# Safeguarding Adults Review Adult B

# Gateshead Safeguarding Adults Board

# Executive Summary

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## 1. Introduction

Adult B was cared for by her son who also lived with her. Prior to Adult B's death, concerns identified as neglect had been reported by a neighbour and her daughter. One of the concerns resulted in Adult B being admitted to a care home for respite care provision. Adult B's son was not happy that his mother had been admitted into respite care provision. Adult B returned home with a full care package in place, however this was cancelled by her son after a short period of time. Adult B missed many appointments and there was growing concern with regard to her access to services.

A referral was received by the Adult Safeguarding Team as a result of Mental Health services calling to carry out a dementia assessment. When they arrived for the appointment, they could not get an answer. Around twenty minutes later Adult B's son returned home. When Mental Health Practitioners entered the house, they found Adult B in a foetal position and covered in excrement. Adult B was transported to hospital where she died on the 01.09.17. She had pressure sores on her bottom and genitals and the pathologist concluded that she had died as a result of the infection from the pressure sores.

Hospital staff reported the house to be in a very poor condition with Adult B described as skeletal and malnourished. There had been a delay in informing the Police about the circumstances surrounding Adult B's death and the subsequent safeguarding referral.

### Gateshead Safeguarding Adults Board (GSAB) Decision to Conduct a Review

On 18th October 2017 the GSAB Safeguarding Adult Review Group considered the proposal made by the Police to conduct a Safeguarding Adults Review. The panel found that the case met the criteria for undertaking a SAR. Consideration was given to a joint Domestic Homicide Review/ Safeguarding Adults Review however upon receipt of further information it was agreed to proceed with the Safeguarding Adults Review.

### Terms of Reference for the Review

## 2. Review Methodology

### The Review Model

The approach chosen by the Case Review Panel was a model that involved:

- Individual Management Reviews (IMRs) commissioned by the SAR Panel from each agency that had involvement with Adult B in the period leading up to her death.
- Appointment of an independent chair and author of the review, to provide an overview report, executive summary report containing analysis, lessons learnt and recommendations.
- A learning event attended by practitioners, managers and agencies directly involved, to clarify outstanding matters and to stimulate debate about learning reflecting upon information presented from research and legislation.
- The review was intended to be inquisitive, with potential to explore hypothesis in relation to lessons learned e.g. If we had tried X then we might have found Y.

On the 13th June 2018 a SAR panel met to consider:

- The lessons to be learned about the way in which local professionals and agencies work together to safeguard adults.
- To establish what those lessons are, how they will be acted upon, by whom and what is expected to change as a result.
- To improve multi agency working to better safeguard adults.

The membership of the SAR panel was represented as follows:

- Chair / Author: Deborah Barnett
- Northumbria Police
- Gateshead Council Business Manager
- Gateshead Council Principle Social Worker
- NTW – Mental Health Services
- Gateshead Health NHS Foundation Trust
- Provider service
- Community Safety Partnership

**The Individual Management Reviews**

The panel received reports from the following agencies:

- Police
- Ambulance Service
- Local Authority
- Foundation Trust
- GP

**Participation by Adult B's Family**

See full report for further information, p12.

## 3. Adult B the Person

Information on Adult B can be found in the full report, including a Pen Picture, background information, and a pen picture of Adult B's family, p12 to p17.

## 4. Summary of Care and Themes

The below is a summary of the care provided to Adult B by multi-agency practitioners and notes some of the key themes, a full case chronology can be found in the SAR report, p17 to p27.

**Cognitive Decline**

Throughout the chronology there are notes of Adult B's cognitive decline by the GP, family, and other medical and social care practitioners. During a period of respite in May 2016 the Social Worker notes Adult B is very confused and displaying verbal aggression towards care home staff. A further note in June 2016 states during a visit

the Social Worker witnessed Adult B accusing her son of not caring for her. The Social Worker described Adult B as the aggressor.

**Domestic Incidents**

During the review period there are two occasions where police were called to Adult B's home regarding domestic incidents. The first in April 2016 when neighbours contacted police after hearing shouting and banging and a male voice could be heard crying and saying that he couldn't take it anymore. Police attended and Adult B's son stated he was drunk, carer stress was identified, and a concern was passed to the Local Authority. No offences disclosed and no further Police action was taken.

In May 2016 Adult B's daughter contacted police during a visit to her mother's home, where there had been a verbal argument between her and her brother regarding their mother's care, Adult B's daughter was concerned this would escalate. Adult B's son had been drinking and was described as very agitated and aggressive. He was shouting at Adult B and did not want police officers to speak to her alone. Adult B's son stated he had been her sole carer for 5 years and it appeared he was not coping well. Officers made arrangements through Adult Social Care for Adult B to go into respite care overnight as they did not believe it was appropriate for her to remain in the address with her son. Neighbours again expressed concern for Adult B, raised voices and Adult B's son swearing; he would also leave Adult B alone for long periods of time. Police raised an Adult Concern Notification (ACN) and a Domestic Violence Notice (DVN) for both Adult B and her daughter. It was subsequently agreed with Adult B and her son to have a short respite stay to allow for further assessment and a carer break.

**Domiciliary Care**

After police attended Adult B's home in April 2016 following a call from neighbours a package of domiciliary care was put in place to support Adult B's son in his caring role. Adult B's son cancelled the evening visit in May 2016 to enable him to take his mother out to the local club.

The domiciliary care package was increased following the Adult B's respite stay, however Adult B cancelled the service a few weeks later, and she was considered to have capacity to make this decision. Her son and a close friend were to take over her care with Adult B's daughter undertaking housework.

**Respite Care**

Respite care was provided once during the review period; this was following a domestic incident at Adult B's home which involved her son and daughter in a verbal argument.

**Health Care Support**

Throughout the review period the GP maintains regular contact with Adult B, home visits and meetings are noted. Support is provided in relation to falls/unsteadiness, urinary incontinence and hearing loss. There are clear records of regular checks including blood and urine tests, referrals to hearing loss, memory loss, falls and incontinence teams and prescription of medication in relation to diagnosed conditions. Liaison between GP, hospital, nursing teams, SALT and memory hub are clear throughout.

In May 2015 Adult B's daughter called an ambulance suspecting her mother had suffered a stroke. Adult B refused to go to hospital and the out of hours GP visited at home. The ambulance crew carried out a capacity assessment which determined Adult B to have capacity to refuse admission and the GP determined that emergency admission was not required. Adult B was however admitted to hospital the following day with suspected delirium and a Urinary Tract Infection (UTI).

In May 2016 Adult B is seen by a consultant from Old Age Psychiatry and possible mixed dementia identified, medication prescribed and referral to the memory hub. In August 2016 nursing notes identify that Adult B has lost 5kg in weight. In December 2016 Adult B is admitted to hospital after suffering a left side stroke, she is discharged from hospital with referrals to SALT, Physiotherapy and Occupational therapy appointments. District nurses also carry out a risk assessment for pressure ulcers, no loss of skin integrity is identified, and a level 1 mattress ordered.

Adult B is admitted back into hospital in early January with low oxygen saturations and shortness of breath. Pneumonia is queried as a secondary aspect of aspiration following recent stroke. Swallowing assessment conducted by SALT, Adult B is identified as being dysphasic and requires thickening powder to prevent asphyxiation.

The District Nurse notes in March 2017 that Adult B has a poor appetite, pressure ulcers were deteriorating, and nutrition was becoming more problematic.

In April 2017 the GP met with Adult B following a request for a home visit made by the Stroke Clinic consultant following missed appointments at clinic. The GP notes declining mobility, and Grade 1 pressure sore. SALT also identifies that Adult B's swallowing has returned to normal but also notes that Adult B continues to lose weight.

**Equipment Assessments and Provision**

In April 2015 Adult B's son contacted the Local Authority indicating that a lifeline and a commode were required by Adult B, he was signposted to the relevant agencies. In March 2016 an assessment of Adult B's needs and a bathing assessment were carried out by the Local Authority.

October 2016 Physiotherapist visits home address to deliver equipment including a walker, bed lever.

**Carers Assessment and Support from Carers Services**

During February 2016 Adult Bs son requested a carers assessment, and a carer relief sitting service commenced in June 2016. There were issues between the carers service and Adult B's son in relation to support for Adult B when being transported via taxi to the local club. Adult Social Care were contacted by the Carers Service, and they were advised to discuss directly with Adult B's son. No further contact was received from the carers service therefore it is assumed by the Local Authority that the service remained in place.

The service is cancelled in February 2017 by Adult B's son when he is informed due to his mother's stroke they will need to undertake a re-assessment.

**Financial Assessments**

Financial assessments were offered to Adult B and her son, on one occasion this was declined with the offer being accepted the second time in April 2016.

**Day Care**

Adult B agreed to attend day care to support her son in his caring role, she did attend but then became increasingly agitated when day care was suggested and subsequently refused to attend.

**Admission to Hospital and Safeguarding Referral**

In August 2017 Adult B missed an appointment at the Memory Hub as she had not been seen since April district nursing staff were asked to visit. Upon arrival Adult B's home, the door was locked, sometime later her son and his partner arrived and let them in. The house was dishevelled, soiled clothing was lying around, and the condition had deteriorated since the last visit in February 2017.

Adult B was found in poor condition lying in soiled bedding in foetal position. Multiple pressure sores observed on her heels, buttocks and clavicle area under the chin. Adult B had a bandage on her leg attached with Elastoplast and her son stated that he had put it on. Adult B had been incontinent of diarrhoea. Staff attempted to clean Adult B, son told staff that Adult B's food and fluid intake had reduced. The GP was called and advised admission to hospital via ambulance.

The ambulance service conveying Adult B to hospital described her as skeletal with bones visible through skin and covered in faeces and pressure sores. The ambulance service made a safeguarding referral and asked if police should be called? Advice given was 'no', as Adult B was on her way to a place of safety. Adult B was taken to hospital. The safeguarding referral was allocated to Safeguarding Team.

Nursing staff within the hospital discussed Adult B's care provision with her son raising concern about her being in a poor physical condition and being home alone. Her son stated that, his partner and sister helped him to carry out all care and Adult B was left alone for minimal periods of time. Formal care provision had been cancelled due to cost. The nursing staff discussed the pressure ulcers and he stated that they had developed over last few days but when informed that this must have deteriorated over several weeks, he stated that "he tried his best".

## 5. Themed Analysis and Recommendations

Single agency areas of good practice and areas for learning were identified as part of the review, these have been presented to agencies to take forward these recommendations.

| **The Safeguarding Enquiry** | |
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| To assess the ability of the family carer to meet the identified eligible needs. For Adult B she was determined to be capacitated to make decisions about care provision. The alternative hypothesis of self-neglect should therefore have been considered and trauma informed responses determined. Trauma informed approaches were not well known during the time span of the review, however, today these approaches can be considered. | **Recommendation 1** - In cases of potential self-neglect for all agencies to determine what happened to the person to make them feel that they do not want appropriate support to meet their needs. Trauma informed approaches to become part of assessment processes. |
| For relevant agencies to seek information from relevant practitioners to determine what the barriers to making a safeguarding referral were. Hypothesis to explore and rule out:<br>• Was safeguarding considered to be a negative thing and was it the perception that agencies were protecting the family?<br>• Did agencies errantly consider that safeguarding referrals should not be made unless there was significant evidence?<br>• Did agencies consider Adult B to be making capacitated decisions throughout their interventions and was the determination of this recorded when Adult B appeared to become more confused?<br>• Did agencies consider statutory carers assessments and if so, what were the barriers? | **Recommendation 2 -** The findings from this are shared along with the other review outcomes. |

| **Needs, Rights and Responsibilities of son as a Carer** | |
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| The safeguarding of carers and services to meet the wellbeing of carers to be considered. | **Recommendation 3 -** Where carers are struggling to provide care and support and this is impacting on their wellbeing safeguarding procedures and statutory carers assessments to be conducted. SAB monitored. |
| A whole family approach, recognising and identifying the needs of an individual and who is meeting those needs is required. In this instance Adult B's daughter and her son's partner should have been considered as carers and their support recorded against the identified needs on the care and support plan along with those met by her son. This would ensure that the Local Authority can monitor change and respond where a care provider is appearing to be struggling to meet need. This would instigate capacity assessments for Adult B to determine whether she could make her own decisions (Variety of matters) or whether the carer was making decisions on her behalf. If carers were making decisions it should then be determined whether these decisions were in the best interests of Adult B. This would ensure that carers were involved and kept informed of the applicable legislation. | **Recommendation 4 -** All agencies to recognise the need to monitor carers ability to meet need as identified on Health or Care and Support Plans. Non commissioned services to be added to all care and support / health care plans and monitored. |
| All agencies to recognise carers needs to be regarded as equal to those being cared for. Support and intervention to meet carers needs to facilitate continued care to be identified and provided. Where needs are not being met, alternative services to be identified in the same way that services would be sought for those with care and support needs. | **Recommendation 5 -** To share via appropriate forums the information provided regarding the duties, responsibilities, rights and needs of carers and the safeguarding of carers. |

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| For services across Gateshead to recognise the benefits of providing preventative support to carers and identify when statutory carers assessments are required. | **Recommendation 6 -** To share national and local statistics about what carers save services and how this could be improved to support carers in providing this support preventing or delaying the need for further services. Add local statistics to information provided about carers and share in appropriate formats and forums. |
| To assess and determine the literacy of the person and carers. To assess the ability of the person / carers to respond to letters (Trauma informed approaches). | **Recommendation 7 –** These assessments to inform communication methodology for all services. |
| Information about financial assessment to be provided in a sensitive and accessible format. The impact of poverty on a persons mental and physical wellbeing to be determined. | **Recommendation 8 -** Health and Social Care assessments to recognise and identify the impact of poverty in a sensitive manner and seek to break down any barriers to maintaining physical and mental wellbeing as a result of poverty. |
| The distress displayed by Adult B's son in his caring roles and responsibilities should have triggered concern for his wellbeing and that of Adults B. Discussion with the Local Authority could have facilitated access to care and support for both her and Adult B. | **Recommendation 9 -** All agencies to recognise, identify and share concern about carer stress. Share information provided via relevant formats and forums. |
| The use of hypothesis for enquiry purposes enables the person leading the enquiry to identify aspects of maintaining a persons safety and wellbeing to determine whether there is cause for concern or whether concerns can be ruled out. | **Recommendation 10 -** Hypothesis should be explored and ruled out as part of a safeguarding enquiry. |

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| A referral to the Police should not be regarded as a bad thing to do. Police are expected to establish the truth through enquiries based upon 'reasonable suspicion of a crime.' | **Recommendation 11 -** An understanding of preserving evidence and credible evidence to be an aspect of safeguarding training and communications alongside 'Reasonable suspicion of a crime' and reporting potential crime |
| **Capacity – Opportunities to assess and recording.** | |
| In assessing a person's needs and determining intervention to meet needs there must be identification of capacity, consent and who the decision maker is in each instance. This does not necessarily mean that a full, detailed capacity assessment is required in minor daily interventions, but something to identify what the decision making was based upon to determine capacity / lack of capacity is helpful to monitor for change. Care and support plans are not person centred if the right to make autonomous decisions is not explored and specifically identified. | **Recommendation 12 -** All care and support plans should explicitly define who the decision maker is. Provider agencies are to report back to the care and support plan holder and / or relevant agency where there is a change of circumstance in order that safeguarding measures can be applied to ensure appropriate and proportionate care and support. Supervision and peer support to be offered to ensure that this practice becomes widespread. |
| **Timely Police Involvement** | |
| Under 'Making Safeguarding Personal' it is determined that all adults have the right to equal access to criminal justice. This should be discussed with Adult B and her wishes, and feelings determined. The exploration of this hypothesis would potentially vindicate family members from suspicion.<br><br>Equitable access to criminal justice and the ability of a person to present evidence in court should be considered in all aspects of safeguarding. The capacity of a person to make a decision about something should not be confused with | **Recommendation 13 -** For all agencies to recognise the importance of preserving evidence and reporting to the Police at the time of 'Reasonable Suspicion' of a potential crime. Monitor via SAB.<br><br>**Recommendation 14 -** For all agencies to recognise the difference between the need for a capacity assessment and the need to determine whether the person can act as a credible witness and clarify Police expectations. Monitor via SAB. |

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| the ability of a person to be a credible witness in court. In potential domestic abuse cases, or cases where there is a suspicion of wilful neglect (Family member) then evidence-based prosecution can also be considered. | **Recommendation 15 -** For all agencies to recognise the rights of individuals to access to criminal justice on an equitable basis. Consider if this were happening to you, would you want access to criminal justice? If the person does not, are they able to make this decision and what are the barriers? Can advice and guidance be provided to ensure that the person is better informed? Monitor via SAB. |

**What happened in the last 6 months?**

14/09/16 The carers service identifies to the Local Authority that they are providing carer relief; however, adult B's son was not compliant with arrangements. The service was asked to confirm whether Adult B wanted to continue with this provision or not. No further contact received and therefore assumption made that care provision remained. There is no further contact to, with or from adult services by the family or service provider until 24/08/17 when a home visit was made. GP follow up admitted Adult B to hospital and on the 01/09/17 adult B died in hospital.

It appears that Adult B's health declined quite rapidly during the last six month of her life. The GP notes that given the complexities of her health conditions it would not be unusual for an elderly person to experience a rapid decline in health.

## 6. Conclusion

To consider the model provided by the author "Things to Consider Should Similar Circumstances to this Review Arise Today", (Appendix 4 in the full report) and share to ensure that practitioners can reflect this example of coordinated multi-agency safeguarding approaches to complex cases where there are a number of potential hypothesis to rule out during the enquiry process.

**Recommendation**

All agencies to recognise and response to coordinated multi-agency approaches in complex situations. Monitored via SAB.

## 7. Next Steps

The Gateshead Safeguarding Adults Board will develop at action plan from the recommendations and progress on the plan will be monitored through the Quality, Learning and Practice Subgroup.