was someone over 18 and who is or may be in need of community care services by reasons of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation”

• From seven categories of abuse. Not self neglect specifically.
Old/current process

• “No Secrets” gave the local authority lead responsibility in adult safeguarding the legal basis in law for their “safeguarding activities” remained as part of their statutory functions under community care law to assess and deliver, if eligible, services under various pieces of legislation, or to share information or to make referrals to other organisations with obligations of their own.

• Safeguarding therefore was not a statutory function, it was a process which worked towards an outcome based on policy. The outcomes of a safeguarding activity were implemented through assessment and care planning functions and sometimes referral to other agencies.

• Policies and procedures were developed around the country interpreting both the Guidance and good practice guidance.
Change

• Safeguarding was not functioning as it was needed
• People who needed protecting were being missed and some were being overly protected.
• There are high profile cases that highlight this - Orchid View a Southern Cross home and Winterbourne View Hospital
• Following a consultation on “No Secrets” the Government issued a Report on the consultation and following that The Law Commission produced a report on the reform of adult social care law. The White Paper Caring for our Future: reforming care and support contained the government’s vision which included a new adult safeguarding framework.
Case Study

• The facts: elderly partners, together for 20 years, and the woman now in a home with dementia.

• Before admission, the couple have chosen to spend their money on one final cruise – they’ve been going for the last 5 years.

• The man has the woman home at weekends, and is doing a good job of coping; and he visits the woman at the home.

• The staff have got to hear about the trip, and have told the local authority.

• The view of the professionals concerned seems to be unanimous that it is not in her best interests to go. The staff have the direct experience of dealing with Mrs R’s daily care needs, of prompting her to take her medication (she is diabetic) and to attend to her other needs, and ensuring her safety and well-being.

• There is concern that Mrs R might ‘wander’ (as she undoubtedly has in the past when living alone) on the ship and go over the side.
What really happened?

• The local authority got a without notice injunction and a DoLS order to stop the holiday!

• The council applied without notice to the Court of Protection in London for interim declarations that Mrs R lacked the capacity to litigate, to decide where she should live and to make decisions about her care.

• Interim declarations were made and the matter immediately transferred to this regional court for hearing on notice. The gentleman immediately issued his application to challenge those interim orders.

• When the matter came back to be heard, however,...
....the judge injected a large measure of common sense...

- Mrs R is on balance, at the very least willing to go on this cruise, despite her somewhat ambiguous utterances.
- If one ‘re-winds’ to a year ago, and for many years before that, it was part of Mrs R’s lifestyle to take cruises on a regular basis each year in Mr D’s company from which it must be inferred that she was happy to do so.
- Mr D, who knows her well, supports this view.
- As already mentioned, this could be their last opportunity to extract enjoyment from such a holiday.
- Looked at in a positive light, the concerns about her safety on board appear to have been given disproportionate emphasis. Mr D, who has proved able to care for Mrs R at weekends, will be with her for the duration of the cruise, sharing her cabin and in a position to keep a watchful eye on her and attend to her needs.
- Concerns about her ‘wandering’ are largely, if not wholly, met by the fact that a cruise ship is a ‘confined space’ such that she cannot wander far. During the night Mr D has formulated strategies to ensure she does not leave the cabin without him becoming aware.
- The suggestion of a carer to accompany the couple was put forward but is unnecessary, too costly and impractical. It is difficult to see how a carer could do any more that Mr D can do.
- Lastly, Mrs R is familiar with the pattern of life on a cruise ship, has travelled on this particular ship in the past and will be with Mr D who has her best interests at heart, such that the fears that Mrs R might find the new environment disruptive and therefore distressing are seemingly allayed.
But the judge was not *unduly* dismissive of the professionals’ concerns

• “Her social worker and the staff at the home *want* to do the right thing for her but are focussed on her safety and are acutely aware of things that might go wrong.

• It was suggested, not without some force in my view, that this smacked of saying that her best interests were best served by taking every precaution to avoid *any possible danger* without carrying out the *balancing exercise* of considering the *benefit* to Mrs R of what, sadly, may be her last opportunity to enjoy such a holiday with Mr D. This led to trying to find reasons why Mrs R should not go on this holiday rather than finding reasons why she should.

• “One must not forget that this is not a life-changing decision, or a choice between two evils or a decision over which an elderly person without Mrs R’s impairment would be likely to agonise. It is a choice of whether to go on holiday or not, in familiar circumstances, with one’s companion of the past two decades.

• “I find myself unpersuaded that Mrs R, whatever her limitations, can be shown on the balance of probabilities to have lacked capacity to make this particular decision.”
Was it wrong to use the CoP and DoLS in a ‘pre-emptive strike’ sort of a way?

It was submitted that there was procedural unfairness in the Local Authority adopting these measures and as a matter of principle the Standard Authorisation procedure should not have been used but instead the known dispute should have been brought to the Court of Protection for resolution.

“My preliminary view is that the submission on behalf of Mr Davies is correct.”
The case law drives the focus on the importance of the wishes and feelings of incapacitated people

• "The wishes and feelings of the incapacitated person will be an important element in determining what is, or is not, in his best interests. Where he is actively opposed to a course of action, the benefits which it holds for him will have to be carefully weighed against the disadvantages of going against his wishes, especially if force is required to do this."

• The nearer to the borderline the particular adult, even if she falls on the wrong side of the line, the more weight must in principle be attached to her wishes and feelings, because the greater the distress, the humiliation and indeed it may even be the anger she is likely to feel the better she is able to appreciate that others are taking on her behalf decisions about matters which vitally affect her – matters, it may be, as here, of an intensely private and personal nature.”

• Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness.

• What good is it making someone safer if it merely makes them miserable?“

• Cases like this that have shaped the ethos of the Care Act 2014

All taken from the MM case in 2007
The Care Act 2014

• The best place to start in understanding this document is the statute itself. If you would like to view it, available online

• As with all statutes it is very wordy

• The Act on its own would be impossible to interpret without Guidance.

• October 2014 version

• Adult Safeguarding page 231. This section interprets S42.
The Care Act 2014

• Section 42 – Safeguarding adults at risk of abuse or neglect

• 42 (1) an adult over 18 who has needs for care and support (whether or not the local authority is meeting any of those needs) and; is experiencing, or at risk of, abuse or neglect, and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.
A wider scope

• Much better definition
• Threshold of “significant harm” has been removed.
• The definition of a “vulnerable adult” was someone over 18 and who is or may be in need of community care services by reasons of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or unable to protect him or herself against significant harm or exploitation”

• Now a much wider definition
• How does this apply to those suffering from mental health problems?
The legal basis for safeguarding adults with mental health problems

- It’s exactly the same as the legal basis for safeguarding any other adults: that they are perceived to be at risk of abuse or neglect, and that their care and support needs may prevent them from protecting themselves: and this triggers a safeguarding enquiry.
- If they are in a mental health hospital, the managers will owe compliance with local protocols for safeguarding process, and substantive safeguarding obligations as part of a duty of care.
- In a regulated care home setting, the new standards ought to ensure that the management is attending to quality, dignity and respect – and can be regulated if not, by CQC.
- In the community – whether that is specialist supported living or in a person’s own home – the Care Act enables the Local Authority to enquire as to a person’s situation or to treat a perception of abuse as a reason for not backing away when the person appears, capacitatively to be refusing an assessment.
- All the Guidance requires a focus on the individual, and a weighted approach to the person’s wishes and feelings in relation to their mental capacity, as opposed to their status, bare diagnosis or position as an informal or sectioned patient.
- For non inpatients, review functions may easily be triggered by a change of circumstances or a reasonable request by or on behalf of the individual by anyone with safeguarding concerns. The plan might be revised, separately, or as a result of a safeguarding enquiry, once it is concluded.
Specific safeguarding points of note in the new Act...

- Although Safeguarding ‘enquiries’ are made into a corporate council duty – the trigger is still harnessed to an adult social care concept - having care and support needs, so not all risk of harm will trigger enquiries.

- An actual service response AFTER safeguarding will still normally depend on whether the person is also eligible in the ordinary way.

- There is no threshold of significant harm for an enquiry. This undoubtedly will increase the volume of enquiries however one could be over in a 30 second call in an appropriate situation.

- Human Rights obligations are imposed directly on all regulated care providers, for publicly funded services – including direct payments clients, despite the private relationship in contract with the provider.
Abuse and Neglect

Safeguarding not only has a wider scope of those that need to be protected but also a wider scope in what they are to be protected from:

Physical
Sexual
Psychological
Financial
 Discrimination
Organisational (Institutional)
Neglect and Omission
Domestic Violence
Modern Slavery
Self Neglect (see previous example)

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Abuse and Neglect

**Domestic Violence** – psychological, physical, sexual, financial, emotional abuse and ‘honour’ based violence

**Modern Slavery** – slavery, human trafficking, forced labour, and domestic servitude.

**Self Neglect** – this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and included behaviour such as hoarding.

- Mental health symptoms such as low mood, lack of motivation, apathy, psychosis may lead to self neglect.
- What about self harm behaviour (cutting)?
- What about those that abuse illicit drugs or alcohol?
Safeguarding related highlights continued

• There’s a re-enactment of duties to protect people’s property, when in residential care or hospital – pet care etc.

• There are very limited duties to support safeguarding in prisons and approved premises – the prison service is to do its own safeguarding.

• There’s a new provider duty of pro-active candour about failings in hospitals and care settings (social care providers will be covered by regs scheduled for April) and new offences regarding false or misleading information whenever it has been sought under an enactment, which would include the SAB requirement under the Care Act, of course.
What have we *not* been equipped with?

- We have not been given free-standing fleshed-out *investigative* powers with any ‘teeth’, or any effective means to *make* people answer questions or share information.
- Maybe this role is more suited to other SAB agencies, the police for example.
- The idea of introducing a *social work power of entry* where it is considered that a third party is preventing a person from being fully ‘heard’ about their situation, came to nought.
The Guidance
What safeguarding is and why it matters

14.7 Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted, including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

14.9 Safeguarding is not a substitute for:

- [all] providers’ responsibilities to provide safe and high quality care and support;
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and
- the core duties of the police to prevent and detect crime and protect life and property.
6 key principles apply to Adult safeguarding

- **Empowerment**, people being supported and encouraged to make their own decisions
- **Prevention**, better to take action before harm occurs
- **Proportionality**, the least intrusive response appropriate to the risk presented
- **Protection**, Support and representation for those in greatest need
- **Partnership**, local solutions through services working together with their communities. Communities have a part to play in preventing, detecting and reporting neglect
- **Accountability**, Accountability and transparency in delivering safeguarding
The Local authority’s role in carrying out enquiries

14.66 What happens as a result of an enquiry should reflect the adult’s wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.

14.67 The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse.
The council’s role in carrying out enquiries

- **14.64** An enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place.

- An enquiry could range from a *conversation* with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their *representative or advocate*, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action.

- Whatever the course of subsequent action, the professional concerned should record the concern, the adult’s views and wishes, any immediate action has taken and the reasons for those actions.

- **14.65** The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, *should do something to help and protect the adult*.

- If the local authority decides that another organisation should make the enquiry, for example a care provider, then the local authority should be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.

- NHS, private mental health hospitals, etc
When should an enquiry take place?

14.77 Local authorities must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it necessary to enable it to decide what (if any) action is needed to help and protect the adult.

The scope of that enquiry, who leads it and its nature, and how long it takes, will depend on the particular circumstances. It will usually start with asking the adult their view and wishes which will often determine what next steps to take. Everyone involved in an enquiry must focus on improving the adult’s well-being and work together to that shared aim.

At this stage, the local authority also has a duty to consider whether the adult requires an independent advocate to represent and support the adult in the enquiry.
Objectives of an enquiry

14.79 The first priority should always be to ensure the safety and well-being of the adult.

The adult should experience the safeguarding process as empowering and supportive.

Practitioners should wherever practicable seek the consent of the adult before taking action. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry.

Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred.
What should an enquiry take into account?

14.80 The wishes of the adult are very important, particularly where they have capacity to make decisions about their safeguarding.

The wishes of those that lack capacity are of equal importance. Wishes need to be balanced alongside wider considerations such as the level of risk or risk to others including any children affected. All adults at risk, regardless of whether they have capacity or not may want highly intrusive help, such as the barring of a person from their home, or a person to be brought to justice, or they may wish to be helped in less intrusive ways, such as through the provision of advice as to the various options available to them and the risks and advantages of these various options.
Who can carry out an enquiry?

14.84 Although the local authority is the lead agency for making enquiries, it may require others to undertake them. The specific circumstances will often determine who is the right person to begin an enquiry. In many cases a professional who already knows the adult will be the best person. They may be a social worker, a housing support worker, a GP or other health worker such as a community nurse.

The local authority retains the responsibility for ensuring that the enquiry is referred to the right place and is acted upon. The local authority, in its lead and coordinating role, should assure itself that the enquiry satisfies its duty under section 42 to decide what action (if any) is necessary to help and protect the adult and by whom and to ensure that such action is taken when necessary.

In this role if the local authority has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory.
Who can carry out an enquiry?

- LAs are not able to delegate safeguarding, as if it was an actual function, to mental health trusts where there are safeguarding issues for mentally unwell patients or clients.
- They cannot get the mental health trust to take responsibility for the work and the decision making.
- Only assessment and care planning can be delegated to the Trust, like all the other social work functions towards that client group.
Who can carry out an enquiry?

- Under the Care Act it is not possible legally to delegate the new s42 freestanding function of running safeguarding.

- It is possible to cause anyone else to make an enquiry, however; but this is not delegating the running of the enquiry – this is saying do an enquiry because you are in the best position too and may even have to do one for your own purposes, but bring it back to us and **WE WILL DECIDE** whether it was a good enough enquiry to stand as a s42 safeguarding enquiry, and if it was, we will look at your outcome and thinking, and decide whether or not to adopt it as our decision as to what should be done.
Who can carry out an enquiry?

• LA could cause a mental health trust to make an enquiry, or even treat the trust as by default the maker of the enquiry for all such issues, but that is not the same as saying that the mental health trust can be empowered to decide what to do as the outcome: that is a decision that cannot be delegated.

• The Trust could make a recommendation, and if there was a worker in the Trust who was actually a senior social services employee, still on the books of the authority, then that person could be empowered to make the decision, working in parallel to the authority’s own safeguarding lead – they would be sharing the statutory responsibility of making decisions about the outcomes of enquiries.

• That is not delegation.

• ALSO, LA responsibility to ensure that whoever is carrying out enquiries on their behalf is properly trained.
A role for qualified social workers in carrying out enquiries

14.68 Professionals and other staff need to handle enquiries in a sensitive and skilled way to ensure distress to the adult is minimised. *It is likely* that many enquiries will require the input and supervision of a social worker, particularly the more complex situations and to support the adult to realise the outcomes they want and to reach a resolution or recovery.

14.69 Whilst work with the adult may frequently require the input of a social worker, other aspects of enquiries may be best undertaken by others with more appropriate skills and knowledge. For example, health professionals should undertake enquiries and treatment plans relating to medicines management or pressure sores.
The guidance makes frequent reference to the knowledge base including the Mental Capacity Act...

14.44 People must be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to make their own decisions.

Where an adult is found to lack capacity to make a decision then any action taken, or any decision made for, or on their behalf, must be made in their best interests.

14.45 Professionals and other staff need to understand and always work in line with the Mental Capacity Act 2005 (MCA).

They should use their professional judgment and balance many competing views. **They will need considerable guidance and support from their employers** if they are to help adults manage risk in ways and put them in control of decision-making if possible.
14.46 Regular face-to-face supervision from skilled managers is essential to enable staff to work confidently and competently in difficult and sensitive situations.

14.47 Mental capacity is frequently raised in relation to adult safeguarding.

The requirement to apply the MCA in adult safeguarding enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected.
Meanwhile, the House of Lords Committee has criticised the application of the Mental Capacity Act including DOLS

• The Committee on the Mental Capacity Act has conducted recent scrutiny on whether the Act is ‘working’.

• The evidence presented was that the Act has not been well implemented.

• The findings were that the processes required by the Act are not widely known, and have not been adequately or consistently followed.

• Care of vulnerable young people and adults where restraint is likely to be necessary, even occasionally, would be a case in point.
Safeguarding plans

14.90 Once the facts have been established, a further discussion of the needs and wishes of the adult is likely to take place. This could be focused safeguarding planning to enable the adult to achieve resolution or recovery, or fuller assessments by health and social care agencies (e.g. a needs assessment under the Care Act). This will entail joint discussion, decision taking and planning with the adult for their future safety and well-being. This applies if it is concluded that the allegation is true or otherwise, as many enquiries may be inconclusive.

14.91 The local authority must determine what further action is necessary. Where the local authority determines that it should itself take further action (e.g. a protection plan), then the authority would be under a duty to do so.
Taking action via a plan

14.94 Once enquiries are completed, the outcome should be notified to the local authority which should then determine with the adult what, if any, further action is necessary and acceptable. It is for the local authority to determine the appropriateness of the outcome of the enquiry. One outcome of the enquiry may be the formulation of agreed action for the adult which should be recorded on their care plan. This will be the responsibility of the relevant agencies to implement.

14.95 In relation to the adult this should set out:
• what steps are to be taken to assure their safety in future;
• the provision of any support, treatment or therapy including on-going advocacy;
• any modifications needed in the way services are provided (e.g. same gender care or placement; appointment of an OPG deputy);
• how best to support the adult through any action they take to seek justice or redress;
• any on-going risk management strategy as appropriate; and,
• any action to be taken in relation to the person or organisation that has caused the concern.
Possible **reactive** safeguarding interventions when a care plan is not working, or there is no framework for the ‘imposition’ of a care plan....

- Use of the MCA’s framework on the basis of a reasonable belief in incapacity on the issue in question remembering Best interests start and stop there.
- Restraint or DoLS in term of risk to **self**
- Referral to the OPG as to concerns regarding a person with a responsibility such as a PoA
- Application to the Court of Protection – for a best interests order, deputyship, or ousting an attorney who is behaving badly
- Re-development of a care plan – a ‘safeguarding’ plan, in this context, for services
- Referral to the police where a crime is suspected – for criminal prosecution
- Referral to the Disclosure and Barring Service in relation to harm that has been investigated under Safeguarding
- Injunction on an incapacitated person’s behalf as their litigation friend – to evict a relative for instance – inherent jurisdiction if client is merely vulnerable, or Court of Protection if actually lacking in capacity
Various responses, continued

• Legal proceedings in the civil courts for unwinding a property transfer on the grounds of undue influence
• Guardianship – where the person would be seriously irresponsible, unless cared for
• Use of a Mental Health Act section where a risk warranting it is posed by the adult to him or herself
• Public Health Act – removal from one’s own home – insanitariness – to be repealed but the Public Health Act achieves nearly the same outcome.
• Protective injunctions under the Family Law Act 1995 or under the Protection from Harassment Act 1997
• Criminal Injuries Compensation Authority and the Criminal Injuries Compensation Scheme 2012
• Forced Marriage Protection Order
Safeguarding Adults’ Boards – in brief

S 43 Safeguarding Adults Boards

• (1) Each local authority must establish a Safeguarding Adults Board (an “SAB”) for its area.
• (2) The objective of an SAB is to help and protect adults in its area in cases of the kind described in section 42(1).
• (3) The way in which an SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does.
• (4) An SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective.

- Safeguarding Adults Boards are statutory
- Serious Case Reviews is made mandatory in certain situations
- There is a new duty to co-operate over information supply
Would advocacy have helped in the RE MW contact case?

• The facts: the man in question had an IQ of 71 but also schizoaffective disorder, a historical index offence, and was living on conditional discharge after a hospital order had been made.

• He had an old friend from when he was young, who was keen to help him, but not necessarily doing so in a way that other people approved of. In particular, MW’s sister, who was the main person in the man’s life, and who kept him on the straight and narrow.

• At one stage the social worker turned to the individual wanting the contact with the vulnerable adult, and said ‘We think you try to take over his life. He becomes anxious and dishevelled at appointments when you are around.’

• Obviously the friend could not be informal involver. But neither could the sister!

• There was a Court of Protection case for a declaration that contact by a third party, with the incapacitated person would not be in the latter’s best interests.

• The judge said this, of the friend: For him, these proceedings involve a friend for whom he cares deeply and that is enormously to his credit. He is on his own facing experienced barristers, and dealing with psychiatrists. It must be stressful and a little alarming. He has acquitted himself with courtesy and dignity and impressively so. JC has told me that he loves MW like a brother. It was JC who told me about MW’s father’s alcoholism, and how horrible he was to his wife MRW, to his children and in particular to MW. ...He agrees that the sister MGW is important, and that MW is a bit lazy and that she is a bit dominant.

• ‘...a slightly lazy or easily persuadable MW and tough dominant MGW works well. A dominant older sister is just what MW needs.’
What did the judge think?

“I have made it plain, if there is any suggestion that he has exploited MW financially, that is a misunderstanding which I have corrected on the record to his face and to the face of the professionals who continue to be involved.”

“It is not a question of JC, in the broadest sense, doing anything wrong; although in the strict sense, he has. He has broken injunctions which were in place and which he knew about. He felt that they were wrong.”

“I am afraid I cannot leave him to come to his own conclusion to override court orders reached on expert evidence. I am not saying he did it maliciously. I am not saying I do not value the support and friendship he represents, the link to the old days, the link to their common childhood, and he is part of the furniture, the wallpaper of MW’s life and mind; all those things should continue.”

“But I am afraid, on the history, that they need to have boundaries put around them…”

“The council obtained a final order restraining JC from visiting at the house, or staying there or residing there, but not from meeting with him out and about, as far as one can tell. A penal order was attached.
What would have helped here, perhaps, before it got formally ‘legal’?

• Agreeing a behaviour protocol?
• Agreeing meeting up out and about, but not at home, or at night?
• Mediation in relation to the sister and the friend’s different perspectives?
• The staff feeling confident about what a court could or might do, if things went that far, so that it could be explained?
• Would this be dealt with differently under the Care Act 2014?
Safeguarding adults from restrictive practices and ensuring the legal use of control and restraint

• ‘Positive and Proactive Care: reducing the need for restrictive interventions ‘ DOH 2014 – guidance document

• This policy was produced last year as a response the general view that guidance on restrictions and restraint was essential given the Winterbourne View Hospital investigations and a 2013 report by Mind. One of the findings by Mind was that in a single year one NHS Trust reported 38 incidents of physical restraint while another reported over 3,000!

• Evidence has shown that practices have been used to inflict pain, humiliate or punish. Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. These interventions have been used too much, for too long and we must change this.

• One of my clients remains clearly distressed by what he describes as the ‘rape and torture’ that he receives on his local acute admission ward.

• Another, young female client was supervised by eight members of staff whilst I was taking instructions (Broadmoor secure hospital)
Care Act – Information Sharing Record Keeping

• Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken. When abuse or neglect is raised managers need to look for past incidents, concerns, risks and patterns. We know that in many situations, abuse and neglect arise from a range of incidents over a period of time.

• In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action.
Care Act – Information Sharing Record keeping

• Staff should be given clear direction as to what information should be recorded and in what format. The following questions are a guide:
• What information do staff need to know in order to provide a high quality response to the adult concerned?
• What information do staff need to know in order to keep adults safe under the service’s duty to protect people from harm?
• What information is not necessary?
• What is the basis for any decision to share (or not) information with a third party?
Care Act – Confidentiality

• 14.157. Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults. Any agreement should be consistent with the principles set out in the Caldicott Review published 2013 ensuring that:

• information will only be shared on a ‘need to know’ basis when it is in the interests of the adult; confidentiality must not be confused with secrecy; informed consent should be obtained but, if this is not possible and other adults are at risk
Care Act – Confidentiality

of abuse or neglect, it may be necessary to override the requirement; and it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

• Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved.

• 14.159. Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.
Safeguarding adults from restrictive practices and ensuring the legal use of control and restraint

• ‘Positive and Proactive Care: reducing the need for restrictive interventions’ DOH 2014 – guidance document

• This policy was produced last year as a response the general view that guidance on restrictions and restraint was essential given the Winterbourne View Hospital investigations and a 2013 report by Mind. One of the findings by Mind was that in a single year one NHS Trust reported 38 incidents of physical restraint while another reported over 3,000!

• Evidence has shown that practices have been used to inflict pain, humiliate or punish. Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. These interventions have been used too much, for too long and we must change this.

• One of my clients remains clearly distressed by what he describes as the ‘rape and torture’ that he receives on his local acute admission ward.

• Another, young female client was supervised by eight members of staff whilst I was taking instructions (Broadmoor secure hospital)
Guidance – Key Actions

• Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor.

• If restrictive intervention is used it must not include the deliberate application of pain.

• If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.

• Staff must not use seclusion other than for people detained under the Mental Health Act 1983.

• People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.

• Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.
Guidance – Key Actions - Leadership

• At board level, or equivalent, lead must be identified for increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions.

• Boards must maintain and be accountable for overarching restrictive intervention reduction programmes.

• Executive boards (or equivalent) must approve the increased behavioural support planning and restrictive intervention reduction to be taught to their staff.

• Governance structures and transparent polices around the use of restrictive interventions must be established by provider organisations.

• Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers.

• Providers must report on the use of restrictive interventions to service commissioners, who will monitor and act in the event of concerns.

• Boards must receive and develop actions plans in response to an annual audit of behaviour support plans.
Guidance – Key Actions - Transparency

• Providers must ensure that internal audit programmes include reviews of the quality, design and application of behaviour support plans, or their equivalents. [Paras 58, 109]

• Accurate internal data must be gathered, aggregated and published by providers including progress against restrictive intervention reduction programmes and details of training and development in annual quality accounts or equivalent. [Paras 111, 118]

• Service commissioners must be informed by providers about restrictive interventions used for those for whom they have responsibility. [Paras 109-128]

• Accurate internal data must be gathered, aggregated and reported by providers through mandatory reporting mechanisms where these apply, e.g. National Reporting and Learning Service (NRLS) and National Mental Health Minimum Data Set (NMHMDS). [Paras 110-112]
Guidance – Key Actions - Monitoring

- Care Quality Commission’s (CQC) monitoring and inspection against compliance with the regulation on use of restraint and its ratings of providers will be informed by this guidance.
- CQC will review organisational progress against restrictive intervention reduction programmes.
- CQC will scrutinise the quality of behaviour support plans which include the use of restrictive interventions.
Restrictive Interventions

17. ‘Restrictive interventions’ are defined in this guidance as:

- ‘deliberate acts on the part of other person(s) that restrict an individual’s movement, liberty and/or freedom to act independently in order to:
- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- end or reduce significantly the danger to the person or others; and
- contain or limit the person’s freedom for no longer than is necessary’.
Ensuring the legal use of control and restraint

• What is restraint?
• The restriction of movement or liberty.
• Something which prevents us from doing what we would desire to do.
• The intentional restriction of a person’s voluntary movement or behaviour.

• Types of Restraint
• Physical - holding or moving a person. Blocking a person’s movement, preventing them from leaving,
• Mechanical – use of equipment, bedrails, chair belts, locks and keypads
• Technological surveillance – tagging, pressure pads, cctv, door alarms used to alert staff when a person tries to leave. Can then trigger physical restraint.
• Chemical Restraint - use of medications to restrain. Regularly prescribed medication, PRN, over the counter or illegal drugs. **Bournwood case**
• Psychological Restraint – constantly telling the person not to do something, or that doing what they want is not allowed, or is too dangerous. May included depriving lifestyle choices – what time to wake up or to go to bed or depriving equipment
Restraint

• These methods are increasingly being included within an individual agreed plan of care, provided they operate within organisational policy, clear guidance and risk assessment.

• If an action fits the definition of restraint, it is not automatically unacceptable or wrong. Malicious and abusive use of restraint can occur, decisions about restraint are not easy or straightforward.

• Important to understand the difference between unacceptable or abusive restraint and the rare circumstances in which restraint may be justified or positively required, to help strike the right balance between independence and safety.
When may restraint be used?

- Displaying behaviour that is putting themselves at risk of harm
- Displaying behaviour that is putting others at risk of harm
- Requiring treatment by a legal order, for example, under the Mental Health Act 2007
- Requiring urgent life-saving treatment
- Needing to be maintained in secure settings.
- This applies to individuals being cared for by nursing and social care staff working in all types of settings, including continuing care, mental health, forensic, critical care and care in the community.
Restraint as a last resort

- In most circumstances restraint can be avoided by positive changes to the provision of care and support.
- It should be noted that a person with capacity to consent might request items, such as lap belts or bedrails, to enhance their feeling of safety and/or security. Whilst this may not accord with a nurse’s recommendation, an individual’s choice should be acknowledged and included in a care plan and risk assessment. When a client cannot give informed consent, nurses should always explain what they are doing, seeking their understanding and agreement.
- A study suggests that even clients who were delirious when restrained, later remembered and valued nurses’ explanations of what was happening to them, particularly reassurances that nurses were trying to keep them safe (Minnick, Leipzig and Johnson, 2001).
Example of good practice

• Recent design principles to help clients with dementia have led to the development of small family-orientated households that support 12 older people, with a ratio of one member of staff to five clients. Through a design that excludes corridors – which can often be confusing for people with memory impairment – these units help clients to live more independently, be involved in purposeful activity and have safe access to a secure garden.

• Cues for behaviour, memory and reality are provided within the design, helping people with dementia to maximise their independence, reducing their reliance on others. An open plan environment enables staff to observe residents without high levels of intrusion. Meanwhile a ‘no uniform’ policy removes the constant reminder that staff are different from clients. The creation of a comfortable, relaxed environment where individuals feel valued, confident and safe reduces incidences of older people trying to leave the building or presenting with challenging behaviour, which may often lead to restraint. In addition, staff who try to understand the underlying reasons for a person’s behaviour, and what that person is attempting to communicate, are more likely to help clients in distress. In essence, a combination of well-considered environmental features and a workforce that has developed person-centred care reduces the need for inappropriate restraint.

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Legal justification for restraint

• Situations in which restraint can be justified include
• where the client gives informed and voluntary consent as part of a planned programme of care.
• professional duty of care to restrain a client to protect that client from a greater risk of harm, or to avoid a foreseeable risk of harm occurring to others.
• Nurse or patient is being attacked or is at risk of physical harm, it is possible to justify the use of restraint as self defence.
• Mental Health Act 2007, prevention from leaving a hospital, to administer medication, to prevent harm to the patient or others.
Restraint and MCA

- The Mental Capacity Act 2005 sets out the conditions in which an act may be planned that would constitute restraint of a client who lacks capacity. Restraint is defined in the Act as action that uses, or threatens to use, force to secure the doing of an act which the client resists, or restricts the client’s liberty of movement, whether or not the client resists.
- This legal authority to restrain a client is allowed only if the following three conditions are satisfied:
  - The client lacks capacity in relation to the matter in question
  - The nurse reasonably believes that it is necessary to do the act in order to prevent harm to the client
  - The act is a proportionate response to a) the likelihood of the client’s suffering harm and b) the seriousness of that harm.
- Escorting residents across busy roads.
- When does restraint on liberty become a deprivation?

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Recent case law on evaluating capacity and best interests in a safeguarding situation

- **Re UF:** UF had moderate vascular dementia. After detention under s2 Mental Health Act, she was placed in a care home under authorisations under the DoLS provisions.

- The best interests assessors in their reasoning had had regard to the long standing and current disputes between UF’s children.

- UF’s daughter (‘D’) was of the view (having seen her mother on a regular basis) that her mother had the capacity to reach the relevant decisions and reported that her mother had expressed to her in strong and worrying terms that she did not want to be at the care home. In her view, her mother would be much better placed back in her own home with an appropriate care package.

- But UF’s other children felt that it was in their mother’s best interests to remain in the care home.

- Applying the Court of Protection Rules, Rule 140, the Judge found that it was not appropriate for D to act as UF’s litigation friend as, on the evidence, she had apparently been unable to take a balanced and even-handed approach to the relevant issues. The judge held that this was a case that required the independence of the Official Solicitor to address both UF’s capacity to litigate and her ability to make the relevant decisions.
UF had been admitted into a care home in a crisis situation but had been there now for many months– a family member admitted to an independent social worker that she "tricked" her mother into making the journey there.

In a challenge under section 21A Mental Capacity Act 2005 to the standard authorisation of deprivation of liberty by AF, UF’s daughter, the issues to be decided by the court were:

• Was it in UF’s best interests to return to her home to live with a contingency plan of maintaining her current placement for a period of time?

• Should a **direction** be given to the Lasting Power of Attorney (“LPA”) finance about releasing equity from UF’s property to pay for her care?

• Should the LPA holder, over finance, be replaced by a Deputy appointed by the Court?

• Would any care regime at home **still** represent a deprivation of liberty?
The course of proceedings

• In 2014 Theis J had directed that it would be lawful for the parties to make arrangements on UF's behalf for her to have a trial period of being cared for in her own home, and to make arrangements so that all necessary care was delivered. That had not in fact happened, awaiting this fuller enquiry on the evidence.

• UF’s children were now bitterly divided about the arrangements for UF’s care. The Official Solicitor, felt it was in UF’s best interests to be permitted to return home as this was in accordance with UF’s wishes, the least restrictive option, and feasible, both practically and financially.

• However, the Official Solicitor recognised that UF may not in fact respond well to a return home and that this may also not last more than 12-14 months in any event, given that UF’s financial resources would expire by then.

• An independent social worker also produced a report for the court, favouring UF’s returning home. He marginally favoured UF returning home, describing this as "positive risk taking".

• X County Council advocated strongly that it was in UF’s best interests to remain at the care home, where she was being well cared for and where she had now settled. The view of X County Council was shared by four of UF’s other children.
A perfect example of an inappropriate ‘advocate’ or informal involver under the Care Act

• The judge said this of the views of the most vehement family member:
  – “Her opinions (expressed both in writing and in oral evidence to me) tend to be dogmatic; she has a confident and unshakeable belief in the correctness of her own opinions, and believes that she has a particular and unique ability to assess the situation concerning her mother.
  – She told me, when cross-examined by PK, that "I feel I know her (i.e. UF) better than anyone. We have a closeness which is envied by everyone. It is unrivalled...".
  – AF is unrepentantly critical of X County Council, and separately (and in similar measure) of the care regime at The Elms. Her evidence on some key issues lacked a degree of objectivity or nuance; this was not at all surprising given her understandable emotional investment in the issue and the outcome; however, I was left by the end of the hearing considering that I should treat her opinions with a little caution.”
The balancing act

- Having reviewed all of the material presented to the court, Mr Justice Cobb reached the conclusion that it was in UF’s best interests that she remain at the care home. The case for UF to return to her home was mounted very substantially on UF’s expressed wishes to “go home” but the court was not satisfied that she had a sufficient or consistent understanding of what was meant by going “home”.

- The evidence presented demonstrated that UF’s view had been neither consistent, nor clear. In addition, the independent social worker (“ISW”) had stated that his opinion that UF should return home was qualified by the essential requirement for a “robust care package”.

- The assessment by the ISW of the care package was predicated on the basis that UF showed no sign of aggression or hallucination, but reports from the care home and by UF’s family made it clear that she did show aggression and there were signs of hallucination, so the care package in those circumstances was more problematic.
The outcome, after conscientious balancing – timely, in relation to the Care Act’s emphasis on positive risk taking...

- Mr Justice Cobb was satisfied that UF was now settled in the care home and that she would be safer there than she would be at home. In his judgement, it would be enormously disruptive to move her back home, only for a short time, followed by moving to another care home.

- “Mr. Watkins is right to describe a plan to move UF to Ridgeways as 'risk-taking'; I agree that it would be. Where he and I differ is that I do not regard this as 'positive risk-taking'.”

- Her home would have to be sold. The LPA finance holder was not in fact challenged by the sister who had sought to move her mother back home.

- The standard authorisation was extended to allow for the normal process of renewing standard authorisation to take place. The Court received extensive and helpful submissions from counsel on the issue of deprivation of liberty in the home.

- In the final analysis, the parties agreed that as a matter of fact UF would have been deprived of her liberty had her moving back home been authorised as in her best interests. The judge would have been likely to agree. This would have then led to consideration of a court authorised order, as DoLS would not have been applicable.
The link between non application of public law principles, and safeguarding issues arising out of council’s financial difficulties is obvious

• Recent cases such as UF chime with the earlier *KK v STCC* case, in which an ‘unwise’ decision to refuse residential care was one which was upheld as potentially capacitated, if only the council’s staff strove to act compliantly with the MCA, *and were open and up-front about what they would offer, were the lady to be adamant in her refusal of care in a care home.*

• The judge there used the words ‘all *practicable* support’ as the notion of what was open to and necessary for a council to acknowledge that it would still need to provide in those circumstances.

• The Care Act requires that councils *fund for sufficiency*; that they do not let age determine the discharge of any of their functions, and that they do not fetter their discretion, and allow customers to assert reasonable preferences when discussing ways to meet need – preferences that *sometimes* justify spending more than the cost to the council, for best value reasons based on wellbeing or desired outcomes etc.
which is an almost faultless summary of 20 years of community care case law:

• “In determining how to meet needs, the local authority may also take into reasonable consideration its own finances and budgetary position, and must comply with its related public law duties.

• This includes the importance of ensuring that the funding available to the local authority is sufficient to meet the needs of the entire local population.

• The local authority may reasonably consider how to balance that requirement with the duty to meet the eligible needs of an individual in determining how an individual’s needs should be met (but not whether those needs are met).

• However, the local authority should not set arbitrary upper limits on the costs it is willing to pay to meet needs through certain routes – doing so would not deliver an approach that is person-centred or compatible with public law principles.

• The authority may take decisions on a case-by-case basis which weigh up the total costs of different potential options for meeting needs, and include the cost as a relevant factor in deciding between suitable alternative options for meeting needs.

• This does not mean choosing the cheapest option; but the one which delivers the outcomes desired, for the best value.”
The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances:

- The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.
- LA’s cannot cope. Some are giving the wrong advice (standard authorisation rather than urgent)
- Patients waiting for months for assessment.
- Are these safeguarding issues??
Thank you for reading this!

• We are supplying trained-up trainers, at affordable rates, for courses over a fairly intense period 2015.

• We never give an opinion about what the law means without having a reason to go with it.

• We think that Suzy Braye’s and Michael Preston-Shoot’s 2011 plea for ‘legal literacy’ in the context of self neglect, is an idea whose time has finally come, within adults’ social care...

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