Safeguarding Adults Review

Subject: Sally
Age: 26

Report Author: Pam Marsden

Contents

1. Introduction

Circumstances of Review

1.1. This Safeguarding Adult Review (SAR) concerns Sally who was 26 years old when she died. She had 2 young children who had been placed in the care of their paternal grandmother and a husband who, although not always living with her, was described as her main family carer.

1.2. She had been known to mental health services since the birth of her second child in 2011. She had a history of drug misuse and self-harm

1.3. Sally had been diagnosed in October 2013 with peripheral sensory neuropathy and having rejected the physiotherapy offered, the illness left her with very little mobility. She eventually spent long periods in bed sleeping and was unable to attend to any of her personal care needs without help.

1.4. The home she occupied was described as filthy or squalid. She had a domiciliary care package to support her which at times was withdrawn or was rejected by her. She was offered assistance by a range of professionals over a period of time. She regularly did not accept the support and she has been described as difficult to engage.

1.5. A number of agency reports have referred to both formal and informal Mental Capacity Assessments having taken place, however the only formal assessment noted is in July 2015 and this appears to have been in relation to her ability to manage her finances.

1.6. In the 6 months prior to her death she made a number of allegations against her husband namely that he left her without care for several days, stole money from her and ultimately that she did not feel safe in the house with him. However, she went on to withdraw these statements and did not want any action taken.

1.7. Sally was found in her house by her husband on the 14th October 2015. Ambulance and police were called and she was pronounced dead at 2300 hours. There were considered to be no suspicious circumstances surrounding her death.

1.8. The Inquest concluded on 14/7/2016 and the Coroner's verdict was death by natural causes contributed to by neglect. The Pathologist's report gave the cause as bronchopneumonia with side effects caused by opiates (prescribed) in a female with physical, psychological and nutritional compromise.

1.9. The case was not identified as requiring a SAR initially by the Coroner's office. It was then reviewed and referred after some considerable time in July 2017 to be considered as a possible Domestic Homicide Review. However, agreement was reached that it did not meet the criteria. A referral was then made to the Devon Safeguarding Adults Review Core Group (SARCG) on the 05/10/2017.

1.10. Pam Marsden was invited to undertake an Overview Report into the circumstances of this case. She is the Independent Chair of the Oxfordshire Safeguarding Adults Board and the Director of Adult Services.

2. The Purpose of a Safeguarding Adults Review

2.1. A Safeguarding Adult Review (SAR) is undertaken when a vulnerable adult dies or is seriously injured and abuse/or neglect is known or suspected to be a factor.

2.2. The purpose of a SAR is neither to reinvestigate nor to apportion blame, but to establish if there are lessons to be learnt to prevent such an incident happening again. The Association of Directors of Social Services in their document "Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services" described the overriding reasons for holding a review as being able to learn from past experience, improve future practice and multi-agency working. Safeguarding Adults Reviews have become a Statutory Duty since the Care Act 2014 came into force on 1st April 2015.

2.3. In Devon the Safeguarding Adults Review Core Group (SARCG) makes recommendations to the Independent Chair of the Devon Safeguarding Adults Board (DSAB) and manages the SAR process in accordance with the DSAB protocol for Safeguarding Adult Reviews. It considers whether a case meets the criteria for a SAR applying the criteria as laid out in The Care Act 2014 and the accompanying guidance.

2.4. Having taken into account the range of factors it was determined that this case met the criteria and a SAR was recommended and commissioned.

3. Terms of Reference

3.1. The SAR had two central objectives:

3.1.1. The first was to review and evaluate the context and circumstances leading up to the death.

3.1.2. The second was to learn appropriate lessons across organisations.

3.2. The Safeguarding Panel established the following questions in relation to Sally to be addressed in the Review:

3.3. What specific issues or questions does the case raise?

3.4. What notable practice was there?

Mental Capacity and ability to make decisions about care and risks to health

3.5. How did agencies assess Sally's capacity? Were these assessments shared? How did these assessments influence practice?

3.6. How were her wishes and feelings assessed and considered? Were services sensitive to the possible root causes behind any presenting incident? For example: her lack of support from family or friends, her isolated rural conditions, substance misuse issues? Were specialist services appropriately signposted or consulted?

3.7. Did Agencies give sufficient weight to any aspects of coercion or control by her husband?

The quality of professional practice

3.8. Were assessments carried out and decisions taken and followed up in an appropriate way?

3.9. How did the intimidatory atmosphere created by husband and his friends impact on professional practice?

4. Contributors- Individual Chronologies and Reports

4.1. The 9 agencies listed below were asked by the sub-group to produce Individual Agency Reports, including chronologies, detailing their respective contact with Sally. These Reports were combined and used by the author as the main basis for this report. A copy is held by the SAR Panel Administrator.

4.1.1. Health and Social Care, Devon County Council (DCC)
4.1.2. Northern Devon Healthcare NHS Trust, Community Nursing (NDHT)
4.1.3. Devon Partnership Trust (DPT)
4.1.4. Torrington Health Centre
4.1.5. Pee Wee's Domiciliary Care Agency
4.1.6. Splitz Support Service
4.1.7. Devon and Cornwall Police
4.1.8. North Devon Against Domestic Abuse (NDADA)
4.1.9. South Western Ambulance Service Foundation Trust (SWASFT)

4.2. Additional Information or content was obtained by the author as required. The author was also given access to the information prepared by Devon and Cornwall Police for the Coroner's Inquest which was opened 15/12/2015 and resumed on the 14/7/2016, concluding on the same day.

4.3. The SAR conclusions represent the collective view of the SAR panel. There have been full discussions of all of the significant issues arising from the review and these have contributed to the shaping of the report.

5. Safeguarding Adult Review Panel Members

Role	**Organisation**
Independent Author	
Panel Chair	Devon and Cornwall Police

Business Manager	Devon Safeguarding Adults Board
Deputy Community Services Manager-Health and Social Care	Royal Devon and Exeter NHS Trust
DCI	Devon and Cornwall Police
Named Professional for Safeguarding Devon and Cornwall including Isles of Scilly	South Western Ambulance Service NHS Foundation Trust
Clinical Specialist for Safeguarding	Devon Partnership Trust
Safeguarding Adults Lead	Northern Devon Healthcare NHS Trust
Team Leader	SPLITZ
Registered Manager	Pee Wee's Personal Home Care
Independent Domestic Violence Advisor Manager	North Devon against Domestic Abuse (NDADA)

6. Responsibilities to Families

Good Practice requires families to be involved in a SAR so that they can contribute as appropriate. Both Sally's husband and also her mother were written to and offered the opportunity to participate in the review. The offer was not taken up.

7. Background, Events and Chronology

7.1. General Background

7.1.1. There was relatively little information available about the life and background of Sally. The summary provides a general overview of key events. It is not exhaustive.

7.2. Family and Social History

7.2.1. Sally was married and had two young children. There were concerns about the couple's drug use. The family were given support by children's social care and through family agreement in early 2012 both children went to live with their paternal grandparents.

7.2.2. During Sally's early life, she and her family had been known to police. The police records reveal that there were a number of incidents of domestic violence in the family home, some of which she witnessed as a child. Her father was reportedly a

heavy drinker and more recently she alleged she had been sexually abused by him although this had not been formally investigated.

7.2.3. In 2004 Sally received a Youth Simple Caution for theft and in 2007 was the victim of common assault by her father. In 2011 she was found to be in possession of cannabis and was dealt with by way of a Cannabis Warning Form. In 2014 it was reported that she and her husband were pressurising her grandfather for money in order to buy drugs.

7.2.4. She lived in a house bequeathed to her by her grandmother which was in a rural, isolated location. At times her mother lived with her and is reported as both a carer and also someone with her own care needs as she had multiple sclerosis. Her husband however is described as her main family carer, but he leaves the family home for periods of time.

7.3. **Physical Health**

7.3.1. In 2013 Sally had a prolonged stay in hospital having been diagnosed with sensory neuropathy of unknown underlying cause. This illness has a number of symptoms such as burning pain, loss of feelings in limbs, sensitivity to touch and ultimately difficulty in walking. Attempts were made to improve her mobility in hospital and to encourage her to engage with further rehabilitation post discharge but she did not wish to work with the physiotherapist or indeed consider a further in-patient stay. She spent long periods in bed. Her condition deteriorated and she became more and more immobile, relying on help with all daily living tasks including personal care. She had two brief periods in hospital in 2015 linked to her self-neglect.

7.4. **Mental Health**

7.4.1. Sally had been known to Mental Health Services since the birth of her second child. She asked for help with what she described as her childhood trauma but did not engage with the therapy offered and was reported as appearing chaotic and under the influence of drugs/substances.

7.4.2. She would at times self-harm by cutting with a knife on her forearms. She was admitted briefly to an inpatient unit under section 2 of the Mental Health Act in September 2014 having taken an overdose and cut herself, albeit superficially.

7.4.3. In July 2015 she was diagnosed as having an emotionally unstable personality and recurrent depressive disorder.

The Safeguarding Adult Review terms of reference set 01/01/2014 as the start point for detailed IMR chronologies.

8. Summary of key events 1/1/2014 - 14/10/2015.

8.1. In January 2014 Sally had been recently diagnosed with peripheral sensory neuropathy and discharged from hospital. Attempts had been made to improve her mobility in hospital

and a 6-week trial of physiotherapy at home had been offered but effectively rejected as on only 2 occasions did she work with the physiotherapist, both times “without enthusiasm”. She was then offered a further in-patient stay at the Mardon Unit in Exeter but this too was rejected.

8.2. CMHT staff, community matron and GP undertook a number of home visits over the next few months. It was noted that she was often difficult to contact by phone or email. She would at times refuse entry and would also miss hospital outpatient appointments. She is described as angry and frustrated. The view from the Consultant Physician was that the prognosis of her neuropathy was complicated by her ongoing illicit substance misuse. She on the other hand was very unhappy that her neuropathy had been attributed to her use of cannabis.

8.3. There are challenges around securing domiciliary care in North Devon and in particular in very rural locations. Some care agencies had withdrawn because of her behaviour towards their staff and at other times she would not accept the care when offered. There were a number of changes of carers during the period of review. Care was also withdrawn on 2 occasions because she refused to pay but the decision was reviewed, and the care was reinstated. (She was also threatened with court action because she was not paying her council tax.)

8.4. According to records the issue of protection of carers had been addressed to ensure they could work safely. A decision was made in June that year that all domiciliary care visits would need two staff and there was a change of social worker agreed as there had been some conflict. Sally is described as at times seemingly randomly picking and choosing who she would deal with.

8.5. In August her mother moves out and her husband moves back in to live with her. Hospital appointments continue to be missed and blood tests have to be rescheduled. At times staff are unable to gain access.

8.6. Towards the end of 2014 it becomes even more difficult to engage with her and it is reported that on at least one occasion her husband refused staff entry because the appointment had not been made and agreed to in advance. Most visits are focused on practical tasks such as catheter changes and advice.

8.7. In Feb 2015 mother reports new concerns that Sally had deliberately cut herself.

8.8. Sally states she has not seen her children for some time and is distressed about this.

8.9. Staff continue to offer advice and support her but still a number of visits by professionals continue to end in no contact or missed appointments.

8.10. In May 2015 there were increasing concerns about her care and general state of neglect. Her husband, who was her main family carer, had moved out leaving her without care. She was offered the possibility of respite in a nursing home, but she did not want this, citing the reasons as concern for her dog and her desire to continue smoking. It is noted that the house is in a poor state, full of rubbish and clothes. On one occasion staff

remove 12 bags of urine and old food. The Rapid Response service offers her support for a period. Locks are changed and a food parcel is obtained from a food bank.

8.11. In early June 2015 her husband returns to live with her. He has been given the key safe number. There is evidence that she is eating and drinking, and she says she feels safe.

8.12. Pee Wee's Domiciliary Care Agency begin to offer care in late June 2015. The care plan is agreed, and staff work hard to engage with her to form a relationship before commencing care.

8.13. In July 2015 once again, there are concerns for her safety. She tells police that she is now estranged from her husband and does not feel safe. She says he has been outside the house with a number of his friends. Care workers from Pee Wees Domiciliary Care Agency also report that they do not feel safe at times in the property which is described as rural, difficult to find, isolated and not pleasant at night. A multi-agency professionals meeting is convened. A number of actions are agreed at the meeting including the decision to convene a Risk Strategy meeting to include the police and to arrange for a Consultant Psychiatrist to undertake a Mental Capacity Assessment. This assessment takes place on 30th July but appears to be in relation to her finances and confirms she has capacity. There are then a further 2 Safeguarding meetings on the 11th and 18th August and a number of actions are agreed which are detailed below.

8.14. Devon and Cornwall Police report that there were numerous calls to them from Sally in July and August expressing concern about her husband and his friends, stating she feels unsafe.

8.15. As a consequence, in August the key-safe number is changed and the local police start to drive by several times each day to see if her husband is there with a view to cautioning him. Care staff are encouraged to contact the police if they are concerned when they visit. SPLITZ become involved and consider Sally to be at high risk of serious harm from her husband. With her consent a referral is made to Multi Agency Risk Assessment Conference (MARAC) and she is offered support from the North Devon against Domestic Abuse Service. She is given a phone that can be plugged in next to her bed.

8.16. The Crime Prevention Officer visits to give advice and specialist domestic violence police become involved. A risk assessment is completed. An alarm is installed which alerts the police if someone unauthorised enters her home.

8.17. On the 4th September the alarm is activated but when Police visit she does not want it reset. She has allowed her husband back in the home. She is described as obstructive about suggestions on how to protect herself and it appears she has continued to have Facebook contact with him throughout the period she was asking for assistance and telling staff she felt unsafe. The alarm is subsequently removed. The Domestic Abuse Service withdraws as she says that she is safe and wants her husband at home.

8.18. In the same month, however, there appears to be evidence of physical deterioration and some general decline in her health. She is prescribed antibiotics. Her vital signs on one visit are then described as unremarkable and she appears to be feeling better. She declines to have blood tests. Concerns are expressed that her decision-making capacity may be compromised and she may not be able to weigh up the risks but the GP, having

spoken with Sally, disagrees.

8.19. There is a meeting at Sally's home with police and the care coordinator from DPT present. It is suggested that a joint assessment involving the Crisis Team is made to assess Sally's mental capacity. The Crisis Team are contacted but they do not consider their involvement appropriate as she is not being considered for pre-admission to a psychiatric ward.

8.20. Pee Wee's Domiciliary Care Agency having reported their concerns refuse to visit on the 26th September because of the continued and perceived risks posed by her husband and his friends. Their staff feel unsafe. The isolation and rurality of the property at night particularly concern them. The Agency then resume care on the 01/10 after some negotiation with Sally but during the daytime only. They report Sally as rude and uncooperative.

8.21. However, within a matter of days she has cancelled her domiciliary care, citing the reason that she is going to stay with a cousin. Staff are concerned this is not the case and so visit to check on her. The front door is open and a young man is in the doorway. The key is not in the key safe. Sally then tells them she does not need any further help from Pee Wee's Care as a family member is now helping her. The next day 4 men are seen leaving the home, there is no key in the key safe.

8.22. 9th October 2015 a Professionals Meeting is held because of ongoing concerns. It was acknowledged that Sally had not effectively engaged with help offered but all those attending also acknowledge the risks to Sally and her ability to safely manage her care at home. All agree she has the mental capacity to make decisions and that the case does not meet the threshold for safeguarding. It was also noted she had not had her medication collected for 2 weeks but those attending agree that she often took tablets out of the blister packs and likely had a surplus of medication as she did not always take it.

8.23. It was further agreed by those at the meeting that a letter should be hand delivered to Sally explaining the risks but also confirming that their involvement would cease and that she would need to contact her GP if she wanted further help. Unfortunately, there are no formal notes of the meeting and it is not clear how either capacity had been assessed or how the threshold for safeguarding was not met. The police are not invited to the meeting.

8.24. On the 14th October the Community Matron visits with a nursing assistant to change her catheter. Sally's husband answers the door and tells them she is asleep, that he is emptying her catheter bag and there was no need for their visit. They did not get to see her but left feeling concerned about her. The Community Matron was about to make a safeguarding referral the next day when she was informed of Sally's death the night before.

9. ANALYSIS

This section of the report analyses the findings of the Individual Management Reports and other relevant information received by the Panel. Any issues or concerns identified are a reflection of the evidence made available.

9.1. **Mental Capacity and ability to make decisions about care and risks to health.**

9.1.1. The Mental Capacity Act 2005 lists a number of key principles in relation to capacity

9.1.1.1. Every Adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.

9.1.1.2. Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.

9.1.1.3. However, the higher the risk, the greater the certainty of capacity must be.

9.1.2. Sally was a complex individual who did not fit into traditional patterns of service. The issue of mental capacity is central to the way Sally was dealt with by the various agencies who were involved in her care and support. It is difficult to form a picture as there is minimal assessment evidence available. Without the relevant formal assessments there was no opportunity to consider Best Interest or indeed Inherent Jurisdiction.

9.1.3. There are only likely 2 broad possibilities in relation to Sally's behaviour as described. That she had capacity and was making unwise choices. This seems to be what, most professionals involved with her, believe to be the case.

9.1.4. The other possibility is that she lacked capacity or possibly executive capacity, but this was not recognised. The impact of her drug abuse, her poor physical health and her mental health diagnosis alongside her attempts at self-harm and the limitations of her family and network support made her particularly vulnerable. This does not seem to have been formally considered in a coordinated way or indeed documented. If she was indeed capacious then further consideration of the risks through a safeguarding approach should have been considered.

9.1.5. The Author is acutely aware of the benefits of hindsight in a review of this type. However, it seems clear that this case would have benefitted from a multi-agency review at a senior level where a plan could be agreed and documented. This escalation and formal review would have supported the operational staff who were clearly struggling with this situation and brought together the agencies with the benefit of both legal advice and also specialist staff if appropriate.

9.2. **How did agencies assess Sally's capacity?**

9.2.1. In the period under review although there are a number of references in all of the reports to informal and formal capacity assessments having taken place, there is however only one formal Mental Capacity Assessment noted and this is in relation to money. The conclusion is that she has capacity to manage her money and has decided not to pay her care fees.

9.2.2. In the analysis undertaken by Devon Partnership Trust within the IMR it is noted that Sally is believed to have capacity to make decisions regarding her

care and support but there is no evidence of any Mental Capacity Act (MCA) assessment clinical record to support this judgement.

9.2.3. The report also notes that professionals were focused on engagement and getting alongside Sally to comply with her wishes. The report argues however that her [1]executive capacity may have been compromised by her experience of trauma, illness and substance misuse.

9.2.4. The report goes on to describe how a series of small steps, each taken with capacity could each incrementally lead to a situation which was not chosen. The concept of executive capacity is however relatively new and is developing in practice. It is not in the Mental Health Code of Practice but is found in Best Practice Guidance.

9.2.5. The distinction between decisional and executive capacity is important for determining responses where self-neglect is a feature. The emotional components of capacity are hard to identify but may prevent the person from using and weighing up information.

9.3. **How were Sally's wishes and feelings assessed and considered? Were specialist services appropriately signposted or consulted?**

9.3.1. Although often difficult to engage Sally appears to have been consulted about her wishes and feelings at regular intervals. Meetings were held at her home and her views sought. Despite her behaviour which at times could be aggressive, rude and obstructive, staff continued to offer her help and support and showed significant ongoing concern for her wellbeing. There were a number of occasions when staff did more than should be expected of them. Specialist services were consulted at times.

9.4. **Were services sensitive to the possible root causes behind the presenting incidents/requests.?**

9.4.1. Devon Partnership Trust's report notes that there appeared to be a complex relationship experienced by Sally and her family with health and social care services in attempting to provide support. She appears angry and there is a pattern of rejecting offers of help, including further support with rehabilitation to maximise her physical independence, but it is unclear why. Support from health services is increased when social care is rejected. There are a number of examples of repeat calls to the ambulance service for a range of reasons, not always appropriate, and sometimes seemingly because she had rejected help offered earlier from another agency and was now requiring out of hours responses. This pattern is set within the context of her self-harm and wider self-destructive behaviour.

9.4.2. The impact on her behaviour and reasoning of Sally's diagnosis of an unstable personality and recurrent depressive disorder, coupled with drug/substance misuse is not fully explored. Furthermore, her husband who is her main carer

[1]Executive capacity, namely, the ability to act on a decision and to manage the consequences of it. SCIE … Self-neglect policy and practice building on evidence base for Adult Social Care.

appears to be emotionally abusive and there appears to be coercion, but this again is not fully explored or understood

10. Summary and conclusions

10.1. Having reviewed the Individual Management Reports and associated documentation, the author has drawn a number of conclusions and identified a range of lessons learned from the case. They are set out below and have been used as the basis for recommendations in section 11

10.2. **Mental Capacity**

10.2.1. Where there are concerns about unwise decision making there should be well evidenced consideration of mental capacity**,** including discussion with managers. The evidence should be formally recorded and circulated to all partner agencies as appropriate

10.2.2. If the assumption is made that all key practitioners believed that Sally had capacity to understand the risks to her health and she was making unwise decisions, then it is surprising that more weight was not given to considering safeguarding processes as a way to reduce the level of risk and self-neglect.

10.3. **Intimidatory atmosphere and impact on professional practice**

10.3.1. The negative impact of the intimidatory atmosphere is not acknowledged in either the reports or the contemporary case notes records except in relation to domiciliary care workers who clearly felt concerned for their safety because of Sally's husband behaviour alongside that of his friends.

10.3.2. We know that he did not always allow key professional staff entry, but we also know that Sally was clearly ambivalent about her relationship with him. This may have been in order to maintain contact with her children, who live with their paternal grandmother, but also could have been to maintain an ongoing relationship with him, however abusive it may have been. The agencies involved could not replace the intimacy of their relationship nor the history they shared together.

10.3.3. On the final day of her life staff are again refused entry by him and they leave feeling concerned. Concerns they may have had about their own safety are not explored but some level of intimidation can be assumed.

10.3.4. There is however a significant gap in our knowledge about Sally's husband's motivations. Neither he nor other family members appear to have been involved in the key decision making and much of what we know is from the information given to us by Sally. Attempting to involve him and or her family in decisions and exploring the concerns professional staff had for her health and wellbeing should have been considered.

10.4. **Notable practice**

10.4.1. In terms of notable practice there was clear evidence of diligent and patient-centred care. There was also continuity of care from particularly Community Mental Health Team and community nursing staff over an extended period in difficult circumstances. Staff were persistent and extremely supportive throughout periods when Sally was motivated to work with them and also when not.

10.4.2. All of the reports acknowledge the close collaboration, communication and good multi-agency working that took place. Meetings and medical reviews were timely. Attempts were made to keep Sally at the centre and staff were respectful and compassionate. There were times when staff undertook tasks that went well beyond what was expected of them. Staff at various times spent considerable periods trying to engage and understand Sally in order to establish an effective and sustained relationship**.**

10.5. **Lessons learnt**

10.5.1. Devon Partnership Trust (DPT) believe a more in-depth assessment of Sally's vulnerabilities to exploitation needed to be undertaken rather than the more reactive practice which focused on the imminent risks.

10.5.2. They also acknowledge that there could have been a greater focus on sharing information and attempting to involve the family in support and care planning. This could have led to a more structured plan around domiciliary care and allowed for contingency plans and better communication.

10.5.3. Furthermore, meetings with the family and family group conferences should have been considered.

10.5.4. They believe there was a need for clinicians to have access to robust safeguarding training to promote their understanding of "professional curiosity" and Mental Capacity Act training to increase confidence in undertaking capacity assessments. The absence of recording meant it could not be confirmed that Sally truly understood the consequences of her choices and weigh up information clearly.

10.5.5. The report also highlights a need for regular and consistent access to supervision around safeguarding issues.

10.5.6. It has been close to three years since the death of Sally and there have been a number of changes within Devon Partnership Trust. The report outlines how the issues identified have been addressed through recruitment of key specialist staff with safeguarding expertise. They have also updated their policies and created more robust incident report protocols. Furthermore, they have delivered specialist training (level3) and are closely monitoring the uptake of training.

10.5.7. Northern Devon Healthcare NHS Trust believe the learning for them has been around acknowledging the need for specialist support, and/or training, on how to structure and plan for a patient with a treatment resistant personality disorder. They believe this would have led to a more coherent approach which was less reactive and would make for a clearer approach to decision making.

10.5.8. The Health Centre accept that new partners in the practice were not familiar with Sally. As a consequence, they have introduced, at their regular practice meetings, discussion of both children and adults who are deemed to be at risk. This ensures all partners in the practice are aware of them and any problems with their care.

10.5.9. Devon and Cornwall police (DCP) identified that there was no clear plan or review of actions taken and that, especially non- specialist staff need more supervisory oversight if holding such a case. The learning they believe, alongside colleagues in DPT and Social Care is that there was a need for a clear multi-agency safeguarding risk assessment to attempt to identify the risks with a contingency plan agreed and documented. The adult concerned should be involved and able to comment on this. If this cannot be achieved, then the recommendation for the police is that they should record the entries on safeguarding enquiries and crimes outlining the action taken and this is reviewed with supervisory oversight.

10.5.10. The Devon and Cornwall Police report outlines how at the end of 2015 the VIST was introduced (Vulnerability Screening Tool). This tool helps to assess risks which can then be RAG rated and shared. The new system allows them to record the views and consent of the vulnerable person. Since that time Devon and Cornwall Police have also introduced a central safeguarding team which ensures staff build their expertise in working with those at risk.

10.5.11. Finally, the report acknowledges that at the end of 2015 the offence of coercive and controlling behaviour, Section 76 of the Serious Crime Act 2015, came into force. The behaviours described by Sally in relation to her husband, despite her ambivalence, would be given more weight and would now justify an investigation and consideration of prosecution.

10.5.12. SWASFT report that, at the time of Sally's death, all attendances by the ambulance service were conducted in isolation and the patient's history was not available to them. Since that time, they have introduced electronic clinical records with hand held devices. They can now view previous clinical records where an ambulance clinician has attended. The number is restricted to approximately 15 previous contacts. They also have access to the Summary Care Record via the NHS spine which gives them details such as medication, allergies and next of kin.

11. Recommendations

11.1. As referred to earlier (see para 1.9) the delays in the system at the time of Sally's death led to this Review being undertaken almost 3 years later. Further scrutiny by the Agencies

involved should provide reassurance that the new systems and processes in place are sufficiently robust to avoid this happening again.

11.2. Devon Partnership Trust (DPT) makes the following recommendations:

11.2.1. Mental Capacity Act training is mandatory in DPT but a review should explore whether this training is achieving the required changes in practice or if other models of training would be more effective.

11.2.2. Guidance and Training should be developed to ensure that safeguarding enquiries consider engaging with carers even if suspected to be perpetrators.

11.3. Training on domestic abuse for all agencies should ensure there is a particular focus on the impact of coercion and control for both victims and staff working in this area

11.4. Devon and Cornwall Police recommend that there is supervisory oversight and regular reviews of work especially where non-specialist staff are holding cases.

11.5. North Devon Against Domestic Abuse will revisit the importance of completing individual entries of meetings rather than summaries. They will achieve this through internal audits and dip sampling of records

11.6. North Devon Healthcare NHS Trust recommend that where complex mental health and physical health needs exist and are compounded by a personality disorder, specialist mental health supervision should be engaged. This may take the form of 1:1 clinical supervision with a mental health practitioner experienced in the management of personality disorder or group supervision for all of the professionals involved to assist in care planning, their team approach and boundary setting.

11.7. In cases such as these, where there are a range of issues which may well span safeguarding, mental capacity and domestic abuse, it is particularly important to have good and accurate recording where the documentation also includes the rationale for key decision making.

11.8. Finally, it is recommended that a multi-agency panel be put in place in Devon to consider cases of self-neglect and other such high-risk situations, where staff may well experience intimidation and are struggling with how to manage or reduce the risk. This would need to have senior level representation and offer a fresh approach with creative solutions, access to specialist support and legal advice where appropriate.

The Author wishes to express her condolences to the family of Sally. She would also like to thank staff of partner organisations who contributed information or advice to the Review.

Pam Marsden
Overview Author
Dated: August 2018