ISLE OF WIGHT

SAFEGUARDING ADULTS BOARD

Independent Review into the care of Mrs P: 24.02.71 – 26.01.17

1. Introduction

The IoW Safeguarding Adults Board (SAB) and Safeguarding Adults Review (SAR) subgroup agreed on 11.07.17 that this non-statutory learning review will focus on the three days up to and including the death of Mrs P that is 24.01.17 to 26.01.17, while being cognisant of the background. As the cause of death cannot be linked to inflicted abuse or neglect the criteria for commissioning a statutory Safeguarding Adult Review were not met. The terms of reference for the learning review are attached at Appendix 1.

2. Methodology

See Appendix 2 for the detailed methodology.

3. Background

Mrs P had a long history of alcohol abuse and connected health problems dating back for at least ten years. There was involvement from the drug and alcohol service IRIS, the Community Mental Health Team (CMHT), the ambulance service and the Accident and Emergency Department (A&E). She had spent periods in hospital and the mental health facility, Sevenacres. Between the 1st January 2014 and the time of her death Mrs P or Mr PQ had called the ambulance more than 20 times, had over 50 visits to A&E, St Mary's Hospital and been admitted on at least 20 occasions, often discharging herself after only one night. She had numerous serious health issues and in January 2016 she fell down the stairs causing multiple fractures in her back and ribs.

She was reported as self harming or taking an overdose at least 10 times, suffered delirium tremens and hallucinations on several occasions and was once sectioned under Section 136 of the Mental Health Act. She could be funny and engaging but also violent and aggressive. She is reported to have frequently lied to professionals, and there is a long history of non-engagement or disengagement with services.

The police were aware of several incidents between 2014 and 2017, in 4 of which Mr PQ claimed to have suffered violence from his wife; on others she claimed that he was abusing her and was controlling. On one occasion she contacted the Women's Refuge. There were incidents in public when police were called.

There are at least 10 occasions documented in the chronology in which Mr PQ said he "had had enough", or that he couldn't cope with her aggression, mood swings and alcoholism. Several times he said he was leaving. The police sometimes expressed concern about the welfare of both Mrs P and Mr PQ.

At the time of the events under review Mrs P had been drinking steadily since Christmas, and was consuming up to 3 bottles of wine a day. She was unsteady on her feet, and was mostly bed bound. She was doubly incontinent and receiving full time care from her husband Mr PQ.

4. **Focus on 24.01.17 – 26.01.17**
A detailed narrative of the events of this period can be found at Appendix 3.

TERMS OF REFERENCE

5. **Existing chronologies, reports and reviews relating to Mrs P: issues arising.**
   i. I have studied the **Police learning review** which is thorough and critical, identifying good practice, while noting shortfalls in the investigation. However, the authors did not have the benefit of input from the investigating officers, who were able to provide detailed information and context at the workshop.
   ii. In particular, the review noted that while the allegations were investigated as crimes, there was a failure to identify this as a safeguarding enquiry under Section 42 of the Care Act 2014.
   iii. Mr PQ's view was that the police assured him that ongoing care was in place for his wife, but the police view was that Mrs P refused all help and said she was able to manage her own care.
   iv. There is no report from **Adult Social Care** (**ASC)** of their involvement, but it would seem that a workshop was held which led to an action plan. The actions particularly focus on internal processes around referrals and internal understanding of the different roles and responsibilities of different parts of the service.
   v. The two versions of the **NHS Trust Root Cause Analysis (RCA) Investigation Report** plus the level **2 Serious Incident Investigation Report (SIRI)** passed to us by Mr PQ lacks detail. The SIRI in particular did not have the benefit of interviewing professionals involved in the case; it is not clear whether the RCA reports did interview staff. The SIRI notes that services appeared to be working in silos and there was no Section 42 enquiry.
   vi. While IRIS, CMHT, A&E and the ambulance service are all part of the IoW NHS Trust, it would have been helpful to have a view in any one of the reports about how the different services worked together and communicated internally.
   vii. It is really unfortunate that there was no full report from ASC and that the NHS RCA was lacking in critical reflection and detail.

6. **Agency interaction and support of Mrs P**
   i. There was close interaction between the police and CMHT, and CMHT made valiant efforts to coordinate the care of Mrs P during this period. At the front line level there was good communication. But it seemed services were unclear about how to make referrals to each other: for example, the CMHT worker passed the allegations of domestic abuse to the police, but through a call centre, so that by the time it reached the investigating officers the information was already filtered.

ii. The referral came through as a 101 call, and was not explicit about the level of alleged sexual violence: both of these factors resulted in the referral being received as less urgent and serious than it should have been.

iii. When CMHT thought they had made a referral to ASC this did not reach the right place.

iv. A member of the Safeguarding team from ASC told us that had they considered talking to the police when they heard about the case they would not have known who to speak to in the police as they did not know the crime number.

v. There was evidence of police officers, ambulance staff, CMHT members listening to Mrs P and taking account of her wishes and feelings but there was a failure to recognise Mr PQ's needs as her carer and a holistic approach was not taken.

vi. There were delays in service responses: the original 111 call was at 9.22 am but there was no visit until 3 pm; there were significant delays in ASC taking action; delays in the ambulance response to Mrs P's fall.

vii. It was unfortunate that police officers had to spend 6 hours supporting Mrs P after her fall because of delays in the ambulance response.

7. Mutual dependency between Mrs P and Mr PQ

i. CMHT had known Mrs P and Mr PQ for many years and in many circumstances. There seemed to be differing views about the relationship: on the one hand, she was seen to be manipulative and unable to sustain engagement with agencies and he was seen as a "saint " for caring for her; on the other hand, she accused him of being coercive and controlling and maybe she was his victim. The fact that he bought her wine was seen as both a good thing (it needed to be managed and she was dependent on it) and a bad thing (she should stop.)

ii. This report has been asked to focus on the last three days of Mrs P's life, while clearly Mrs P and Mr PQ had been together for many years, and had both helpful and damaging interdependencies.

iii. Mr PQ's role as Mrs P's carer was clear and CMHT staff in particular made considerable efforts to meet her care needs in his absence but there was a lack of focus on his needs as a carer and his vulnerabilities given evidence of her abusing him in the past.

8. Missed opportunities

i. There was a 5 hour delay from the allegations of abuse being made to CMHT and the police and ASC being informed. At no time was a Section 42 enquiry initiated. Had ASC and the police been informed at the time the allegations were made, a strategy discussion could have been held and a plan, both for the investigation and safeguarding Mrs P, made during normal working hours. It is possible the police could have seen Mrs P in the hospital and got a statement from her there.

ii. It is also possible that Mr PQ would have been arrested at the hospital and Mrs P interviewed without him present.

iii. Furthermore, Mrs P was not told that the police were to be informed nor involved in the planning for the enquiry.

iv. The delay in informing the police meant that the referral was received close to a shift change, which may have meant a delayed response.
v. The muddle about the referral to ASC meant it was not dealt with promptly by that service, and indeed it was dealt with as an assessment of need rather than a Section 42 referral.
vi. The request for an Out of Hours Service (OOHS) welfare check on Mrs P when she was known to be vulnerable and alone, which was refused, was a missed opportunity to visit and begin an assessment of need. There must be mechanisms for doing such checks even when no risk assessment has been undertaken – going in twos or with the police?
vii. Had the CA12 been received by ASC promptly maybe it would have prompted a strategy discussion and a Section 42 investigation.
viii. There was a lack of professional challenge and escalation by agencies such as the police and CMHT when other services did not respond as requested.

9. Good practice

i. There is evidence of good relationships between CMHT workers and Mrs P, with thoughtful and generally a person centred approach.
ii. The issue of capacity was at the forefront of professionals' minds and they allowed Mrs Pto make poor decisions.
iii. There is also evidence that CMHT staff tried hard to coordinate the support to Mrs P and communicated well, though not always effectively, with other agencies.
iv. Police officers remained with Mrs P for an extended period after her fall because of delays to the requested ambulance.
v. They also repeatedly offered to transport her to hospital.

10. Hard to engage service users

i. As I have said, focusing solely on the last three days of Mrs P's life makes it hard to identify how she and Mr PQ could have been helped more effectively over the period of their engagement with services.
ii. There is research available to support innovative work, and since this must be a common issue it would be cost effective for the SAB to explore what might work on the IoW.
iii. What seems to me apparent is that there would need to be a different sort of service for users such as Mrs P, which engaged her and her partner over a long period and was not based on episodes of care.

11. Safeguarding Adults: Multi-Agency Policy, guidance and toolkit

i. The operational policies in place across Southampton, Hampshire, the IoW and Portsmouth (SHIP), which came into operation in December 2016 are comprehensive and in line with the requirements of the Care Act 2014.
ii. They were newly in place at the time covered by this review and it is possible that staff were unfamiliar with them, although since the Care Act was implemented the principles behind it are well established. Some of these are particularly relevant to both Mrs P and Mr PQ:
    - Promoting wellbeing;
    - People's wishes and feelings central;

- Person led safeguarding;
- Outcome focused;
- Proportionality;
- No delay.

iii. In addition, widespread training has been given in the IoW on Making Safeguarding Personal.

iv. There is evidence that staff worked to promote Mrs P's well being, took account of her wishes and feelings and tried to engage her in planning for her safety.

v. But the policy states clearly: *Under Section 42 of the Care Act 2014 the local authority has responsibility to make enquiries when they reasonably suspect an adult is at risk of neglect or abuse… The duty applies if the adult has care and support needs….and is not negated by the adult's refusal to participate….*

vi. Safeguarding involves achieving a balance between protecting people and preserving their right to make decisions for themselves.

vii. The guidance goes on to talk about how the local authority with the help of other agencies such as the police and health might conduct the enquiries, but also makes it clear that if they do not lead the enquiry they should oversee its progress.

viii. A care assessment, and a carer's assessment, can be conducted in parallel with a Section 42 enquiry.

ix. As it was, CMHT tried to coordinate Mrs P's care, while having their own area of responsibility, while at the same time the police were undertaking a criminal investigation.

x. These are all complex processes and need to be undertaken within the structure of a Section 42 investigation and a whole system approach.

xi. It seems that no agency involved in the care of Mrs P understood these procedures.

xii. It also seems that the role of ASC is not clearly understood either by partner agencies nor their own staff.

xiii. It has been said that having an IoW MASH will resolve these issues. It will certainly provide the basis for face to face relationships and better understanding of each other's roles and pressures, but these relationships do not just happen by setting up a MASH, especially when there is a history of misunderstanding. There will need to be very careful preparation and planning for the MASH to be successful.

12. Summary

There was

1) A fundamental lack of understanding of Section 42 of the Care Act 2014;
2) A failure to report allegations of sexual and physical abuse to the lead agencies promptly;
3) A lack of challenge to partner agencies when an appropriate response was not forthcoming;
4) A failure of agency out of hours services to work together to support a critical situation appropriately.

13. Recommendations

The police learning review identified a number of findings and makes some suggestions about how the issues might have been addressed and what remedies could be considered for the future, but falls short of making recommendations. The NHS Trust reports do make recommendations for services within the Trust: these differ between the RCA reports and the SIRI. No doubt the Trust will develop an action plan.

Further recommendations for the SAB to consider are as follows:

A. The SAB should oversee refreshed training and guidance for all agencies based on the SHIP Safeguarding Adults policy, so that all agencies are clear about the need for action based on Section 42 of the Care Act 2014 when abuse or neglect of an adult with care and support needs is suspected, and that the lead agency for safeguarding under Section 42 is the local authority.

B. The SAB should ensure that all agencies have robust systems to challenge each other respectfully, and escalate concerns in a timely way when appropriate.

C. All agencies should consider whether their out of hours services are sufficiently robust to meet the needs of vulnerable adults and their families, and how services work together out of hours.

D. The SAB should commission research into what works best with hard to engage service users and those with fluctuating capacity and develop a programme of work to implement best practice on the island.

E. The SAB should closely monitor the development of the IoW MASH to ensure that joint policies are clearly understood within the context of a whole system approach and a shared value base.

Hilary Corrick
23th November 2017