Buckinghamshire's Safeguarding Vulnerable Adults Board

Executive Summary: The Murder of Mr C

A Serious Case Review

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Introduction

During February 2010, the dismembered body of 70 year old Mr C was found under concrete in the back garden of his home. In September 2010, Mr C's son, who was a 22 year old undergraduate, was found guilty of his father's murder.

The Thames Valley Police had become concerned that between August 2008 and February 2009, when all contact with this older man had ceased, neither the NHS nor Adult Social Care raised concerns about Mr C who was a Direct Payments Recipient.[1] In the absence of information to the contrary, both Adult Social Care and the support agency commissioned to support all Direct Payments Recipients believed that Mr C employed Personal Assistants. However, the police were unable to trace them. Also, it has become subsequently apparent that Mr C's son might have fallen within the statutory definition of a carer but there is no evidence that he had been recognised as such by either the NHS or Adult Social Care.

About this Serious Case Review (SCR)

The review was commissioned by Buckinghamshire's Adult Safeguarding Board and is based on information from

- Buckinghamshire County Council, Adult Social Care
- Milton Keynes Hospital NHS Foundation Trust
- NHS Bedfordshire and
- Oxford Radcliffe Hospitals NHS Trust.

Also, a Detective who contributed to the police investigation and murder trial shared insights from both procedures.

The Scope and Timetable of the Review

On 29 June 2010, the Terms of Reference for the Review were identified as: provide a chronology of agencies' contact with Mr C and his son from March 2007; provide relevant background information regarding Mr C and his son; establish the quality of assessments undertaken and whether or not agencies' policies on assessment, review, planning and financial controls were adhered to; and to establish whether or not professionals shared information effectively.

Information from Adult Social Care, Milton Keynes Hospital, NHS Bedfordshire and Oxford Radcliffe Hospitals was considered in September 2010, and amendments to these, including the recommendations and action plans (see Annex 1) were completed by January 2011. The

[1] Mr C was assessed as being eligible for a community care service (NHS and Community Care Act 1990, S.47; Health and Social Care Act 2001, S.57); using Direct Payments, the service to be purchased would reasonably meet that need (Statutory Instrument 2003/ 762); Mr C consented to having Direct Payments (Health and Social Care Act 2001, S.57); and he was able to manage the payment with or without assistance (SI/762).

draft of the review was submitted in February and a request to prepare an Executive Summary was made in April 2011.

Mr C and his son

Mr C had lived in England for 40 years. Although he was known to have both an English and North African name, this was not known to most of the agencies concerned with Mr C's care, i.e. the pre-2007 records of Radcliffe Hospitals NHS Trust referred to Mr C by his birth name, NHS Bedfordshire, Milton Keynes Hospital and Adult Social Care only knew of him as Mr C. (Mr C identified himself as "*White British"* during his initial Community Care assessment).

The Radcliffe Hospitals' records noted that he was divorced in 1969 and that he was planning to re-marry. Little is known about such significant milestones in Mr C's life. A former teacher, Mr C was said to have had an intimidating manner and was variously described as "a bully…really controlling."[2] The trial heard that such behaviour had been instrumental in the departure of his wife from the family home when their son was a small child. The separation resulted in Mr C assuming sole parental responsibility for their son.

Discord characterised Mr C's early contact with his neighbours. Further, a suggestion by a neighbour that their small children might play together was declined. This rejection of potential friendships for his son extended into the son's later childhood, adolescence and adulthood e.g. his son was not allowed to bring school friends home and, as an undergraduate student, he was discouraged from having friends.

Although much less is known about him, it does not appear that Mr C's son had an easy life. He was expected to invest in homework rather than play and to avoid the distractions of peers.

During the period in which Mr C developed chronic health problems he came to rely excessively on his son, including during the night. In turn, his son's life became progressively more circumscribed. In contrast to their views about Mr C, neighbours regarded the son as polite, well-mannered and "devoted" to his father. A glimpse of the father-son dynamic was afforded by a neighbour's visit to see Mr C when he was recuperating after discharge from hospital. The neighbour observed that he rang a bell to call his son to attend to his needs.

The trial heard that a woman responded to Mr C's advert for a Personal Assistant to help with care-giving. However, she declined to proceed with her application reflecting that "Mr C wanted a slave, not a carer."

The trial heard that Mr C's difficult behaviour extended to people who sold goods and undertook work for him. Described as being "out for everything he could get," this part of his life was difficult to fathom as Mr C was asset-rich – living in a large, detached house.

Little of this information, which emerged during the son's trial, was known to the services supporting Mr C. From their point of view, as Mr C became progressively frail, a less extreme picture of Mr C's character emerges. He contacted Adult Social Care when he was

[2] This information is derived from discussion with a Detective who took part in the police investigation and trial

poorly and, ultimately, he was assessed as having the capacity to manage Direct Payments and take responsibility for managing his own care.

Finally, it should be pointed out that the trial's portrayal of Mr C was inextricably connected to his son's defence. His son was seen as a life-long victim. Since this was relevant to his crime, he was not portrayed as harshly as Mr C.

Key events and service interventions

A crucial backdrop to Mr C's contact with services was his health. Over a 30 month period, he was treated for ulcerative colitis, heart problems, a problem with his salivary glands, the after effects of pneumonia and rheumatism. He received nutritional supplements. Ultimately Mr C had a stoma and he required continence aids. The following chronology outlines the decisive events in Mr C's contacts with health and social care services, beginning with the first five months. These are important because it is apparent that Mr C had clear requirements and expectations of both health and social care professionals which were given particular expression during these early months. His GP recalled that he was "*challenging…because of how forthright he was, sometimes unreasonably so and would complain if his exact requirements were not met*."

March - July 2007

During **March 2007**, Mr C became known to Adult Social Care – he self-referred because he was weak and poorly. Adult Social Care contacted Mr C's GP and Mr C was subsequently treated in Milton Keynes Hospital for ulcerative colitis. The hospital referred Mr C to Adult Social Care on the date that he was discharged[3] home where Mr C was unable to manage without help.

During **April**, an Occupational Therapist reported "*difficulty in contacting Mr C."* This heralded what became a long term challenge for both Adult Social Care and the NHS – Mr C could be both elusive and selective in his dealings with individual professionals. Having been assessed, it was determined that Mr C required assistance with personal care and shopping. However, from the outset Mr C was unhappy about the timing of carers' visits and the discontinuity of carers and he cancelled two visits. Mr C visited his GP.

During **May**, Mr C made three visits to outpatients' at Milton Keynes Hospital and two visits to his GP. Adult Social Care assisted Mr C in applying for an Attendance Allowance. (The expectation is that prospective Direct Payments Recipients will honestly disclose their income and provide supporting bank statements.) Mr C's Direct Payments began in **June**,

[3] This was an unsafe hospital discharge. The Community Care (Delayed Discharges) Act 2003, requires the NHS to give social services two notifications (i) an assessment notification (under S.2) which gives notice of possible need for services on discharge, following which, social services have a minimum of three days to carry out an assessment and arrange discharge; and (ii) a discharge notification (under S.5) which gives notice of the day on which it is proposed that the patient will be discharged.

and he was referred to People's Voices, the agency contracted by Adult Social Care to provide Direct Payments advice and support services in the county.[4]

During **June**, Mr C was prescribed medication for a heart condition which, significantly, he declined to take. Also, he refused to go into hospital for gastroenterology treatment.

A Direct Payments Agreement with Mr C was *signed off* in mid-**July**. His relations with Adult Social Care became strained because he believed that the process of securing Direct Payments was unduly tardy. He was recorded as being *rude* to an individual in the Finance Section, he requested no further dealings with his care worker and his dissatisfaction with Occupational Therapy led to visits from a senior Occupational Therapist.

August - December 2007

During the final five months of 2007, it appears that Mr C gave different versions of his son's living circumstances to Adult Social Care and to health professionals. The trial heard that Mr C's son returned home to live with his father when he left school. It appears however, that as an undergraduate he commuted daily to university from the family home. Significantly during this period, Mr C offered to be proactive in contacting Adult Social Care if he required assistance.

Between **August** and **October 2007**, Mr C visited his GP on two occasions, he attended two outpatient appointments and he was referred to an Ear, Nose and Throat consultant.

In **November**, Mr C had three outpatient appointments and he visited his GP. A *telephone review* of his circumstances was undertaken by a social worker. Although the social worker had intended to visit Mr C the latter thought this was unnecessary and *"did not appear to want to continue in conversation."* He reported *no concerns* and said that he would contact Adult Social Care should any arise. It was noted that Mr C's son had *come to live with him* and that Mr C queried *his son's role as a carer* i.e. he appeared concerned about his son's increasing involvement in his care.

During **December 2007**, Mr C visited his GP on three occasions and he attended an outpatients' appointment.

January – June 2008

During the opening months of 2008, the challenges that Mr C presented to health and social care professionals were firmly established. He declined treatments and his dealings with his son were observed to be unpleasant, irrespective of his increasing reliance on his son. The GP understood that *Mr C's son had recently left a degree course in* [Europe and] *moved in with his father prior to his colectomy…*The GP believed that "*Mr C relied on his son to do all post-operative care for example, helping Mr C to move around the house, cook, clean etc."*

[4] Although Bank Transfer is the most typical/ favoured means of paying Personal Assistants, all monies drawn from Mr C's Direct Payments account were cash withdrawals which were evidenced in Mr C's bank statements and by signed receipts from the Personal Assistants.

During **January 2008**, Mr C attended the Gastroenterology clinic where he declined treatment.

In **February**, a telephone review of Mr C's circumstances was undertaken. This noted that since Mr C *"was having great difficulty recruiting carers as they have to travel from X, it was decided that he should receive an increase (in) his Direct Payments."*

In February Mr C visited his GP on three occasions, he attended an outpatient appointment and he visited A&E. Mr C's GP noted that Mr C's son attended appointments with his father. The son was perceived to be, "*very able bodied and there was nothing to suggest* [that he] *couldn't cope with the physical demands his father was putting on him… he was extremely quiet and suffered verbal abuse from his father on occasions.* (Mr C could be) *verbally aggressive towards his son, shouting and swearing at him."*

Mr C had four outpatient appointments during **March**, one of which was a *private rheumatology appointment;* and he had three contacts with his GP, two of which were at the GP practice.

In March, Adult Social Care informed People's Voices of Mr C's increased Direct Payments.

During **April**, Mr C had three outpatient appointments and he was referred to the John Radcliffe Hospital. The following month it was confirmed that Mr C required surgery to remove his colon.

A referral to the Radcliffe Hospitals Occupational Therapy team in **June 2008**, noted that Mr C's son lived with him and that he was "*due to go abroad…as part of his degree…prior to admission Mr C had been finding it increasingly difficult to manage at home and reported that his mobility had deteriorated in the few weeks prior to admission…would prefer to stay upstairs rather than downstairs and that he had carers three times a week to assist with personal care by providing a bath. Mr C stated that he had not been washing the rest of the week…he got up three times a night* (assisted by his son) *and* (his son) *had been doing the domestic tasks at home but as he* (was to leave) *he would no longer be able to rely on his support at home…agreed that care would need to be increased."*

The GP understood that *"Mr C's son had recently left a degree course abroad and moved in with his father prior to his colectomy…Mr C relied on his son to do all post -operative care for example, helping Mr C to move around the house, cook, clean etc. Following the operation Mr C would have been quite immobile and dependent on his son to help him…"*

Mr C was in hospital until mid-**June** and his Direct Payments were suspended for the duration. He was recorded as being "*resistant to physiotherapy whilst in hospital."* The hospital notes described him as a *"very assertive"* patient who *"needed a high degree of encouragement to mobilise in his post-operative period." Mr C forcefully expressed his concerns that nurses' encouragement to mobilise… were 'bullying.' He did not wish specific members of staff to care for him."* He declined to take medication. Mr C's wishes and preferences were acted upon even though *"they may have been unhelpful to his general recovery."* A referral to the Hospital's Occupational Therapist noted that *Mr C stated that he would arrange for his care package to* (recommence) because he was *"classed as their employer."* Although the Ward Sister contacted Adult Social Care to advise that Mr C *will*

need an increased care package, they learned that Mr C *had refused to let the ward arrange extra care to be organised for his discharge.* A telephone call to Mr C confirmed that he wanted (i) the Direct Payments to resume and (ii) a re-assessment. Mr C was concerned that he was discharged with an insufficient quantity of stoma bags and Adult Social Care arranged for a delivery of more bags. His circumstances were assessed as "*urgent."* In a telephone call from Adult Social Care to Mr C, he explained that he was *crawling…to and from the bathroom* and a referral was made to Occupational Therapy. Mr C reported that he had "*sourced more carers."* Towards the end of the month a telephone call to Mr C confirmed that an Occupational Therapist's visit would follow a physiotherapy assessment. Mr C said that he *"would not let a physiotherapist set foot in"* his home. Although the origins of a decision to increase the value of Mr C's Direct Payments during **June** are unclear, a new Direct Payments Agreement was signed.

Mr C received a home visit from his GP and from a District Nurse in June. On an occasion when "*District Nurses went to Mr C's house to assess his post-operative wound,* they were told *"to go away and make contact before visiting in the future."*

July – December 2008

During these six months, conflicting information concerning Mr C's mobility and health status existed. Adult Social Care accepted that he was *bed bound* and yet he was not receiving home visits from his GP. A carer's assessment with regard to Mr C's son was deemed inappropriate, irrespective of the challenges of disturbed sleep and dealing with his father's incontinence/ stoma care and hygiene (see, for example, Miller 1997).

During **July 2008**, an assessment was completed. Information about how this was undertaken is unavailable. It noted that Mr C was "*able to self-medicate but with the support of his son who provides fluids for him during the day… has to call for his son 3-4 times at night due to his stoma bag leaking over him and requiring help to clean up."* Mr C explained that he could *"manage his toileting independently but was prone to occasional accidents."* He relied on his son "*to bring him a bowl of hot water in the mornings or after his bag has leaked…his needs have changed and* (his units of Direct Payments) *do not cover the change."* However, the assessment also noted that the Direct Payments were insufficient to fund assistance in his home when his son *"leaves for university."* The outcome of the assessment was the recommendation that "*his current allocation of 7 units of Direct Payments to be increased to 21 in order for Mr C to have sufficient funds to meet his urgent care needs and to relieve pressure* on *his son from the carer's role…carer's assessment not appropriate."* Telephone calls to Mr C in mid-**July** indicated that Mr C was unwell and *"still bed bound…he has been able to arrange further care for himself, which is now in place but unfortunately* his son *is providing more care for him during the night.* On one occasion Mr C reported that his GP had visited and that there was *"not much else they can do."*

During July, Mr C had an outpatient appointment at the John Radcliffe Hospital and he visited the GP practice on three occasions. A full OT assessment resulted in a "*referral* (i) *for wheelchair assessment* and (ii) *to community rehabilitation therapy*."

During **August**, Mr C was referred to community physiotherapy.

In early **September**, Mr C contacted Adult Social Care to report that he was finding it difficult to find a carer to attend to him at 7.00a.m. He was advised to re-refer after contact with People's Voices if this continued to be a problem. Occupational Therapy reported having difficulty in contacting Mr C. Their file notes recorded, "*Mr C complaining that he should be seen as an open case. Explained cases seen on basis of need and date referred. Physiotherapist reports telephone call to Mr C who refuses to answer questions."*

Mr C had telephone contact with his GP on at least two occasions in **September** and a Senior Continence Advisor visited him.

During **October**, Mr C made two visits to his GP's practice and a physiotherapist and Occupational Therapist visited Mr C. Subsequently, a letter was sent asking Mr C to contact Occupational Therapy because he was *"not responding to telephone calls."* Mr C made contact.

During **November**, Occupational Therapy files noted, "*Telephone call to Mr C to check everything OK. Record of physiotherapist visit but now case closed to that service."*

In **December**, Mr C had telephone contact with his GP.

January – June 2009

These six months hinged on Mr C's on-going contacts with health personnel. Case closure is an understandable response to non-engagement. However, it is unclear why Mr C's case was closed to Occupational Therapy when his non-engagement was familiar to this and other services.

In **January 2009**, Mr C's GP undertook a medicines review.

Mr C had no recorded contact with any services during **February**.

During **March**, the Occupational Therapy service telephoned Mr C and because there was no response they closed the case. Later, Mr C rang them and they "*agreed to keep case open and review his needs in **November***."

Mr C was visited by the GP Out of Hours service during **March**, which was followed by a home visit from his GP within hours. In mid-**March**, Mr C telephoned his GP about his medication.

Mr C had no recorded contact with services during **April**.

During **May 2009**, Mr C telephoned his GP about his medication and he went to the GP practice a week later. This resulted in a referral for a chest X-ray.

Mr C went to see his GP at the beginning of **June 2009** when he was referred to General Medicine at Milton Keynes Hospital.

July 2009 – February 2010

Mr C was medically frail and fully engaged with his medical treatment. He kept NHS appointments with senior clinicians and he had confidence in his GP, with whom he was in

frequent contact. Given that "Did Not Attend" or "no-shows" cost NHS hospitals £600m a year and that "patients of both sexes aged 70-74 years are the most conscientious about keeping an appointment" (see Dr Foster Health, 2010), it is surprising that Mr C's non-attendance during and after mid-August 2009, did not trigger an expression of concern or an alert to either Mr C's GP or to Adult Social Care.

Mr C had no recorded contact with services during **July 2009**.

On **4** August, Mr C had a CT scan for his chest symptoms. This indicated *recovery from pneumonia.* Mr C went to the GP practice on two occasions in **August**.

Mr C attended three outpatient appointments at Milton Keynes Hospital during **August**, and he was admitted for two days. When he required continence pads, "*he was offered the continence phone number but refused it*." A District Nurse visited at the end of the month to deliver pads. The following day the District Nurse was unable to gain access to Mr C's home.

During August, the Occupational Therapy service wrote to Mr C asking him to contact them because, *"several telephone messages left without response. Call to GP surgery: informed no reason why Mr C would not respond."* Mr C did not attend an outpatient appointment at Milton Keynes Hospital in mid-**August**.

Mr C had no recorded contact with services during **September 2009**. Mr C did not attend an outpatient appointment at Milton Keynes Hospital at the end of September.

Mr C had no recorded contact with services during **October 2009**. He did not attend two outpatient appointments at Milton Keynes Hospital on in October.

During **November 2009**, ileostomy appliances were requested from the GP practice for Mr C. However, it is not known who requested these.

In early **December 2009**, the GP practice requested Mr C to make an appointment *for* a medical review*.* It is unclear whether the request was by letter or telephone.

During **December 2009**, Mr C's Occupational Therapy file was closed because there was *"no response from Mr C."*

During early **January 2010**, Adult Social Care noted that Mr C was telephoned *"as part of an attempt to ensure vulnerable service users are safe during inclement weather. No response from Mr C. No record as to whether this was followed up."* However, there is a possibility that Mr C was overlooked*.*

In **February**, Mr C's Direct Payments (of c. £900 a month) were suspended as a result of the police investigation. Within days, the police found Mr C's body and a murder investigation commenced.

The Policy, Legislation and Guidance Context

Five legal and/ or policy frameworks are relevant to this SCR. They are lenses through which Mr C's circumstances and those of his son should be viewed:

1) **Community Care Assessment**

The NHS and Community Care Act (1990) obliges social services authorities to assess a person's needs for community care services. Mr C had a Community Care Assessment (NHS and Community Care Act 1990, S.47) in 2007, and as a result became a Direct Payments Recipient. In making a service provision decision, a person's financial status is relevant insofar as they may be required to contribute to the cost of the service.

2) Direct Payments

Where certain conditions are met, local authorities have a duty to offer "Direct Payments" to people so that they can buy their own non-residential, community care services i.e. local authorities do not provide or arrange these (Community Care (Direct Payments) Act 1996; Department of Health 2003).

In 2006-2007, Buckinghamshire County Council had 622 Direct Payments recipients. The number increased to 711 in 2007-2008, when Mr C began to receive Direct Payments.

Councils have a duty to ensure proper provision for meeting a person's needs because they have a duty to monitor and review the care package (DH and DfCSF 2009). *Buckinghamshire Social Care Services Policy and Procedure* (2007) specifies the nature and frequency of the monitoring and reviewing arrangements i.e. an initial review after three months and after six months (involving the "Care Management Worker and Direct Payments Advisor") followed by reviews "in accordance with standard care management procedures."

A Service Level Agreement between Buckinghamshire County Council and People's Voices for the provision of a Direct Payments Advice and Support Service for 2006-2008, specified the role of People's Voices. This included,

> "To provide assistance and support on all aspects of the employment of a Personal Assistant, including advice on recruitment and selection where required.
>
> To facilitate access of service users to a pay roll service…
>
> To record anonymously the background information of potential service users to inform diversity monitoring of the Council…Adult Social Care and People's Voices will participate in the monitoring and review of services."

The Service Level Agreement states that, *inter alia,* on a monthly basis People's Voices will record and return to Adult Social Care "ethnicity for those referred."

3) Care Management

In Buckinghamshire care management is subject to monitoring and review. The monitoring involves informing a "user/ carer how to request a review or reassessment if needs change or services are not satisfactory." Reviewing entails an appraisal of all care plans. The process involves a re-assessment, "if the needs of the user change significantly," and "Partial case closure/ In abeyance" i.e. "when the user is in receipt of services that have a cost component to the Dept. and there is no need for on-going CM involvement."

The process involves the care management worker deciding "with their supervisor or team manager which category will be appropriate for future reviews i.e. Category A for "people receiving complex packages of community care…people with a deteriorating condition

whose needs are likely to change…" and Category B for people receiving a simple package…whose needs are predictably stable."

4) Carers

The legislation relevant to carers is the Carers (Recognition and Services) Act 1995 and the Carers (Equal Opportunities) Act 2004. The purpose of a carer's assessment is to identify their ability to provide and to continue to provide care. The legislation is concerned with:

- the sustainability of the care-giving relationship, and

- whether or not the care-giver is engaging in, or wishes to engage in work, training, education or leisure activities.

Local authorities have a duty to inform carers about their right to request an assessment. If a carer does not request an assessment the local authority is obliged to take account of the carer's ability to undertake caring activities.

Buckinghamshire Social Care Services (2007) noted of judgements about the contributions of carers that they depend on the personal circumstances of individual users and their carers and are "*a matter of the professional judgement on the part of the care manager, and if in doubt, in consultation with line management." A Strategy for Carers in Buckinghamshire: Five Year Multi Agency Strategy 2006-2010,* affirmed the legal duty of local authorities to consider whether or not a carer is in education; and highlighted the "…need to involve carers in monitoring services and the importance of taking into account their experiences in the evaluation of services…Carers' views should be listened to and their views recorded." This is a position endorsed by The Report of the Standing Commission on Carers (DH, 2009) and the Association of Directors of Adult Social Services and Directors for Children's Services' (2009) model local memorandum of understanding

5) Hospital Discharge

Department of Health (2003a) guidance concerning hospital discharge sets out the need for, and advocates, the setting up effective arrangements for ensuring that people's needs and wishes, as well as those of family carers, are taken into account (see, for example, ADASS 2010). The guidance highlights the importance of effective communication between primary, secondary health care and social care services:

> "…effective discharge planning is facilitated by a 'whole system approach' to the commissioning and delivery of service…The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of successful discharge…(the latter) is a process and not an isolated event. It has to be planned for at the earliest opportunity across the primary, hospital and social care services…" (p3)

Analysis

Had the police not commenced a missing person investigation, which was triggered by neighbours' concerns, it is likely that Buckinghamshire's Adult Social Care would have continued to pay Direct Payments to Mr C, i.e. having had telephone reviews in November 2007 and February 2008, it does not appear that the planned OT review for November 2008 occurred and there was no proactive Adult Social Care action in 2009. It is not known how consistent this level of attention was with that of other Direct Payments users.

There were a cluster of indications that things were not right regarding Mr C. Beginning with his identity, neither Adult Social Care nor the NHS knew much about him or his history. The fact that he had two names, one of which was North African, was not known to either the NHS or to Adult Social Care – irrespective of the monthly ethnicity recording required of People's Voices. A member of the SCR Panel observed, "*He seemed not to exist."* While the processes of identity construction involve *where* we are in both a physical and social sense, they also impact on the identities we choose to convey, as well as the ways in which we might be identified (e.g. Panelli 2004). Accepting Mr C's self-identity as "White British" arguably disadvantaged the Adult Social Care professionals working with him in terms of understanding his (i) sense of belonging (see, for example, Nolan *et al* 2001), (ii) beliefs about the way he understood his condition and circumstances, and (iii) his expectations of his son as a student carer.

Given that it is unusual for the sole custody of a young child to be given to a father, it is significant that the circumstances in which Mr C secured the custody of his son were not known to Adult Social Care. Community Care Assessments demand the collection of more complex information than is true for monitoring and yet neither furnished professionals with a credible biography or evidence of concrete, practical data for assessing the care package.

A further indication that things were not right hinged on Mr C's relationships. His son was a carer and yet any assessment of his support needs was deemed "inappropriate". Mr C reported that he had assistance with bathing three times a week and yet he required incontinence pads and his stoma bag leaked – suggesting that more frequent washing was necessary. It does not appear that anyone checked how his son was managing to maintain his university course work and undertake unfamiliar and unpleasant care-giving tasks. Assessment is critical to the provision of appropriate and sensitive services and yet there was no consideration of the son's choice on attending to his father's needs, no information was offered about the assistance which may have been available, nor were the implications for his own health and wellbeing taken into account. Irrespective of the County Council's policy regarding carers and multi-agency working, this did not shape Adult Social Care interventions. It appears that the son was invisible to carers' services (see, for example, Twigg and Atkin 1994).

With regard to Mr C's relationships with professionals, he refused to engage with certain NHS and local authority personnel. He was articulate, informed about his condition (he spent a lot of time on the internet and could discuss his medication, for example, with NHS clinicians) and, it seems, somewhat dismissive of less senior professionals. Such behaviour was capable of creating tension between him and professionals in primary and secondary care and the local authority. He did not appear to countenance negotiation and was rigid in his demands. It is troubling that such behaviour was not considered in the context of family

dynamics, not least since Mr C was observed by his GP to have a bullying manner towards his son.

A further indicator concerns Mr C's behaviour. It appears that he misrepresented his health status to Adult Social Care. In July 2008, he reported to Adult Social Care that the GP had visited and that, "there is not much else they can do." Questions which should have been asked were not asked, e.g. "How do your Personal Assistants gain access if your son is not at home? How are you getting to hospital outpatient appointments? Do the GP/ OT/ physiotherapist share your view that you are bed-bound? How are you managing to get to the toilet? How are your carers/ is your son managing to lift you without a hoist?" Have they had moving and handling training?"

It is possible that Mr C may have fraudulently secured Direct Payments having given incomplete information about his income and at the same time, using his son for care and support. For example, although being a Direct Payments Recipient does not prevent a person from accessing private health care, it appears that the information Mr C supplied to Adult Social Care suggested that he could not afford such care and treatment.

The final set of indicators that things were not right cluster around information and its adequacy. In the light of Mr C's medical frailty and the challenges he presented to health and social care professionals, the absence of risk assessments and the management of risk are striking. In January 2008, Mr C declined to have a colonoscopy. In June 2008, the Radcliffe Hospitals noted that Mr C required a "high degree of encouragement to mobilise" after an operation and that he would not take prescribed medication. Such inherently risky decisions should have been assessed. Similarly, Mr C was known to refuse entry to some professionals and yet, this risky behaviour escaped a risk assessment by Adult Social Care. Ultimately Adult Social Care closed Mr C's case even though his avoidance of/ refusal to allow entry to certain professionals was known to primary care as well as to Adult Social Care. Risk assessors and managers are familiar with the fact that outcomes are often unpredictable and uncontrollable. That is the reality of risk assessment. However, in this case, there is no documented discussion concerning Mr C's risky decisions.

From the existing documentation concerning Mr C, it is unclear when the Community Care Assessment began and ended; when Mr C had person to person contact with Adult Social Care personnel; or whether or not appointments noted on file were kept Furthermore, it is not known whether the revised times reflected Mr C's preference or those of the professionals, or if matters which were significant to Mr C were addressed e.g. how were Mr C's documented concerns about his son's support in the home reflected in subsequent decision-making?

That four Personal Assistants were employed to support Mr C was an unchecked presumption. While there is no obligation for local authorities to have the contact details of Personal Assistants employed by Direct Payments Recipients, arguably the monitoring process is a vehicle for engaging with some, if not all employees. It is difficult to make sense of a significantly enhanced care package i.e. increased by 2/3 within 12 months, premised on the challenges of Personal Assistants' travel times and the relief of *"pressure on his son."* The veracity of Mr C's claim, which would have required the addresses of Personal Assistants, was not considered. As there is evidence that Mr C interviewed at least one

potential Personal Assistant, perhaps it was the difficulty in securing such help that led him to promote himself as a bone fide Direct Payments Recipient to People's Voices and Adult Social Care. It is not known what evidence People's Voices accepted - Mr C's own account of interviewing a single potential Personal Assistant?

Mr C's Personal Assistants should have been paying National Insurance contributions, tax and Public Liability insurance. Information about these matters would have allowed the police to trace them, if they had existed, either as self-employed or employees of independent agencies. Furthermore, as an employer, Mr C should have been paying Employer's Liability insurance and yet there is no reference to this, to National Insurance, to holiday cover, to setting up Pay As You Earn with the Inland Revenue, or to Employer's Liability insurance in the monitoring information cited in the Service Level Agreement with People's Voices. People's Voices did not operate a Payroll system. Their paperwork only indicates that Mr C's Personal Assistants were self-employed. Accordingly, "the audit trail and the regular review (of at least once a year)" hinged on bank statements and receipts.

The actions and decisions concerning Mr C were inconsistent with Buckinghamshire's framework of monitoring and reviewing processes and their proper and required timeframes. It appears that the expectation that monitoring would produce evaluative information was unrealistic given what appears to be an overburdened system (with three people in the Direct Payments Team and three people supporting around 700 Direct Payments Recipients employed by People's Voices. Seven hundred is a very modest number given the anticipated legislation regarding self-directed care (DH 2010). How does Adult Social Care in Buckinghamshire anticipate monitoring and reviewing very many more people?)

In December 2007, a telephone call to Mr C was prompted by his concern regarding the travelling expenses of his Personal Assistants. It was noted that this was *"to be reviewed at next review"* and yet Adult Social Care appears not to have required any evidence to verify this, or even to have proposed alternatives. In March and September 2008, unexplained references to irregularities in Mr C's finances were made.

Conclusions

This Serious Case Review highlights flawed practices in Buckinghamshire's Adult Social Care with regards to the oversight of Community Care Assessments and Direct Payments. The police investigation and murder trial revealed more of the complicated father-son relationship than was known by Adult Social Care. Mr C was a complex 70 year old with an array of health support needs and yet his circumstances were not deemed to merit anything other than a passive and remote degree of social work oversight. Valuable information was not committed to records. Regrettably, social worker expertise was not deployed – not even in a professional advisory capacity.

Irrespective of a Community Care assessment, remarkably little was known about Mr C, or his son's care-giving. It appears that the way that social workers undertook their role meant that it promoted access to Direct Payments without professional challenge as to need, appropriateness or outcome. Their role appeared to be reduced to that of administrative approval. The rationale for increasing "units" of Direct Payments without any checking with Personal Assistants or Mr C's son, for example, is unclear. The Community Care

Assessment and “reviews” uncovered little. It seems that as the son’s dependency on his father reduced, so Mr C’s dependency on his son increased, and yet this significant turning point went unacknowledged by Adult Social Care and the relevant agencies.

The son’s willingness to assume care-giving responsibilities for his father was not verified. The care roles assumed by Mr C’s son seem most inappropriate. Even a loving partner might have felt that some tasks should be dealt with by health professionals. He was apparently getting up two or three times a night then commuting to and from university. It is not known how Adult Social Care envisaged the role of the Personal Assistants in all of this.

The lack of scrutiny of Mr C’s care presents a stark picture. Policies and procedures which were in place to audit public expenditure were not followed. Perhaps this inattention reflects naivety regarding potential problems in the delivery of Direct Payments; and/ or the absence of healthy professional scepticism about human behaviour and motivations; and/ or inexperience; and/ or targets to keep the numbers of Direct Payments Recipients climbing forever upwards. Direct Payments are a process and not an outcome. People do what is measured and rewarded. With little experience on which to draw, it appears that Adult Social Care operated under the assumption that what was agreed would occur. It appears too that Mr C was regarded as a client with a less complex care package and, as such, was subject to an unduly light-touch reviewing process captured via vague and arms-length recording.

Arguably Mr C’s forthright manner and intermittent engagement with Adult Social Care personnel were instrumental in shaping the reviews concerning the effectiveness of his care plan. Mr C was disadvantaged by failure to adhere to policies regarding the review of his Community Care Assessment and separately, his Direct Payments. It does not appear that Mr C had any sustained person-to-person contact with an experienced and qualified social worker.

Although many patients fail to attend hospital appointments, a blanket assumption that this signals their considered withdrawal from clinical treatment carries many risks. While not seeking to minimise the challenges the NHS faces in addressing non-attendance, “Did not attend” data are potential alerts that something is wrong with regard to frail, older patients.

This Serious Case Review highlights major shortcomings in the oversight of public funds by Buckinghamshire Adult Social Care. It appears that Mr C received Direct Payments which he did not use for the purposes intended. In turn, his son continued to access these monies. It is not known what happened to the money. Although Direct Payments Recipients can be offered considerable flexibility in what they want to purchase, the local authority still has a duty to ensure that the money is spent for the purpose intended. Mr C’s circumstances indicate that that duty was not enacted effectively in Buckinghamshire.

Recommendations

An advice and support service for people directing their own support should collate and furnish Adult Social Care with tangible evidence of the employment of Personal Assistants*.* Minimally, a Service Level Agreement should specify the oversight of National Insurance, tax and Public Liability Insurance of Personal Assistants, for example.

Adult Social Care personnel should adopt a risk assessment and risk management stance with regard to the support of frail, elderly Direct Payments Recipients*.* The records regarding Mr C do not indicate whether or not planned actions were undertaken. The "facts" are not readily discernible from the records. Good record-keeping with attention given to "biographical" as well as "case" knowledge would have assisted social care practitioners in the professional tasks of assessing the care package and making defensible decisions regarding reviews. The real time management of risk requires situation-specific analyses at agreed time intervals.

The deployment of staff by Adult Social Care to assess and review the care packages of frail older people should be reviewed*.* How are the reviewing tasks undertaken and by whom? What would prompt the allocation of a social worker to the assessment task? What are the qualifications of the practitioners involved? What form does the managerial and supervisory oversight take? Remote, arms-length monitoring is insufficient.

Buckinghamshire County Council should review their documentation specifically in relation to questions concerning ethnicity, nationality, culture and language with a view to assessing what positive outcomes result for service users. It is not known what sense is made of People's Voices' monthly recording of ethnicity. "Race" and "ethnicity" feature in Buckinghamshire's documentation regarding Community Care Assessments, Direct Payments, the Service Level Agreement with People's Voices, and family carers – but only in a limited sense. Contacts with Mr C suggest that this information was neither used nor perceived as relevant to his situation and confirm that self-identification is a complicated matter.

Hospital discharge notifications regarding Direct Payments Recipients should trigger a review of support needs*.* The statutory framework does not distinguish between the various kinds of possible care packages. Assessment and notifications of discharge are required, irrespective of whether the person is a Direct Payments Recipient employing one or more Personal Assistants or a patient who refuses the assistance of health professionals to organise additional help (see June 2008).

Milton Keynes Hospital NHS Foundation Trust and Oxford Radcliffe Hospital NHS Trust should negotiate with NHS Bedfordshire (and emergent GP consortia) ways of raising concerns about medically frail older people who abruptly cease to keep appointments in primary and secondary care.

This Serious Case Review should be shared with (i) the Equality and Human Rights Commission's Inquiry into the home-based care of older people Their concern that such individuals are "acutely vulnerable to human rights violations" is borne out by the circumstances leading up to Mr C's murder. There are two sets of concerns:

- Given that there will be many more individuals directing their own care, how might information be legitimately exchanged between Adult Social Care and emergent GP consortia?

- Adult Social Care's reviews were compromised by Mr C's representation of his health status – he was not entirely bed-bound; he continued to attend hospital and GP appointments; and he did not possess the aids associated with immobility such as a

hoist and Keysafe for example. Although his needs arose principally from his poor health, there was no expectation that Mr C's care plan should be negotiated with health professionals in primary and secondary care.

This Serious Case Review should be shared with (ii) the Department of Health Personal Health Budgets Policy Team and researchers responsible for the evaluation of Personal Health Budgets.

- Given the anticipated extension of Personal Health Budgets and the emergence of GP consortia, the relevant DH policy teams should be informed about Mr C's circumstances, including those responsible for the promotion of *Think Local, Act Personal*.

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