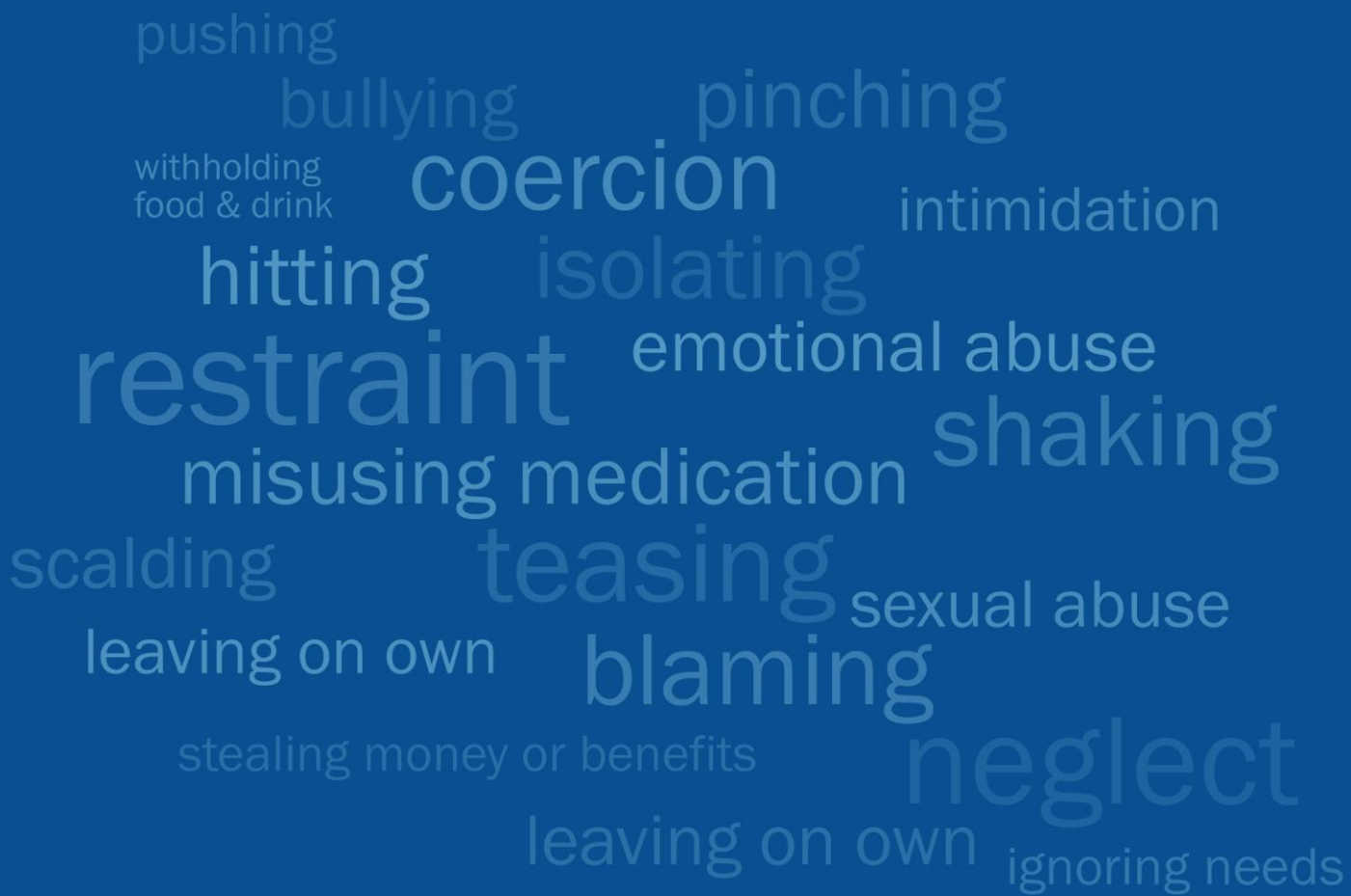
Solihull Safeguarding Adults Board
Protecting Adults Together

SAFEGUARDING ADULT REVIEW

REPORT

Graham



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1. Introduction

In March 2018 Solihull Safeguarding Adults Board received a request from University Hospitals Birmingham HGS (formally HEFT) to arrange an s44 Safeguarding Adults Review in respect of a 54-year old man due to:

- Concerns about his condition on arrival to Heartlands Hospital emergency department, when it was noted he was very frail and family members had also expressed concern about possible neglect and that he hasn't been "looked after properly". Due to the concerns a referral to Birmingham and Solihull Coroner for a Post Mortem was also made.

  and

- There was possible cause for concern about how the Safeguarding Adult Board member agencies or other persons with relevant functions worked together to safeguard the adult.

The purpose of Safeguarding Adult Reviews under s44 of The Care Act 2014, is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

The purpose of the reviews is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

2. Background

Graham was 54 years of age when he passed away on 15th February 2018 in Heartlands Hospital of natural causes (respiratory infections).

Graham lived with his partner Mary and three children aged 13, 7 and 4-years of age. The older children are Mary's children from a previous relationship but Graham supported Mary to care for them and the youngest child is Graham and Mary's child together. Mary is also the 'carer' for one of her children. Mary held the tenancy agreement.

In February 2016 Graham experienced a stroke which affected his speech and mobility. On discharge from hospital he was provided with a personal budget to provide 3 calls a day from an agency to support with personal care needs such as help to use the toilet, maintain personal hygiene and assist with dressing. This offer was cancelled within 2 weeks.

In February 2017 Graham had a left above knee amputation following emergency left popliteal embolectomy (removal of a blood clot).

In early 2018 Mary requested an urgent assessment for respite as Graham was non weight bearing, was reported to be confused at times and could be both verbally and physically aggressive towards her.

Graham had never been subject to any safeguarding procedures.

3. Methodology

To enable a Panel to determine if this case meets the criteria for a Safeguarding Adult Review the following agencies were asked to provide a summary of the contact their organisation/agency had with Graham and to clarify the key safeguarding issues.

SMBC Adult Social Care
West Midlands Police
Solihull Clinical Commissioning Group (now BSol CCG)
Solihull Community Housing
WM Ambulance Service
West Midlands Fire Service (WMFS)

A Panel of experts who had no direct involvement with Graham was organised involving SSAB Board Members.

After considering and discussing the scoping responses they concluded this case did not meet the criteria for a Safeguarding Adult Review set within s44 (1), (2) or (3) of the Care Act 2014 (see Appendix 2) because:

- There was insufficient information to suspect Graham's death was a result of abuse or neglect.

However the Panel did feel there was learning to be achieved so recommended a proportionate review be conducted under S44 (4) using an Action Learning model with this case as the basis to explore how agencies worked with this family and together specifically in relation to:

- Support for carers
- Effective liaison with children's services
- Hospital discharge
- Domestic abuse and
- Mental capacity.

To achieve this we used the 'World Café' model[1] rather than an action learning model, as it was felt to be more effective for the purpose of the

[1] A World Café is a structured conversational process for knowledge sharing in which groups of people discuss a topic at several tables, with individuals switching tables periodically and getting introduced to the previous discussion at their new table by a "table host".

learning event. There were 5 tables – one of each of the above topic areas and each table had a facilitator (table host). For each of the topic areas participants were asked to consider:

- What are we worried about? (Past, current and future harm and danger)
- What went well? - (strengths and safety)
- What needs to happen/change? (Future practice) and
- What lessons do we need to communicate to the Safeguarding Adults Board?

4. Summary of facts and findings from Learning Event

Practitioners and managers from SMBC Adults and Children Services, UHB HSG, SCH, Carers Trust Solihull, West Midlands Police and BSOL CCG attended the event, as their organisation was involved with Graham and his family.

The aims of the Learning Event were to:

- enable participants to reflect on the circumstances of their own and other agencies involvement with Graham and his family
- work through the issues surrounding that involvement
- challenge perceptions of the circumstances and outcomes and
- share ideas about learning and future practice.

Pre-reading was sent out to participants that summarised the key events in Graham's life and the contact with the various services and organisations.

The Learning Event began with an outline plan for the day and reflections from Graham's Partner.

4.1 Reflections from Graham's Partner.

Graham's partner was contacted and asked if she would like to participate in this review, which she declined. Mary stated she was satisfied with the support and help she received from all agencies.

Feedback from the group discussions

4.2 Support for carers

This table was facilitated by SMBC All Age Disability Team Manager.

Graham's "carer" was his partner Mary who also had responsibility for a toddler, 7-year old and 13-year old. Mary was also the carer for one of her older children. Participants were asked to think about: What opportunities were there to identify Mary's carer's needs? What support is available for carers? What opportunities were there to share information?

The information in the agencies chronologies which were used to inform this learning event suggested the support to Mary was minimal. However participants disputed this reporting, Mary was offered significant support which

she refused; therefore the discussion centred on how agencies should/could be more proactive and follow up with families where there is a lack of engagement.

The table discussions identified a number of interventions when support for Mary could have been followed up – for examples: following hospital admissions and discharges, when emergency respite was requested and when agencies had contact with the family due to crises.

The group felt specific support to Graham and Mary in relation to the psychological needs and support following a stoke and amputation was important to enable them to understand and manage the impact of the stroke and amputation. Whilst it was clear Mary was offered and received support from the Carers Trust Solihull, but it was less clear if other 3rd sector organisations with specialist knowledge had been involved with Graham and Mary – such as the Stroke Association. This brings into question did agencies assume someone else was making the referral or was a referral to the Stroke Association just not considered?

The areas for change were identified as:

a. A 'Whole Family'[2] approach and 'Relationship-based practice' approach should be the approaches used with complex families such as Graham's.

   (*A whole family approach includes - Identifying families with the greatest need to provide the right support at the earliest opportunity. As far as possible address the range of needs within a family through accurate identification and co- ordination of a family wide response. Strengthen the capacity of family members to provide care and support to each other. As a minimum a whole family approach requires an understanding of the key 'family' structure and composition as well as being alert to wider family issues that may have a bearing on the overall well- being of the family as well as any specific individuals an agency is working with*).

b. A method to identify individuals and families with significant risk should be considered so that support to them can be coordinated, monitored and robust.

4.3 Effective liaison with children's services

This table was facilitated by SSAB Business Manager.

Graham lived with his partner Mary and three children aged 4, 7 and 13. Participants were asked to think about: How was the Think Family approach used? Was there any liaison with children services to support this family? What opportunities were there to share information?

[2] https://www.local.gov.uk/sites/default/files/documents/care-act-and-whole-family-6e1.pdf

The initial information from agencies did not identify there were any children in Graham's household. This information was only identified when the Panel met to review the scoping responses. This raised a couple of significant questions for participants:

> Who should have known there were children in the household?
> Would this information have changed people's interventions?

Hospital staff were unaware of the family make up – their involvement was only with Graham and Mary. Graham was not visited by any of the children when he was in hospital.

SMBC Adults Social Care Teams do not use as part of their assessment process genograms or ecograms, which are practical and easy tools commonly used by children services to identify and illustrate a person's family relationships and history to assist a whole family approach.

The family GP and Solihull Community Housing responded to the needs presented to them for resolution.

The table discussions identified concerns about not assessing the significant changes to the family - such as the impact of Graham's significant health issues on the rest of the family, the change in housing to accommodate Graham's disability and the financial implications. Also it is not clear how the anti-social behaviour, domestic abuse and neglect concerns had on all family members.

Practitioners noted that it appears that all agencies only come together for multi-agency working within safeguarding procedures – so if these procedures are not needed or used effective multi-agency working can be missed.

The areas for change were identified as:

c. A 'Whole Family' approach would help to consider the whole family and support multi-agency working.

d. Using genograms or ecograms as part of all assessment processes would be effective within a 'Whole Family' approach.

4.4 Hospital discharge

This table was facilitated by West Midlands Fire Service (Panel Member).

Graham had 2 significant hospital stays – the first in February 2016 following a stroke and again in February 2017 when he had a left above knee leg amputation. Additional information from UHB HGS identified following his stroke he did not engage, was low in mood, had been aggressive to staff. Participants were asked to think about: The impact these hospital stays would have on discharge home. What support was offered to them on discharge? Was the discharge planning robust? What opportunities were there to share information?

The initial scoping process missed asking UHB HGS for information. So following the Panel Meeting UHB HGS were approached for feedback and they identified following his stroke Graham did not engage, was low in mood and had been aggressive to staff. It is not evident whether this information was shared with Mary on discharge.

The table discussions identified Graham was: discharged with a care package, seen by a clinical psychologist and his mental capacity to consent to treatment was assessed. UHB HGS staff also advised there have been significant changes in leadership on the ward where Graham was, resulting in improved assessments and discharge arrangements.

Participants were concerned within discussions that they did not and could not know what Graham was like before his stroke or amputation. What was his health, family life and financial situation like?

Through this learning event participants identified there were a lot of agencies involved with Graham over the last 2 years of his life, however it is not clear how these organisations shared information and provided a coordinated approach.

The areas for change were identified as:

e. All Board Member agencies should be asked for scoping information so SAR Panels can make robust assessment and recommendations.

f. Consider if a 'Whole Family' approach would: help to understand individuals situation before they required support from health and social care, assist individuals voices to be heard and enable effective multi-agency coordination.

4.5 Domestic abuse

This table was facilitated by West Midlands Police.

There were a couple of incidents of domestic abuse Graham to Mary and Mary to Graham. Participants were asked to think about: how was that managed? Was it considered to be Domestic Abuse or treated as 'carer/looked after stress'? Was the impact of these incidents in relation to the children considered? What support were they/could they have been offered? What opportunities were there to share information?

The discussion in relation to domestic abuse raised the most issues. Participants identified:

- Two-way domestic abuse is complex.
- Consent to share information needs to be more clearly understood.
- Mental capacity when there is coercion and control needs to be more clearly understood.

- The link between domestic abuse and safeguarding adults needs to be clearer.
- Recording systems should assist practice across departments not create barriers.
- A key worker approach to coordinate, look at the 'bigger picture' and ensure multi-agency working together might have been beneficial for Graham and his family.
- There is a lack of knowledge or availability of support services for male victims of domestic abuse - particularly men with disabilities.
- The need to ensure the effect of domestic abuse on all family members is considered by all professionals and practitioners.
- Agencies must be clearer why they are making a referral to a partner agency and those receiving the referral should be clear about what is being expected. What outcome do professional and practitioners want from a referral?

The areas for change were identified as:

g. The link between domestic abuse and safeguarding adults needs to be clearer.

h. Solihull should consider if an Adult MASH would enable effective information sharing and multi-agency collaboration at the earliest point.

4.6 Mental capacity

This table was facilitated by SMBC First Point of Contact Team Manager.

Within the scoping information the only reference to Mental Capacity was made by the Police. In the additional information from UHB HGS following his stroke when he was not engaging, low in mood and occasionally being aggressive to staff his mental capacity was not 'formally' assessed. Participants were asked to think about: Were there any missed opportunities to assess Graham's mental capacity? Would assessing Graham's mental capacity helped? What opportunities were there to share information?

Participants discussed if there is too much emphasis placed on mental capacity rather than assessing and supporting individual's mental wellbeing, physical ability and understanding Acquired Brain Injuries. Participants also discussed how the psychological impact of significant physical changes might affect mental capacity.

Table discussions identified that information was considered in isolation: for example – his low mood was identified in hospital but was it shared on his discharge? Graham missed GP appointments – should that have been shared with other agencies as he would have needed support to attend? EDT responded to an alleged Domestic Abuse incident but did not inform the police.

Across the partnership participants acknowledged the Mental Capacity Act 2005 requires that we should always start from the assumption that the

person has the capacity to make the decision in question – however participants felt the triggers for a formal mental capacity assessment are less clear and known.

The areas for change were identified as:

i. How to ensure psychological impact of significant physical changes and Acquired Brain Injuries are incorporated into Mental Wellbeing and Capacity assessments should be considered.

j. All partners must ensure Information Sharing and Multi-Agency collaboration across the partnership is timely, proportionate and meets legislative duties.

5. Conclusion

This learning event provided a safe forum for debate and discussion, not only regarding Graham and his family but also regarding the safeguarding adults process in Solihull.

The overriding theme from this event was “think family”. Whole-family approaches can be key in maximising the impact of resources and identifying opportunities to support carers and to ease the very real risks to health and wellbeing that caring can bring. A whole family approach would coordinate services and support around the person and their family.

Effective multi-agency working is recognised as crucial and challenging in situations of both domestic abuse and safeguarding adults. In some situations, abuse or neglect can be the result of ‘carer stress’, however, the assumption should be that any form of abuse can cause serious harm. Caregiver stress is a risk factor for abuse / neglect, but, caregiver stress should not excuse abusive behaviour. Making the connections between safeguarding adults and domestic abuse will enable more effective safety planning.

Participants of this learning event often came back to the psychological effect Graham’s stroke and amputation would have had on him and his family, the impact of his physical disability on family life and the impact his physical disability had financially. But throughout this learning review it was not clear if any one agency attempted to address these serious and significant issues for this family.

Agencies involved with Graham and his family responded appropriately to the presenting issue which was in their remit to solve. What was lacking was the sharing of information and coordination of support and services, which can be difficult when presented with an individual or family who do not want to engage.

5.1 Recommendations

The following recommendations are intended to improve practice across the partnership:

i. Health and Social Care consider how a 'Whole Family' approach and 'Relationship-based practice' approach could be used with complex families.

   When scoping out this approach consideration should be given to how:

   - It would support multi-agency working;
   - Genograms/ecograms tools should be used;
   - It would assist individuals voices to be heard and
   - It would ensure effective multi-agency coordination

ii. Health and Social Care to develop a method to identify individuals and families with significant risk so that support to them can be coordinated, monitored and robust.

iii. SSAB Business Team must ask all Board Member agencies for scoping information for all SARs so SAR Panels can make robust assessment and recommendations.

iv. Social Care must make it clear how the link between domestic abuse and safeguarding adults will be made and how it will improve the lives of adults with care and support needs who are experiencing Domestic Abuse.

v. Solihull should consider if an Adult MASH would enable effective information sharing and multi-agency collaboration at the earliest point.

vi. Health and Social Care to ensure staff are equipped to consider psychological impact of significant physical changes and Acquired Brain Injuries when carrying out Mental Wellbeing and Capacity assessments.

vii. All partners must ensure Information Sharing and Multi-Agency collaboration across the partnership is timely, proportionate and meets legislative duties.

This report has been produced by the SAR Panel:

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