Ombudsman
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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mr A against Caerphilly County Borough Council

A report by the Public Services Ombudsman for Wales

Case: 200901188

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Introduction

This report is issued under section 21 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of this Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr A.

Summary
Mr A complained about Caerphilly County Borough Council's response to allegations that family members had injured his mentally impaired adult son, "H". In particular, he was concerned that H was moved to a care home without a court order, about the adequacy of a protection of vulnerable adults (POVA) investigation, about the time the POVA investigation took, about the standard of communication with the family, and about the Council's response to letters from the family's solicitor and their AM.

The Ombudsman found that the delay in completing the POVA investigation was due to the time the police took to conclude their investigations and was outside the control of the Council. The Ombudsman did identify some limited failings by Council staff in the POVA process; in particular there was a failure to obtain an adequate medical assessment of H on two occasions. The Ombudsman also considered that once it was apparent that the police investigation would take some time, the Council should have sought legal advice about the basis for H remaining in residential care.

The Ombudsman found that while communication between H's social workers and the family was generally good, it could have been improved by written updates after POVA case conferences. He also considered that the family should have been given the opportunity to meet with the POVA Coordinator. The Ombudsman accepted that there was a limit to the information which could be given to the family and their representatives while the police investigation was ongoing; however, he criticised the Council for not addressing some of the points raised by the family's solicitor.

The Ombudsman partially upheld Mr A's complaints. He recommended that the Council should apologise to the family for the failings he had identified, and also made some procedural recommendations aimed at improving the Council's POVA process.

The complaint

1. Mr A complained about the way the Council dealt with accusations that members of his family may have harmed his mentally disabled adult son, H. H was taken into care while the accusations were being investigated and Mr A complained that this was done without a court order. He complained, too, about the length of time the investigation took, as this meant that H was away from his family for eight months. Mr H also complained that there was a lack of communication between the Council and his family and that the Council failed to adequately respond to letters from their solicitor and their local Assembly Member.

Investigation

2. One of the Ombudsman's investigators obtained comments and copies of relevant documents from the Council and these were considered in conjunction with the evidence provided by Mr A. Advice was obtained from one of the Ombudsman's Professional Advisers, a senior social worker. Her report is attached as Appendix 1. Both Mr A and the Council were given the opportunity to see and comment on a draft of this report before the final version was issued.

3. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

4. I have issued this report under the authority delegated to me by the Ombudsman under paragraph 13 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2005.

Relevant legislation, policy and procedures

5. Extracts from the relevant legislation, policy and procedures are set out in Appendix 2.

The background events

6. Mr A and his wife have two adult sons, G and H. H has a mental impairment and needs large amounts of support. Before the events complained about, H's normal routine in the week was to go to a Day Centre (both Mr and Mrs A work) before returning home in the evening. He would then have a snack and wash and change with the assistance of a support worker. The support worker would then take H out for few hours in the evening before returning him home.

7. On 5 January 2009, H's key worker at the Day Centre (the Key Worker) noticed that H had a red mark on his face. He asked H what

had happened, and H apparently told him that he had "burnt it" and that G had done it (it should be noted at this point that H will invariably refer to any bruise or injury as a burn). The Key Worker discussed the situation with H's social worker (the Social Worker) and took H to his GP. However, the Key Worker and H left before the GP could fully examine H as the Key Worker was concerned that H might otherwise miss his transport back home. Mrs A was told about the incident the next day.

8. A POVA[1] strategy meeting was held on 12 January and it was agreed that the Police would investigate the allegations.

9. On 5 March, H returned from the Day Centre as normal. While preparing H to go out for the evening, H's Support Worker (the Support Worker) apparently noticed that H appeared to have a black eye and scratches on his body. When the Support Worker asked H about this he replied that he "burnt it". The Support Worker took H out as normal and then telephoned his manager. She in turn contacted the Social Worker. It was decided that H should not return home and he was taken to a care home (the first Care Home).

10. The POVA investigations continued, and Mrs A was suspended from her job with the Council. H was moved to a second care home (the second Care Home). It was not until July 2009 that the Police concluded that there was no case to answer. The POVA investigation came to an end in August 2009 and Mrs A's suspension from work was lifted. As Mrs A was due to go abroad for a while in October, it was agreed that H would not return home until November 2009.

Mr A's evidence

11. In his complaint to the Ombudsman, Mr A said that H will say the first thing that comes into his head and had in the past blamed G for things even when G was not there at the time. Mr A said that H will pick and twist his cheek, particularly if distressed, and therefore needs watching constantly. Mr A was concerned that the Key Worker had not waited at the GP surgery for the GP to examine H. He understood that the GP had been annoyed by this and had written to the POVA Coordinator about it. Mr A said he was concerned that the POVA Coordinator appeared to have ignored this letter and not drawn it to the attention of his successor.

[1] Protection of vulnerable adults.

12. Turning to the incident on 5 March, Mr A said that neither the bus driver who brought H home from the Day Centre nor his assistant noticed any marks on H. Mr A said that his wife did not notice any marks either. Mr A said he could not understand why Social Services did not ask the staff on the bus if they had seen anything before taking H away from the family. He said, too, that they had never been shown any photographs of H's alleged injuries.

13. Mr A said that when H was removed from their care they did not receive any letter of explanation, there was no court order, and the only communication with the family was a telephone call from the Social Worker.

14. Mr A said that after H was taken to the first Care Home, they raised their concerns via their solicitors and their AM. Mr A said that the solicitors and AM came up against a "blank wall" and did not receive a response from the Council.

15. Mr A said that the situation had dragged on for months, causing the family unnecessary distress, anxiety and depression.

The Council's evidence

16. In its written response to the Ombudsman, the Council said that in relation to the family's complaint about lack of communication, decisions about what information can be shared are informed by the POVA Guidance. The Council said that in this case family members were suspected to be the perpetrators of the alleged abuse and as such there was a limit to the information which could be shared with them.

17. That said, the Council said that throughout the process there had been communication between the family and Social Services, mainly through conversations with H's social workers. The Council provided copies of notes of the conversations. The Council said that consideration was given to Mrs A's concerns, and feedback given to her by officers. It added that contact was arranged between H and Mr and Mrs A while H was at the care homes.

18. The Council said that it acknowledged the distress that families experience when they are the subject of allegations of this nature. However, the Council said that where the Police are undertaking a criminal investigation, care has to be taken that communication with the alleged perpetrators does not undermine the Police investigation.

19. The Council said that throughout the case consideration was given to H's mental capacity (in particular whether he had capacity to decide where to live) and for that reason an Independent Mental Capacity Advocate (IMCA)[2] was commissioned to provide support to H.

20. The Council said that after the POVA process came to an end, Mrs A was visited at home on 20 August 2009 by H's then social worker (the second Social Worker) and the Police investigating officer (the Detective Sergeant) to inform her of the outcome. The Council said that Mrs A then returned to work and the Council's Customer Service and Performance Coordinator contacted Mr and Mrs A and visited them at home to discuss how to take their complaints forward.

21. Turning to the letter from H's GP about the 5 January incident, the Council said that this was placed on file as part of the POVA records and would have been available to relevant staff. The Council said that the contents would have been discussed with the GP as part of the POVA process, but she did not attend any of the meetings, despite being invited.

22. The Council said that it had reviewed the minutes of the POVA meetings and was satisfied that the POVA Coordinator had acted in line with the POVA Guidance. The Council commented that the decisions made in POVA meetings are the outcome of discussions between professionals from a wide range of organisations. The Council said that the POVA minutes show that there was no disagreement between the group members about the decisions made.

23. Turning to Mr A's concerns that the bus driver and his assistant had not been spoken to at the outset regarding the 5 March incident, the Council said that the investigation of any potential witnesses was a matter for the Police.

24. The Council said that the family's cultural needs were taken into account. It said that an Asian support worker had been arranged to support H and that it had considered Mrs A's request for an Asian social worker (albeit had not been possible to provide one). The Council said that when Mrs A queried whether the family were being discriminated against due to their ethnic origin, the second Social Worker discussed this with Mrs A and assured her that the difficulties the family were

[2] A independent person whose role is to support and represent a person who lacks mental capacity to make decisions in certain circumstances. Representations made by an IMCA must be taken into account by the organisation or person when making a decision about the person lacking capacity.

experiencing were due to the length of time the Police investigation was taking rather than prejudice about their ethnicity.

25. Turning to the occasion the Key Worker took H to his GP, but did not stay long enough for the GP to carry out a full examination, the Council said that the Key Worker and H saw the GP, who examined H and asked for more information. The Council said that the Key Worker was unable to provide this information so the GP left the room to telephone Social Services. The Council said that the GP was out the room for a substantial amount of time so the Key Worker asked a receptionist how long the GP was going to be. The Council said that the receptionist said the GP would only be a couple of minutes so the Key Worker waited with H for a further 5 – 10 minutes. The Council said that the Key Worker did then leave as he was mindful that they needed to be back at the Day Centre in time for H to catch his bus back home. The Council said it supported the Key Worker's actions as he did not have the authority to remain at the Surgery when doing so could have risked H missing his transport home.

26. The Council said that it had not applied for a court order to house H in the care homes as it was acting under the "doctrine of necessity" as codified in the Mental Capacity Act 2005. It said that in this case, H had been assessed as lacking the mental capacity to decide where to live and it was deemed too risky for him to return him home while the POVA investigations were ongoing as family members were alleged to be the perpetrators. The Council said that an IMCA was commissioned to advocate on H's behalf and it noted that the IMCA had the power to make a referral to the Court of Protection at any time if she had considered H's rights were being infringed. The Council said that if the allegations had been proven then it would have applied for a court order. The Council said it considered that it had followed the relevant statutory guidance on mental capacity and did not consider H's rights were breached as he had regular contact with his family while the POVA investigation was ongoing.

27. The Council said it had undertaken a POVA case review to see what lessons could be learnt from this case. It said that this had concluded that it would have been good practice to have attempted to obtain an informal written agreement from Mr and Mrs A that H would be moved to a place of safety for his protection and theirs while the allegation was being investigated. The Council said that had this not been forthcoming then its legal services would have been consulted. The Council reiterated, however, that it believed it had acted in

accordance with the relevant legislation and guidance about mental capacity in this case.

28. The Council acknowledged that there were delays in the POVA process in this case. It said that the factors contributing to the delays included:

- The Police Authority underwent restructuring leading to the formation of a dedicated Police POVA team.
- The original Police investigating officer went on maternity leave, thus delaying the Police investigation.
- There was a change in the POVA Coordinator during the investigation.
- There was a change in social worker during the investigation.

29. The Council said that it was unable to progress the POVA investigation while the Police investigation was ongoing; however, it acknowledged that changes in key personnel within Social Services added to the lack of momentum. The Council said it wished to apologise to Mr and Mrs A, and to H, for the delays they experienced in the POVA investigation.

30. The Council said that joint working with the new Police POVA team had since resulted in a significant improvement in the timeliness of investigations.

31. The Council said that it had responded to the letters it received from Mr and Mrs A's AM, albeit it had not been able to provide a full response at the time as the POVA process and the Police investigation were still ongoing. The Council said that it had acknowledged the letters sent by Mr and Mrs A's solicitor.

Professional advice

32. The Ombudsman's Professional Adviser's report is at Appendix 1.

Analysis and conclusions

33. In reaching my conclusions I have been guided by the advice of the Ombudsman's Professional Adviser.

34. Mr A complained about the response of the Council's Social Services Department to allegations that members of his family had injured his son. In particular, he is concerned that H was moved to a care home without a court order, about the adequacy of the POVA investigation, about the time the POVA investigation took, about the standard of communication with the family, and about the Council's response to letters from the family's solicitor and their AM.

35. I would like at the outset to acknowledge that this must have been a difficult and distressing time for the family; however, it is also important to recognise that the Council and other agencies did have a responsibility to act on the concerns that had been raised. As the allegations on 5 January 2009 and 5 March 2009 related to possible physical injuries to H, the Police needed to be involved. The POVA Guidance states that any Police investigation must take priority and as such the Council could do little while the Police investigation was ongoing.

36. It is regrettable that this process took as long as it did. H was removed from the family home in March 2009, but the POVA investigation did not end until August 2009. That said, the Council was obliged to wait for the outcome of the Police investigation and I cannot criticise the Council for a delay that was out of its control. In addition, it is clear from the records that I have seen that the POVA Coordinators made repeated and frequent efforts to encourage the Police to complete the investigation. As such, I do not consider that there was much more that the Council could have done in the circumstances. I therefore do not uphold the complaint that there was undue delay on the part of the Council.

37. Turning to the Council's role in the POVA process, it is apparent that regular meetings were held and comprehensive minutes were kept. Overall, the records I have seen are of a high standard. Mr A was concerned that the bus driver and his assistant were not spoken to at the beginning about the incident on 5 March 2009, but as the Council has pointed out, the investigation was the responsibility of the Police, and I cannot therefore criticise the Council on this point. I have also not found any evidence to indicate that Mr and Mrs A were discriminated against on the basis of their ethnic origin.

38. As the Ombudsman's Adviser has pointed out, there were some failings on the part of the Council; in particular its staff did not obtain an adequate medical assessment following the January and March 2009

allegations. To this extent only I partially uphold this part of the complaint.

39. I turn next to the question of whether the Council should have obtained a court order before moving H to residential care. Ultimately this is a matter for the courts rather than the Ombudsman; however, I share the Ombudsman's Adviser's concern that there is little evidence that consideration was given to whether or not a court order should have been applied for. As the Adviser has said, it was reasonable for H to have been moved to the first Care Home in the short term to protect him from potential harm (and his family from further allegations) while the POVA investigation began. In fairness to the Council, it also probably did not expect the Police investigation to go on as long as it did. However, with hindsight I consider it would have been prudent for the Council to have taken legal advice on the matter and ensured that the ensuing discussions were documented. I was pleased to note, also, that the Council has said that following a review of this case it will in future cases seek an informal agreement with the family involved. I therefore only partially uphold this part of the complaint to the extent that once it became apparent that the Police investigation was going to take some time, legal advice should have been sought about the basis for H remaining in residential care.

40. I turn finally to the communication with the family, both directly and via their solicitor and AM. It is clear from the records that the social workers spoke regularly to the family (Mrs A in particular) and kept them up to date with developments. This is commendable. However, as the Ombudsman's Adviser has identified, it would have been preferable had the family also been given written updates following the POVA case conferences and been offered the opportunity to meet the POVA Coordinator. I accept that given the Police investigation was ongoing the amount of information that could be shared was limited (I do not consider, for example, that the family could have attended the POVA meetings), but I agree that more could have been done to allay their concerns by providing written information to reinforce what they were told verbally by the social workers. Similarly, while some responses were provided to the AM which (correctly) pointed out that there was little that could be said while the Police investigation was ongoing, it is disappointing that the letters from the solicitors appeared to only be acknowledged and no response was given to the solicitor's questions about why a court order had not been applied for. I therefore partially uphold this part of the complaint.

Recommendations

41. I recommend that the Council apologises to Mr and Mrs A for the failings identified in this report.

42. The Ombudsman's Adviser has, at paragraph A107 of her report, identified some constructive suggestions for future improvements. I therefore also recommend that the Council carries out the recommendations proposed by the Ombudsman's Adviser.

43. I am pleased to note that in commenting on the draft of this report the Council has agreed to implement these recommendations.

Suzanne Ryan
Investigation Manager

18 October 2010

Appendix 1

Report of the Ombudsman's Professional Adviser

A1. This report has been prepared at the request of the Ombudsman to consider a complaint by Mr A against Caerphilly County Borough Council. The report has been prepared by Ruth Forrester BSc MA CQSW DMS MBA, a Registered Social Worker with the Care Council for Wales.

A2. Mr A is the father of H, a man with severe learning difficulties. The complaints arise from the removal of H from the family home in March 2009 because of concerns about alleged abuse of H. H did not return home until November 2009.

Sources of information

A3. The Ombudsman originally provided a summary of the complaint. Further documentation was sought from the Council. This included the POVA Guidance; case records relating to H; POVA records; and health service records.

Methodology

A4. Under the All Wales Complaints Procedures, it is normal in such circumstances for the local authority to commission a Stage 2 investigation. This is undertaken by a person independent of the local authority and it consists normally of interviews with the complainant and his or her family and the agencies involved, as well as a review of the file. There was no local investigation in this case and this has disadvantages for the preparation of this report, because the complainant, family members and agency workers have not had the opportunity to speak directly about their concerns or to answer questions.

A5. The weakness of this report is the absence of direct discussion with the complainant and the agencies involved and although the local authority and the health service have co-operated fully with providing additional documentation, this cannot be a substitute for direct interviewing.

A6. Approximately 108 documents were reviewed to construct a chronology of events.

H

A7. H is an adult man who normally lives with his parents, Mr and Mrs A, and their other adult son, G. Mrs A works for the Council.

A8. H has moderate to severe learning difficulties and Autistic Spectrum Disorder. Assessments record that he is "echolalic in his responses". In other words he echoes what is said to him.

A9. H was supported at home by attendance at a Day Centre. He was taken out regularly by support workers and was also reviewed from time to time by a Consultant Psychiatrist. He had a nominated key social worker. H's services are provided by a team with staff from health and social services. Some services are commissioned from the private and voluntary sector.

A10. An assessment of H's mental capacity was carried out in 2008. This clearly illustrated that H was not capable of consenting to key decisions, for example giving agreement to moving out of his family home. This is a crucial factor in evaluating the decisions made about H subsequently. Later assessments have not found any change in his capacity to make key decisions.

Policy and Legal Framework

A11. Because of concerns about the abuse and neglect of vulnerable adults, a framework has been developed to respond to allegations and concerns. This is called "POVA" or the Protection of Vulnerable Adults. The procedure used by the Council was developed by the South East Wales Executive Group for the Protection of Vulnerable Adults.

A12. There are a number of laws relevant to the POVA process. These are listed in the POVA Guidance. In addition, the Mental Capacity Act 2005 empowers people who lack capacity to make decisions. The Mental Capacity Act is important to this case because the Council relied heavily on a "best interests" defence under this Act to justify its decision making in this case.

Timeline of key events

05/01/09	POVA Concern 1: Marks on H's face noted by Key Worker.
05/03/09	POVA Concern 2: Marks on H's face and arms reported by the Support Worker. H removed from family home. He was taken to a care home by the Domiciliary Care Agency

	Manager. The decision to arrange the placement was made by the Social Services Team Manager.
09/03/09	Mrs A was suspended from employment by the Council.
15/03/09	H moved from first to second Care Home.
July 09	Police Investigation of both concerns completed. The police are to take no further action.
19/08/09	POVA process closed.
Sept 09	Family decide to pursue a complaint through the Ombudsman
16/09/09	Mrs A's suspension lifted. Arrangements made for her to return to work.
03/11/09	Arrangements made for H to return to the family home on 10/11/09.

Narrative

A13. I have not been provided with records relating to H before 2008. I was originally provided with records relating to the key events of 2009. I requested additional records from 2008. The reason for this was to establish any concerns the Council had before the two POVA referrals in 2009.

A14. H was attending a local authority Day Centre each day during the week. He was also in receipt of Independent Living Fund money to purchase support in the evenings and at weekends. He is able to manage his own personal care and medication, but requires verbal prompts. He can make snacks but does not prepare cooked meals or hot drinks. He has 42 days respite care per year for 2 – 7 nights, apart from a longer block in October. He has annual reviews by a Consultant Psychiatrist working with a Community Learning Disability Nurse. Although H was receiving services from a number of different organisations, his social worker, employed by the Council, was the care manager and was responsible for coordinating the programme of help and support. H also had a key worker at the Day Centre he attended.

A15. On 5 January 2009, H made a "limited disclosure" to the Key Worker at the Day Centre about a mark on his temple and left cheek. H stated "[G] did it. Burnt it". His social worker discussed the issue with her Team Manager. It was agreed that a discussion would take place with H about how this happened, with his mother, and the marks would be reviewed by his GP. The Key Worker took H to see the GP, who had made a special arrangement to see H before afternoon surgery. The Key Worker told the GP that he was not able to give her details about the marks, although he eventually divulged that it was due to POVA

concerns. Whilst the GP was trying to get more details from the field social worker, the Key Worker left with H because he was concerned that H would miss the transport home from the Day Centre. When the GP returned, the Key Worker had left with H. The Key Worker subsequently tried to speak with Mrs A that evening by telephone.

A16. Mrs A was informed about the concerns the following day.

A17. A POVA Strategy Meeting was held on 12 January. It was agreed that the Police would investigate the allegations, and that Mrs A would be informed by the Social Worker. Mrs A was subsequently visited by the Social Worker and her manager, and was informed that because of unexplained injuries, the Police would be making enquiries.

A18. A further Strategy Meeting and POVA Case Conference were held on 16 February. G was interviewed by the Police on 4 March and denied assaulting H.

A19. A further POVA Strategy Meeting was held on 5 March. This was planned as a POVA Case Conference but the Police were not present and it was changed to a Strategy Meeting. The Strategy Meeting heard that the Police had interviewed G and that he had denied assaulting his brother. A further meeting was arranged and it appeared that Mrs A would either be invited to part of the meeting or might be visited by the Chair of the meeting.

A20. Later that day, H was removed from the family home because he appeared to have a black eye and scratches on his body.

A21. The Social Worker was contacted by the Support Worker's Manager. H had travelled home on the usual transport from the Day Centre. No injuries were noted by the Day Centre staff, minibus driver, or driver's assistant. H arrived home at about 4.30pm and was bathed by the Support Worker who noticed possible injuries. The Support Worker did not inform Mrs A but whilst out with H contacted his supervisor who contacted the Social Worker. The Support Worker had been working with H for a few weeks.

A22. The Support Worker said that H had bruising in the corner of his right eye and scratches under his right arm. The Support Worker asked H about the bruise and he replied "burnt it". The Support Worker did not ask H about the scratches because he believed they could have been caused by eczema.

A23. The Support Worker's Manager consulted the Social Worker who in turn consulted her Team Manager. The Team Manager advised that given this information, the history, and the current circumstances, it would not be safe for H to return home and it was arranged for him to be placed in the first Care Home. The incident was reported to the Police. The Social Worker contacted Mrs A by phone. Mrs A said that it was well documented that H self harms. She said her husband drew attention to previous concerns about bruising, but nothing was done at the time. Mrs A was reportedly very upset and tearful.

A24. The Social Worker contacted the IMCA by email to tell her of this development.

A25. The first Care Home prepared a body map recording possible injuries. The following were recorded:

- Red patch on side of cheeks, particularly around the left eye
- Mark on left upper shoulder blade – purple
- Bruising to right armpit
- Bruise on inner arm and tricep
- Bruise moving from side to back and under armpit

No medical opinion appears to have been sought by the Care Home.

A26. The following day (6 March) a POVA Strategy Meeting took place. It was agreed that the Council's Personnel Department should be notified, because Mrs A was its employee, the GP was to be asked for a medical opinion, and a reassessment by the psychiatrist was to be considered. The marks on H were photographed by a police scenes of crime photographer.

A27. The Social Worker rang Mrs A on 9 March. Mrs A had been suspended from her job. Mrs A said that H had been agitated when he came home from the Day Centre and had started to self harm again. She spoke of occasions when H had "pushed her flying" which had been witnessed by H's long term support worker. The Social Worker told Mrs A that supervised contact could be arranged. The Social Worker described Mrs A as agitated and confrontational.

A28. The Council's Social Services Department received a first letter from Mrs A's Assembly Member on 10 March asking for information. He

would write regularly to Social Services asking for the investigation to be completed.

A29. On 15 March, H was moved to the second Care Home.

A30. On 19 March a Professionals Meeting took place about the mental capacity assessments that were being undertaken and whether H had had his liberty deprived. An IMCA was present and shared information about her observations of H at the day centre and at home.

A31. On 19 March, a letter was sent from the Council's Social Services Customer Officer to the AM saying that Social Services could not disclose the whereabouts of H because of an ongoing criminal investigation.

A32. On 27 March there was a case note that H had slipped and twisted his ankle while on a visit to a mining museum. Mrs A discussed this with the Social Worker and was unhappy about the visit because H is frightened of the dark. The Social Worker was not aware of this and said it would be added to the assessment. Subsequently, Mrs A raised the visit as a Stage 1 Complaint with the Council's Social Services Customer Services Officer, and the matter was also raised in a letter from the AM, together with concerns about the delay in the POVA process. Mrs A also requested the allocation of a social worker from her own ethnic background.

A33. On 2 April a further POVA Case Conference was held. Those present included Social Services, the residential care provider, community nursing staff, IMCA, Speech and Language Therapy Assistant and Day Centre staff. No Police were present. H was reported to have asked for his mother a few times; however, he had been easily pacified. He was also reported to have come on in "leaps and bounds" since his placement at the second Care Home (though how precisely is not made clear). A Day Centre staff member reported less anxiety and that H was beginning to take pride in his appearance. It was reported that H had indicated that he wanted to see his mother. She had visited him at his previous placement and there were plans for her to do so in his new placement on 3 April. It was noted that this visit would be supervised by the "least intrusive method possible". The IMCA agreed that contact should be supervised. A discussion took place about deprivation of liberty and it was agreed that it was not felt that H was being deprived of his liberty due to the opportunities that were offered to

Mrs A to visit him on three occasions. It was noted that Mrs A had declined two of the dates offered.

A34. A mental capacity assessment was reported to have been "completed ... 12 months ago and it was concluded that [H] did not have the capacity to decide where he lives". The need for a further capacity assessment was discussed. There was no reference in either report to liaison with the Police. A further Strategy Meeting was also held on the same day with the same participants. The Strategy Meeting identified Mrs A and G as the alleged perpetrators.

A35. Mrs A decided to consult a solicitor and on 5 April, the Council received a letter from them. The letter asked about who made the decision to remove H, for what reason, the legal basis for the removal, and suggested the removal was illegal and breached Articles 6 and 8 of the Human Rights Act 1998. A holding letter was sent by the Council's legal department.

A36. Around this time there was a change of social worker from the Social Worker to the second Social Worker. There was a joint visit to Mrs A followed by a visit to H at the Day Centre.

A37. An assessment of H's mental capacity was conducted on 27 April by a Community Psychiatric Nurse. It was deemed that H did not have the capacity to make decisions about where he lived. When given multiple options, H would always choose the last option. The assessor also referred to H's "echolalic" responses.

A38. There was concern among Council staff about the lack of Police participation in POVA meetings, and the POVA Co-ordinator contacted the Police to emphasise the importance of Police participation in the meeting planned for 30 April. A POVA Case Conference and Strategy Meeting were held on that date. The Police were not present because the officer in charge of the case was on leave. The POVA Case Conference decided that the Chairman would contact the Police and impress on them the need for a resolution of the case.

A39. The Council's Overview Report indicates that numerous efforts were made to contact the Police to progress the investigation on 30 April, 8 May, 19 May, 27 May and 11 June. On 11 June, a police officer informed the Chairman that he had received the file, was on annual leave until 29 June, and that he had been unable to interview the Support Worker.

A40. The visits between Mrs A and H continued to be supervised. There were indications of H's unhappiness before, during, and after the visits, but it is not clear whether these were shared with his parents.

A41. The AM continued to raise concerns about H's continued absence from home and wrote to the Council on 21 May. The Department responded through the Customer Services Manager on 27 May that the investigation was Police led and that the Council could not offer any advice about the time frame of the investigation.

A42. The Consultant Psychiatrist reviewed H on 9 June. She reported that

> "[H] looks extremely well ... in this new setting ... [H] was verbally far more communicative than when I had seen him before. He was also quite relaxed and was socially interactive during ... the meeting ... Staff report no problematic behaviours."

The Consultant Psychiatrist was able to reduce H's medication and then discontinue it.

A43. On 26 June, Mrs A and the second Social Worker spoke on the telephone. Mrs A reported that she was suffering stress and asked if she was being discriminated against.

A44. A further POVA Strategy Meeting was held on 2 July. A new POVA Coordinator had been appointed and this person acted as the Chairman of the meeting. There was a new Police investigating officer (the Detective Sergeant) who was present and reported that work on the file for the Crown Prosecution Service had begun, but was on hold pending the completion of the investigation. It was noted that contact continued and that H enjoyed the visits by his parents. H was noted as being "very happy in his placement ... Day Centre concur with improvement". The IMCA felt that H had greatly improved and that it would be appropriate to assess his mental capacity prior to any decision being made about his accommodation. The second Social Worker noted that the Consultant Psychiatrist would prefer the decision about residence to be made by a Court. It was agreed that H would remain at the second Care Home while the investigation continued.

A45. On 3 July the second Social Worker rang Mrs A and told her that there was a new Police investigating officer.

A46. The new POVA Chairman rang the Detective Sergeant on 16 July and requested an update. On 22 July the Detective Sergeant visited H's family in their home. He spoke with family members under police caution. No family member was able to offer any explanation for the injuries noted on 5 March. G was told that the Police would not be taking any action regarding the first incident on 5 January. The Detective Sergeant took away diaries that detailed accidents and incidents of H self harming for many years.

A47. The Detective Sergeant prepared two reports on the allegations. The conclusions were as follows:

> **Pova Concern 1:** the Detective Sergeant noted that whilst in respite care, H would self harm by picking at his skin causing scabs. When asked about this, he would say he "burnt it on cooker". The Detective Sergeant commented that this could be an indication that H could provide false information. The mark on H could not be identified as a burn, scald or a bruise. Its origins were unknown. It was documented that H would refer to any imperfection on his skin as a burn.
>
> **Pova Concern 2:** the Detective Sergeant concluded that the injuries reported on 5 March could not have been inflicted by a member of H's family. This was based on interviews with Day Centre and transport staff who confirmed that no injury was visible in the period that H was in their care. The photographs prepared by the Police did not show any notable injuries. The mark on H's torso was widely accepted as a permanent feature and not an injury.

A48. On 23 July, Mrs A's solicitors wrote to the Council's Chief Executive outlining the history of the case since 6 January and complaining about its handling. The solicitors complained specifically about failure to provide information in writing; failure to inform about process; and failure to explain the powers exercised in removing H. The solicitors cited a recent court case.[3] Their view was that the Council should have applied to the High Court for a ruling that the placement was legal.

[3] London Borough of Ealing v KS & Ors [2008] EWHC 636 (Fam)

A49. On 24 July, there was a telephone conversation between Mrs A and the second Social Worker. Mrs A said that she was confident that she had been cleared after meeting the Detective Sergeant.

A50. On 28 July, the Council's Head of Legal Services sent a "holding letter" to Mrs A's solicitor.

A51. On 3 August, the second Social Worker received an email from the staff at the second Care Home saying that on recent visits, Mrs A had told H that he is going home.

A52. On 7 August, Mrs A telephoned the second Social Worker and asked about the progress of the investigation. Mrs A said that she had contacted a Community Psychiatric Nurse who had worked with H in the past and was willing to act as a character witness.

A53. On 19 August, a POVA Case Conference was held. The Police report was available to the Case Conference. A Community Learning Disabilities Nurse questioned the use of the "best interests" route to remove H from home, rather than the use of an application to court. The residential manager reported that H had made great progress during his placement, including speech and communication, increased independence, and increased ability to carry out household chores. The IMCA commented on an apparent improvement in H's capacity. As a result of the police reports, the Council's Personnel Officer said that Mrs A's suspension from her job would be lifted. It was agreed that Mrs A would be visited to be told the outcome. It was agreed that H would remain in the second Care Home for the time being.

A54. Mrs A decided to pursue a complaint now that the POVA process was finished. After a discussion with the Council's Customer Services Officer, she decided to pursue her complaint with the Ombudsman rather than through the Social Services complaints process.

A55. An e-mail from the second Care Home to the second Social Worker noted that Mrs A would be going abroad for a time and that the plan was for H to return home after her return in November 2009. The member of staff from the Care Home expressed doubts that H wanted to go home, although she also said that his father and mother were desperate for him to come home.

A56. The new POVA Coordinator completed an overview report of the POVA process in September.

A57. A professionals meeting on 13 October discussed H's return home. The care plan in place when H was removed from home was to continue.

A58. A further professionals meeting was held on 29 October.

A59. H returned home on 10 November 2009.

Analysis of key factors

Legal basis for H's removal from home

A60. The legal basis from H's removal from the family home is an area of controversy. I note that there is no case recording of any legal advice being sought before or immediately after the decision was made to remove H under the best interests route rather than referring the decision to Court. There was no Council solicitor advising the POVA Strategy Meetings or Case Conferences, or any evidence of the Council seeking specialist legal advice, such as through a barrister experienced in adult protection cases. The solicitor acting for Mrs A does not appear to have received an answer from the Council about this key issue. I note also that other professionals involved in H's care (particularly health professionals) expressed disquiet about the failure to go to Court. The Council produced a view set out in the Overview Report prepared by the POVA Coordinator that the "best interests" route had been used but there is no evidence of a discussion about which route should be used.

A61. A referral to Court would have been a painful and costly process for H's family, the professionals involved, and the Council. It might have been possible to have sought a voluntary agreement with Mrs A if the POVA investigation could have been completed within a reasonable timescale.

The POVA process

A62. When a concern about possible physical injury was expressed in January 2009, the Social Worker asked the Key Worker to take H to his GP. It is not known whether the Key Worker had any specific training in adult abuse or realised the significance of this visit. He appeared to be reluctant to discuss the background with the GP to the extent that the GP felt she had to contact Social Services. The Key Worker and H then left with the GP's assessment incomplete, because of the need for H to be taken home by the Day Centre transport. The GP did subsequently express her concern about the decision to leave prematurely, especially

as she had made a special arrangement to see H. It surprises me that the Social Worker did not attend this examination herself, rather than delegating the task to a member of staff who was clearly not able to act appropriately and possibly lacked training in such a crucial task.

A63. Following the allegations in March 2009, H was not returned home. Staff at the first Care Home completed a body map. There was no medical examination, and police photographs were not taken until the following day. It surprises me that the Social Worker did not arrange for a medical examination, leaving the task of initial recording to care home staff. There is a reference in the records to a police medical adviser examining H, but this seems to be incorrect information as there is no reference to it elsewhere in the records.

A64. Mrs A was excluded from the POVA meeting because she was part of the potential pool of perpetrators. I can see no evidence of any communication with her in writing about the decisions of the POVA Conferences, although the records made by the two social workers do demonstrate regular discussions with Mrs A.

A65. The key problem with the POVA process is the delay in the Police interviewing witnesses and completing the investigation. The Police were not present at a number of POVA meetings. The first allocated Police Officer went on maternity leave and the case was not reallocated until June 2009. There were many telephone calls to the Police from the POVA Coordinator to try to get the Police to complete the process. After the case was reallocated, the new Police Officer did approach the matter decisively and interviews were completed with witnesses including the family.

A66. Mrs A did suffer from great stress during the investigation and said this affected her health. The delay also meant that she was suspended from work, and felt shame and stigma within her family and local community. I would have expected the police interviews to have been completed within 1-2 months enabling a resolution by May 2009. It should be noted that under the POVA procedures, interviews must be undertaken by the Police and in this sense, the Council was powerless to force these interviews to take place. In fairness, the POVA Coordinator made a number of attempts to speed up the process, but these failed.

Welfare of H

A67. It is evident from the case recording that the staff working with H had a positive attitude towards him and felt very protective towards him. H was receiving a good range of services from the Council, the NHS and the voluntary and private sectors. H had an allocated social worker, GP, linked community nurse, Consultant Psychiatrist, key worker at Day Services, a variety of support workers provided by a private agency and access to respite care. During the POVA process, he also had access to a Speech and Language Therapy Assistant and an IMCA.

A68. Looking at the POVA processes in 2009, it surprises me that there was no reassessment of his needs with perhaps a care plan offering a placement in residential care after the completion of the POVA process. There are many records suggesting that H was benefiting from living in residential care in terms of an increase in his confidence and communication skills. His medication was also decreased and then stopped.

A69. Unfortunately, because of the level of conflict created by the POVA process, an objective discussion between H's parents and his social workers was probably not possible. It was a lost opportunity to take into account the new information gained through a sustained period in residential care in planning services for him.

A70. The period that H was in residential care was an opportunity to reconsider his care plan. One option would have been for the POVA Conference to consider commissioning an independent report from an experienced social worker or clinical psychologist to work alongside H's family, IMCA, social worker, and provider staff to reconsider his care plan in the light of the information produced when he was living away from home. This might have transformed a period of waiting to a period of positive progress. Undoubtedly if the matter had been referred to Court, a report of this kind would have been commissioned.

A71. The IMCA made a positive contribution to the POVA Conferences. It was helpful to see that an advocate had been appointed for H and there is evidence that she was starting to question the care plan on behalf of H. It concerns me that the questions she was asking were being put aside.

Changes in staff

A72. H had a number of significant changes in staff during 2008 and 2009. He had at least two if not three allocated field social workers.

There were also two POVA Coordinators in post during this period. There were also a number of Police Officers involved in the POVA investigation.

A73. The lack of consistency in staffing meant that there were potentially differing understandings of the threshold for initiating POVA procedures as well as changes in personnel for the H and his family.

A74. It surprises me slightly that there were two POVA Coordinators in such a short period of time. The change in allocated field social worker was probably more positive for the family. The first Social Worker was associated with the investigations and the removal of H from the family home. The second Social Worker was able to build a more positive relationship with the family.

Ethnicity and potential discrimination

A75. The family felt they had been subjected to discrimination because of their ethnicity.

A76. The issue of having an Asian worker had been raised before the current difficulties. An Asian support worker was located through a support agency and Mrs A was happy with his input.

A77. Mrs A did make a number of attempts to question whether she and her family had been the subject of discrimination, and asked for an Asian Social Worker. This request was seriously considered but unfortunately no such person was employed within Learning Disability Services in the Council.

A78. At one level, the Council did try and respond to Mrs A's requests. At another level, there seemed to be a lack of understanding of the situation of the family. It is particularly difficult to live as a member of an ethnic minority within an area with very low numbers of other people from ethnic minorities and this factor can create isolation and fear. The family must have felt that they had many achievements. Mr A had a good job, and Mrs A was employed by the Council. They were also looking after their disabled son at home. These were important contributions towards their sense of self worth in the local community and within their extended families. The family also made a significant contribution towards their community. The allegations of abuse and neglect were devastating to them. The absence of written information was probably a significant factor in increasing their sense of fear and isolation.

Response to concerns and complaints

A79. A positive feature of this case is the response by the Customer Services Section of Social Services to concerns and complaints by the family. The response was timely and attempts were made to resolve issues quickly.

A80. There were a number of issues that the internal complaints process could not resolve. One crucial matter was the delay in conducting the Police investigation. This was a matter for the Police rather than Social Services.

A81. The letters from the solicitors acting for Mr and Mrs A did not receive a reasonable response. Crucially, the solicitors asked why there was no court involvement. No response appears to have been given to this question. The solicitors also questioned the lack of written information given to the family and the delay in completing the investigation. It is of great concern to me that these legitimate questions were not answered properly and promptly.

Good practice

A82. There were many elements of good practice in this case despite the difficulties. These include:

- Genuine commitment to H by Health, Social Services, and provider agencies;
- Good range of support services to H;
- Regular review by the Consultant Psychiatrist;
- Good communication between the Consultant Psychiatrist and GP;
- Regular POVA reviews and strategy meetings;
- Efficient and caring support from the Customer Services Manager and staff;
- Early involvement of the IMCA in the POVA processes;
- Efforts by the second Social Worker to rebuild the relationship with the family;
- Appointment of an advocate for H after the involvement of the IMCA ceased.

Response to the Ombudsman's Investigator's specific questions

1. **Do you feel that the Council acted in accordance with relevant guidance and good practice in relation to the POVA investigation?**

A83. In considering the POVA investigations in 2009, there is a very mixed picture about whether the Council acted in accordance with relevant guidance and good practice.

A84. The initial investigation of potential physical abuse in January 2009 was flawed because an examination by the GP was not completed and there was not a suitably trained and qualified member of staff with the client. In March 2009, no medical examination was arranged at all.

A85. The POVA Guidance lacks explicit guidance about arranging health assessments in the case of alleged physical abuse.

A86. The Strategy Meetings were held quickly, and there were regular POVA Case Conferences. However, due to the delay in the Police investigation, the process was unduly lengthy and was not resolved quickly enough. This is not the responsibility of the Council, which made many efforts to try to encourage the Police to complete the investigation.

A87. Recording of the POVA process was confusing with the records of at least one POVA Conference being misdated.

2. **Do you feel that the decision to take H away from his family was reasonable?**

A88. The decision to remove H from his family for a short period after the second allegation of physical abuse in March 2009 was reasonable, given the earlier allegation of physical abuse in January 2009 and the concerns expressed about his care during the previous POVA process. It was reasonable for the Council to protect and safeguard H until the investigations and assessments had been completed. It was not reasonable for H to be taken away for such a long period.

3. **Should initial enquiries have been made before doing this?**

A89. H was well known to Social Services and was, and is, receiving a substantial amount of service provision. There had been previous assessments under POVA. I do feel, however, that in both cases of

alleged physical abuse, there should have been a thorough medical examination. In one case, this was not completed, and in the second, it did not take place at all.

4. Do you consider the Council should have applied for a court order?

A90. There was considerable opposition to the actions of the Council in placing H in a residential home away from his parents, who were also his main carers. There was also disquiet about the Council's actions in taking this step without referring it to a Court among some professionals. H's parents also sought legal advice and their solicitor asked on a number of occasions for an explanation of the legal basis for H being removed from their care. No explanation was forthcoming from the correspondence I have seen.

A91. Whilst an application to the Court would have been a last resort, because of the expense and the distress it would have caused H's parents, I would have expected to see evidence of legal advice being sought and the presence of the Council's solicitor at the POVA Strategy Meetings and Case Conferences. Because the removal of an adult from his family is a relatively rare event, I would have expected the POVA Coordinator to take a lead in seeking legal advice. The Council might have wanted to seek specialised legal advice. I would have expected to see a discussion at a POVA Case Conference or other meeting about the advantages and disadvantages in seeking a Court Order and the other alternatives available.

5. Do you feel there were any avoidable delays in the process, and if so, to what extent do you feel these were the responsibility of the Council?

A92. There was considerable delay in the Police interviewing witnesses and family members. The Police also failed to attend a number of POVA meetings. This was because the Police Officer concerned was on maternity leave. The POVA Coordinator tried on several occasions to encourage the Police to complete the investigation. This is not the responsibility of the Council. The Police did complete the investigation quickly once it was reallocated and apologised to the family for the delay.

6. Was communication between the Council and the family reasonable?

A93. The family were told immediately after the two allegations in 2009 and were aware of the POVA process. They were excluded from the POVA Conferences because they were potential perpetrators. Whilst there was a positive attempt to maintain contact with the family by the two social workers involved, there was no evidence that the family were notified in writing about the decisions of the POVA Conference and while there was a reference to the family being given the opportunity to meet the Chairman, this did not appear to have happened. I would have expected that each POVA Conference would generate a letter to the family, if they were excluded, or for the Chairman to have met with the family.

7. Was communication between the Council and other agencies (e.g. police/health care bodies/care agencies/etc) reasonable?

A94. Communication was good between the Council's social workers and health service staff. It was also good between Social Services and providers of services for H. There was poor communication with the Police, which was not the fault of Social Services. The POVA Coordinator tried hard to encourage the Police to complete the POVA investigation, but the Police, because of reasons of staff absence, did not complete it until July 2009. It is difficult to see what more the Council could have done to encourage the Police to complete the investigation.

8. Was the Council's consideration of the family's cultural/ethnic needs reasonable?

A95. The family consider that the actions of the Council were not sensitive to their cultural and ethnic needs. When the issue was raised after the second set of POVA investigations in 2009, the family made a request to the Council for an Asian Social Worker, but there were no Asian Social Workers in the team, and the family were advised of this. An Asian Support Worker had been provided in 2008 for some sessions with H. Whilst I do not feel that the family were discriminated against, and the actions taken in H's case would have been the same, regardless of his ethnicity, I do feel that the family would have felt particularly vulnerable because of their ethnicity, in an area where there are low numbers of people from ethnic minorities. The POVA process and the removal of their son from their care should have been followed by better communication, and although the two Social Workers concerned made

efforts to communicate with the family, the lack of any positive participation in the POVA process and the lack of written information increased their anxieties and suspicion that they were being targeted because of their ethnicity.

9. Are there any other outstanding issues that need to be addressed by the Council?

A96. There are a number of issues where the POVA Guidance is insufficiently detailed. These include:

- Medical examination following allegations of physical abuse.
- Legal support to the POVA process.
- Involvement of family members in POVA Conferences if they are potential perpetrators.
- Written information to families during the POVA process.
- There is a lack of reference to the Mental Capacity Act which post-dates the POVA Guidance.

Some of those participating in this investigation needed better training in the POVA process, and this case might be an opportunity for the Council to review staff training.

10. Any other comments you may have.

A97. It is a pity that information gained after H was removed from his home was not used to develop a different care plan. Unfortunately, because of the conflict associated with the POVA process, H's care became a matter of conflict, and a simple choice between H remaining away from home and the previous care plan being restored. There were a number of professionals who disagreed either with H returning, or the previous care plan being restored, but the majority felt that the care plan could not be changed because the family would not agree. I hope that now the conflict has been reduced, there is a possibility of negotiation with the family to review the arrangements.

Conclusions and recommendations

A98. H is a man with moderate to severe learning difficulties, who normally lived with his family, but received a care plan with a mixture of day care, support work in the evenings, and respite care. His care is coordinated by a social worker with clinical support from a psychiatrist, learning disability nurse and a GP.

A99. Following two referrals about marks on H to Social Services in 2009, H was removed from his family's care. He remained away from his family from March 2009 until November 2009, although the last two months was by agreement. His removal was pending police investigations which were not completed until July 2009.

A100. Both investigations were flawed in terms of achieving best evidence. The first investigation had an incomplete medical assessment and H was accompanied, inappropriately in my view, by his key worker from his Day Centre who was clearly unable to cope with the task. The second referral did not result in a medical assessment at all.

A101. The family's complaint about delay in the investigation should be directed to the Police. There were frequent POVA meetings and the POVA Coordinator made several attempts to speed up the police response. The delay appears to have been due to the absence of the initial police officer on maternity leave. When a new police officer took on the case, it was resolved quickly.

A102. H's removal had a serious impact on the family. His mother was suspended from her post with the Council, and they felt deeply the stigma of the removal of their son within their extended family and local community. Although there is no evidence that the family were racially discriminated against, and Social Services did make some effort to find an Asian support worker, there was a lack of empathy about the situation of a family from an ethnic minority in a community where there are few ethnic minorities.

A103. Social Services decided that the way to remove H from home was through the "best interests" route of the Mental Capacity Act 2005 rather than through an application to the Court. There is no evidence that legal advice was taken through the POVA process or that this was appropriate. There was also no substantive response to Mr and Mrs A's solicitor on this point. I also note there was unhappiness from NHS staff. Whilst a referral to Court would have been expensive and difficult for everybody involved, it would have ensured transparency. A pre-court legal meeting might have avoided the need to go to Court.

A104. Communication with the family was mixed. In 2009, the POVA process was not accompanied by letters of explanation to the family, who were excluded from the POVA process as potential perpetrators. I cannot see why the family, perhaps accompanied by their solicitor, could not have attended the POVA Conferences in part, or had a meeting with

the Chairman. The social workers did try to communicate regularly with the family by telephone, but I do not regard this as an adequate substitute.

A105. The welfare of H seems to have been lost in the POVA process which concentrated on the Police investigation. It is striking how much the papers I have received are concerned with the family rather than H. He undoubtedly made good progress in residential care. There are a number of objective observations to support this point. Crucially, his medication was reduced and stopped. A reassessment of his care plan should have been undertaken, probably by a social worker or clinical psychologist independent of the POVA processes.

A106. The removal of an adult from his or her carers is an unusual event and there is little experience in Social Services compared with the removal of children. There is also very little case law. As awareness of staff increases of the POVA processes, referrals will increase. This case illustrates the gaps in the process and suggests a number of areas where it could be improved. Current procedures also need to be reviewed, together with the availability of legal support.

A107. It is recommended that:

- the Council reviews this case again focussing on the key issues raised by this complaint. This includes:

    a) Written information given to families as part of the POVA process;
    b) Medical investigations following concerns about the physical abuse of adults;
    c) Legal advice and support to the POVA process;
    d) Response to solicitors representing families;
    e) Reassessment of care plans during the POVA process;
    f) Training of staff in POVA, especially staff employed in provider services.

- Caerphilly County Borough Council discuss with Gwent Police the adequacy of support to the POVA process.

- Caerphilly County Borough Council, together with partner local authorities who use the POVA procedures, consider the issue of the removal of adults from the care of their families compulsorily in the light of the difficulties of this case, and develop a protocol.

Ruth Forrester
Registered Social Worker

Relevant legislation, policy and procedure

Protection of vulnerable adults

B1. The South East Wales Executive Group for the Protection of Vulnerable Adults has produced guidance (the POVA Guidance) on POVA procedures.[4] This includes at section 3.2:

> "Whenever complaints about abuse suggest a criminal offence may have been committed, the police must be contacted urgently. This takes priority over other enquiries."

And at section 13.5:

> "If during the investigation/assessment there is evidence that the vulnerable adult(s) is exposed to serious risk, immediate action must be considered to protect them. This may include:
>
> - Moving the vulnerable adult to a place of safety;
> - ..."

Mental Capacity and Deprivation of Liberty Safeguards

B2. The Mental Capacity Act 2005 ("the MCA") enshrined in statute the Common Law principle that a person is presumed to have the mental capacity to make a decision unless it can be shown otherwise. S.1 of the MCA sets out the principles of the legislation. These include:

> "(2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

[4] "Protecting Vulnerable Adults: inter-agency policy, procedures and practice guidance for responding to alleged abuse and inappropriate care of vulnerable adults in the South East Wales area", September 2003

(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."

S.2 of the MCA defines when someone is considered to lack capacity:

"(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."

S.3 of the MCA states that for the purposes of s.2, a person is considered unable to make a decision for himself if he is unable:

"(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision ..."

B3. In 2004, the European Court of Human Rights ruled (in a decision commonly known as the "Bournewood" judgement after the name of the hospital involved)[5] that a mentally incapacitated patient "L", who had been informally admitted to hospital for treatment of mental illness had been "deprived of his liberty" within the meaning of Article 5(1) of the European Convention on Human Rights.

B4. The UK government reacted to the Bournewood judgement by amending the MCA[6] to introduce a mechanism (known as the Deprivation of Liberty Safeguards; essentially a system of authorisation) to be used when it is considered necessary to deprive a person who lacks mental capacity of their liberty.[7]

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[5] HL v United Kingdom (2004) 40 EHRR 761
[6] By the Mental Health Act 2007
[7] "Deprivation of Liberty Safeguards", supplementary Code of Practice on the Mental Capacity Act 2005, TSO, August 2008

B5. The then Lord Chancellor issued a code of practice ("the Code") in 2007,[8] which provides additional guidance on the operation of the MCA. It includes:

> "6.52 It is difficult to define the difference between actions that amount to a restriction of someone's liberty [the restraint of a person without mental capacity is allowed in some circumstances under the MCA, and would not necessarily lead to a breach of Article 5] and those that result in a deprivation of liberty. In recent legal cases [e.g. Bournewood], the European Court of Human Rights said that the difference was 'one of degree or intensity, not one of substance'. There must therefore be particular factors in the specific situation of the person concerned which provide the 'degree' or 'intensity' to result in a deprivation of liberty. In practice, this can relate to:
>
> - the type of care being provided
> - how long the situation lasts
> - its effects, or
> - how it came about.
>
> "The European Court of Human Rights has identified the following as factors contributing to deprivation of liberty in its judgements on cases to date:
>
> - restraint was used, including sedation, to admit a person who is resisting
> - professionals exercised complete and effective control over care and movement for a significant period
> - professionals exercised control over assessments, treatment, contacts and residence
> - the person would be prevented from leaving if they made a meaningful attempt to do so
> - a request by carers for the person to be discharged to their care was refused
> - the person was unable to maintain social contacts because of restrictions placed on access to other people
> - the person lost autonomy because they were under continuous supervision and control."

[8] Mental Capacity Act 2005 Code of Practice, TSO, April 2007