Safeguarding Adults
NORTH EAST LINCOLNSHIRE

1.

AA is a 76-year old woman who has difficulties with memory and self-care. She has family members who visit her at home, and involvement with mental health services and adult social care. Despite having these networks around her, her presentation and health declined significantly over the course of several months leading to concerns over her health.

2.

The decline in AA's circumstances eventually resulted in her being admitted to a psychiatric unit. At the unit, they cut AA's hair due to its condition and it was noted she had severe head lice in her hair, under her armpits, under her breasts and in her groin. AA was found with dried faeces and a severe case of scabies across her body. She also had a rash on her arms, legs, chest and abdomen. It seemed AA had been scratching herself so severely that the wound sites had become infected. The decision to intervene in AA's self care was done in her 'best interests'. Whilst it is agreed AA received the help she required at the unit, it is queried if 'less restrictive' options could have been considered prior to these steps being taken.

3.

Concerns relating to AA's personal care and health were raised roughly six months prior to her admission into the psychiatric unit by the Navigo worker allocated to AA; she described AA's headlice as one of the worse cases she had ever seen. AA was also not consistently allowing her family to help her. AA was deemed to have capacity to make these decisions; however, Navigo made a referral to Focus given the clear concerns regarding AA's self care.

4.

It is noted that AA's family were worried about AA, but they struggled to care for her. Despite them being very involved in AA's care, there was no evidence of AA's family being offered a carer's assessment. Upon Focus becoming involved, records showed AA's capacity came into question and the Navigo worker noted that she believed AA to lack capacity in relation to consent to/participate in an assessment of her care, support and treatment. The Navigo worker therefore continued to work with AA in her 'best interests'; however, no formal capacity assessment was completed in relation to this decision.

5.

Over the coming weeks, Navigo and Focus visited AA and she voiced she was coping; however, professional observations suggested differently. There appeared to be some reliance on family members to administer AA's treatment, despite it being known AA was resistant to this. Concerns around AA's headlice and scabies were also growing and AA's daughter started to question if her mother had insight into the concerns. Focus was considering if their involvement should end, given AA's lack of engagement with Focus. Despite the worries, AA's reluctance to accept necessary care from her family and professionals, there was no evidence of any ongoing considerations relating to AA's capacity and the implications of this.

6.

Some 2½ months after the Navigo worker initially noted her concerns around AA's capacity, Focus agreed a formal capacity assessment was required but that this could not be completed for a number of weeks. Prior to this assessment being completed however, the Navigo worker made an Independent Mental Capacity Advocacy (IMCA) referral and a Best Interests (BI) meeting was arranged. From this meeting plans were put in place to escort AA to hospital for medical treatment. AA was then informally admitted onto a unit where a capacity assessment was completed, and it was assessed that AA did not have capacity to consent to being admitted into the unit. She was then detained using holding power 5(2) of the Mental Health Act 1983.

7.

Good Practice:

- Persistence of a Navigo worker.
- Some creative ideas suggested by a Focus staff member to try to engage AA with treatments.
- There is evidence of liaison between the community nurses and the GP, and a prompt GP response.
- Navigo worker engaged AA's family in discussions of LPA/ Court of Protection processes regarding AA.
- Navigo worker actively sought out the previous views and wishes of AA from the family and secured an IMCA to promptly represent AA at the BI meeting.

Learning

A key element in this case is the absence of formal capacity assessments. At an early stage some evidence of memory issues, confabulation, and cognitive impairment are recorded; however, there was a delay of 12+ weeks before a formal assessment was completed.

There was lack of clarity between roles and responsibilities of agencies and family carers, especially with regard to the administration of treatment for the head lice and scabies. The family members had described AA's reluctance for them to administer treatment; however, an alternative does not appear to have been sought, and the emphasis appears to have been on the family to persist.

AA is reported to have left her home willingly to accept treatment on the ward, and it is not known whether this could have been successfully achieved without admission, as the administration of the treatment does not appear to have been suggested or attempted by anyone other than family members within the home environment.