Person F Safeguarding Adult Review Report

Final Report

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1. Introduction

This review was commissioned by Sheffield Adult Safeguarding Partnership following reports that Person F may have experienced wilful neglect. Person F was well known to a number of services across Sheffield. Following Person F's death concerns were raised that Person F may have died prematurely as a result of not taking necessary life-saving medications which, it was purported, his wife (FW) believed were poisoning him and causing his symptoms of ill health. Professionals had raised numerous concerns over the 4-month period prior to Person F's death about FW's coercive control with regard to Person F's medications, her tampering with his medication and Person F not receiving prescribed treatment that could have prevented his death. There were questions around whether there had been an appropriate response to FW's actions and whether coercive control had been considered. Following Person F's death the police conducted an investigation, which was closed with no further action being taken, and the Coroner concluded Person F had died of managed cardiac failure.

2. Subject of the review

2.1 Person F was a 73-year-old gentleman who was married with two children. Person F's daughter (FD) lived independently however, Person F's son (FS) had a mental health condition and care needs. FW indicated she was autistic, she cared for Person F and FS within the family home. Person F had been under the care of Cardiology and Vascular services for a number of years. Person F was known to have heart failure[1], atrial fibrillation[2] and diabetes[3]. Person F was seen on a regular basis in Out-Patients.

2.2 Person F was at high risk of suffering a further stroke or heart attack if he did not take his anti-coagulation medication.

3. Summary of Learning Themes

The following are the main learning themes resulting from this review:

- Greater use of Advocates/Mediators
- Greater consideration of the support needs for Carers
- Mental Capacity Assessments to become part of routine practice
- Introduce and embed a Complex Case Management process and guidance
- Focus on risk to improve risk management and increase clarity on when to progress into safeguarding procedures
- Ensure meetings keep to their remit
- Raise the profile of Vulnerable Adult's Risk Management Model (VARMM)
- Capture and use historical information
- Accept when patients make choices that go against medical advice if they are doing so with full information and with mental capacity

[1] Heart failure means that the heart is unable to pump blood around the body properly. It usually occurs because the heart has become too weak or stiff

[2] Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate

[3] Type 2 diabetes is a common condition that causes the level of sugar (glucose) in the blood to become too high.

4. Context of Safeguarding Adult Reviews

4.1 One of the core duties of a Safeguarding Adults Board (SAB), under Section 44 of the Care Act 2014, is to review cases in its area where an adult with needs for care and support (whether or not the Local Authority was meeting these needs):

- has died and the death resulted from abuse and neglect, or
- is alive and the SAB knows or suspects that they have experienced serious abuse or neglect

4.2 The Safeguarding Adults Review Sub Group considered the known facts in relation to this case, in accordance with the Care Act 2014, and concluded the criteria were met for a Safeguarding Adult Review. Nicki Walker-Hall, an experienced reviewer of Children and Adult Safeguarding Reviews, from a health background, was commissioned to undertake this review. It was agreed that the period for review was from June 2018 until Person F's death on December 26th 2018.

5. Methodology

5.1 The methodology used and terms of reference were agreed at an initial set up meeting. The methodology was based on an adapted version of the Child Practice Review process.[4] This is a formal process that allows practitioners to reflect on cases in an informed and supportive way.

5.2 The start of the review was significantly delayed whilst waiting for Toxicology results. Further delay was caused by the impact of Covid-19 on the capacity of services to undertake the review.

5.3 Each agency reviewed their records and developed a chronology of their involvement with Person F. The single agency chronologies were merged and used to produce an integrated chronology.

5.4 The merged chronology was analysed by the reviewer further informing the key focus areas for exploration and consideration.

5.5 Key practitioners attend a practitioner's event. This event focussed on Person F's journey through the system, reflecting on and sharing learning as well as identifying opportunities for improved working within and between agencies in the future. A separate managers/commissioners event was held to explore whether frontline practice was being delivered as expected and whether the golden thread from strategic vision to frontline practice was evident.

5.6 The reviewer, via the SASP informed FW of the review and invited her to share her views and opinions of the services offered; this was declined.

5.7 The reviewer completed a draft report which was analysed by the SASP SAR review sub-group and actions to address the findings agreed. The panel considered the most appropriate method to share the learning across the wider workforce in Sheffield.

5.8 The reviewer offered to meet with FW again to share the content of the report. The full report was considered and agreed by the SASP prior to publication.

6. Terms of Reference

6.1 The terms of reference were as follows:

[4] Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012

- An analysis of how “Making Safeguarding Personal” was applied in listening to Person F rather than family members and how effective this was.
- An understanding of the quality of Mental Capacity Assessments carried out. What options are there for working with someone who is assessed as having capacity but is displaying disguised compliance or has beliefs that are contrary to medical advice.
- How were the dynamics of Person F and FW’s relationship managed across the GP, Adult Social Care and the Hospital? How effective was the support to health staff and the GP who had concerns about FW’s control over Person F’s decisions, care, medication and her failure to act in his best interest and where do they get advice and support to address this.
- Was sufficient professional curiosity and judgement shown in using opportunities to ask appropriate questions, make further enquiries and highlight potential risk’s
- An analysis of the lack of effective professional challenge to FW. How do professional’s engage with people who won’t accept their advice?
- An understanding of the use of carers assessments, when to trigger their use, their possible use in determining FW’s beliefs and actions and how they can be used to identify the potential for a carers role to move into coercive control or abuse.
- Would the Office of the Public Guardian (OPG) been able to provide any assistance as members of the family had Power of Attorney (POA)?

7. Succinct summary of case

7.1 Person F had a number of health conditions including heart failure, atrial fibrillation and type 2 diabetes. From June 2018 his health began to deteriorate. He was admitted to hospital on a number of occasions, firstly following a Transient Ischaemic Attack[5] and later following a stroke[6]. Person F had Paroxysmal Atrial Fibrillation which if left untreated can lead to a heart attack or stroke, for which he was prescribed Apixaban, an anticoagulant medication. Concerns were expressed by the professionals involved that FW was not administering the various medications deemed necessary to treat and prevent further complications, as prescribed.

7.2 FW expressed her concerns that Person F was not able to metabolise medications, she believed the adverse drug reactions were caused by the 3A4[7] pathway, and that this was leading to a toxic build-up of medication within Person F. FW produced a three-page document which she indicated was from her daughter. This document formed the basis of her belief that Person F could not metabolise medications. When professionals challenged FW she became verbally aggressive. FW appeared to feel her Power of Attorney (POA) for health and welfare entitled her to make all the decisions. It was explained that Person F’s capacity was assumed and Person F was able to give a decent history of his symptoms. The consulted pharmacists believed there was not enough evidence to suggest that Person F was unable to metabolise his medication; blood test results supported the pharmacists’ view.

[5] A transient ischaemic attack (TIA) or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain. The disruption in blood supply results in a lack of oxygen to the brain.

[6] A stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off.

[7] CYP3A4 is responsible for the metabolism of more than 50% of medicines.

7.3 Professionals working with Adult F became so concerned, a number of them raised a concern to the Local Authority (LA) Safeguarding Adults Team. At the time the LA Safeguarding Adults Team became involved Person F was acutely unwell and not expected to survive a significant stroke. They remained involved until an assessment was completed which concluded Person F had mental capacity to make decisions and that Person F was in agreement with FW regarding medication. This conclusion was not communicated well to all the referrers and as Person F's condition deteriorated health professionals' concerns escalated once more.

7.4 At a multi-agency meeting a decision was made that Person F's carers would take responsibility for administering Person F's medication. This initially worked well until FW took over the role and, once again, medication was not administered as prescribed.

7.5 In the final month of his life Person F was dragging his leg. The GP visited, Person F was sleepy and there was new confusion. Person F and FW agreed to admission to hospital. Person F's symptoms settled in hospital but the hospital noted Person F was no longer on insulin. A request was made for a permanent care provider. It came to light that there had been an incident when FW had tampered with the Medication Administration Record (MAR) and crossed out one type of medication; the Clinical Support Workers (RAs) had dealt with this. The heart failure nurse team transferred Person F's care to the consultant.

7.6 Person F was short of breath (SOB) and having episodes of panting. FW was querying whether Person F's medications were causing this. FW discussed Person F's genetic profile results with his GP. FW indicated she thought the results showed that Person F didn't metabolise Apixaban properly. The GP explained the results, but FW was unconvinced. The GP offered to check Person F's Apixaban blood levels or consider warfarin instead. FW insisted on a referral to a consultant pharmacologist.

7.7 The GP discussed medication with Person F who was feeling sick. Person F believed it was due to the medication. The GP assessed Person F's capacity and found he had capacity. The GP referred Person F to haematology to discuss anti-coagulation further. In the meantime, the GP reduced Person F's dose of apixaban and lansoprazole[8] as requested.

7.8 A decision support tool (DST) was booked. The original SW was to support the assessment as she knew the background. The SW spoke with the GP who reported multiple calls daily from FW regarding concerns re Apixaban. The SW advised MCA to establish if they were Person F's concerns or FW's concerns. The SW raised concerns that the GP was going along with what Person F and FW wanted and this was not in Person F's best interests. The carers raised concerns that they had not seen the son once. Person F's blood results were all at normal levels and his kidney function was stable. Checks were made regarding FS and whether he was getting his medication. FS was having a monthly blood test which satisfied everyone that he was.

7.9 In the days prior to Person F's final admission FW was in regular contact with Person F's GP concerned that medication was causing Person F to be unwell. The GP was responsive to FW's requests for review of medication.

7.10 Person F went into heart failure, was admitted to the coronary care unit but he sadly deteriorated and died.

8. Analysis

[8] Lansoprazole - medication used to treat gastric problems and acid reflux

8.1 Making Safeguarding Personal

8.1.1 This section considers whether the Six Principles of Adult Safeguarding were applied in this case. Those principles are empowerment, prevention, proportionality, protection, partnership and accountability.[9]

8.1.2 There is clear evidence that professionals were cognisant of these principles. What proved difficult in this case was applying those principles to a situation, where the subject had some fluctuation in his mental capacity as he experienced periods of acute illness, and where the couple had some unusual and fixed belief's regarding Person F's ability to metabolise medication.

8.1.3 There were opportunities to talk with and empower Person F, independently of FW, that were not taken. There was seemingly a reluctance to have conversations that would be difficult. At times, particularly in the community, professionals found it difficult to circumnavigate FW who appeared dominant, defensive and difficult. This served as a barrier, making partnership working difficult. Alternative suggestions made to FW by professionals were met with a negative response.

8.1.4 This case did not follow the usual safeguarding process (see section 8.3). When the SW first visited Person F he was acutely unwell and was not expected to live. The SW deemed Person F did not have mental capacity at that time and felt a best interests meeting would be appropriate. A SW assessment was completed, but there was no safeguarding or best interest's meetings held, and as a result what was lacking was a forum where all the information was discussed, a multi-agency assessment of risk undertaken and a clear safeguarding plan produced.

8.1.5 Risk was not clearly articulated and was being rephrased as 'worry', anxious' or 'concerned'. Professionals were noting the behaviours but they were not exploring the underlying reasons for the behaviours or clearly stating that Person F was at risk of death. The use of sanitised language can have the effect of diminishing the level of perceived risk.

8.1.6 Whilst the assessment completed by the SW was thorough, with a clear directive from Person F that he did not want safeguarding involved, the full content of that assessment wasn't shared across all partner agencies demonstrating a gap in partnership working. It would have been helpful if all involved professionals had known Person F held the same beliefs as FW regarding medication, and that he felt FW was following through with his wishes.

8.1.7 It is not clear who was taking the lead at this time, and as a result the lines of accountability are blurred. There was a lack of clarity as to whether this case was being managed within safeguarding or not. A meeting, either safeguarding or best interests, would have allowed for open discussion, clear plans and clarity on accountability. The lack of a dedicated meeting to discuss the issues proved problematic.

8.1.8 A medication plan was put in place for the RAs to administer Person F's medications to ensure his safety, communication of the reasons for this decision were not well articulated to those delivering the care. As a result, when FW started to take over administration of medication, the risks this posed were not fully recognised, it was not immediately flagged as a concern, and did not result in a concern being raised.

8.1.9 It is always hard for professionals when patients chose not to take or follow medical advice. Health professionals have a duty of care and it becomes a dichotomy when you prescribe lifesaving, life preserving or life enhancing treatments and patients

[9] https://www.local.gov.uk/making-safeguarding-personal-outcomes-framework

make an active choice to reject these. However, it must be remembered patients are able to have a contrary view to professional opinion and this should be supported if they have Mental Capacity to make the decision (see section 8.2). All staff need to accept the right of the person to make lifestyle choices and to refuse services, provided they are doing so with Mental Capacity and from an informed position[10]. The underlying issue in this case was health staff needed to feel confident that the decision to not take medication were Person F's and Person F's alone, and that Person F was not being unduly influenced or controlled by FW, and there was no wilful neglect.

8.1.10 The police were not involved in any discussions. However, if the allegations were founded, FW would be deemed to be committing a criminal act. Police involvement through a strategy meeting in the initial stages could have helped bring greater clarity to the situation. The SW through her assessment did not find evidence of wilful neglect and therefore saw no need to involve the police.

Learning point 1: The safeguarding process has been developed to ensure that the principles of making safeguarding personal are central. It is important to be clear regarding the status of a safeguarding investigation and whether a case is open or closed.

Recommendation 1: SASP to seek assurance that the status of all cases referred to safeguarding is clear and that no case is left in suspension.

8.2 Mental Capacity Assessments

8.2.1 The Mental Capacity Act was introduced in 2005. It is designed to protect and restore power to vulnerable people who lack capacity. The MCA says:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise
- wherever possible, help people to make their own decisions
- do not treat a person as lacking the capacity to make a decision just because they make an unwise decision
- if you make a decision for someone who does not have capacity, it must be in their best interests
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms

8.2.2 The Mental Capacity Act also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future.[11]

8.2.3 A previous local SAR[12] found that there were differing interpretations of the application of the Mental Capacity Act (2005) and its use.

8.2.4 Through discussions at the practitioners' event the reviewer is satisfied that practitioners had considered Person F's mental capacity. Throughout the review period there were multiple occasions when there were discussions regarding mental capacity however, clarity around Person F's mental capacity was rarely recorded and mental capacity was only formally assessed on three occasions. On some occasions it

[10] Mental Capacity Act (2005) Principle 3 Unwise decision making

[11] https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

[12] Adult C SAR (2020)

was though Person F was too unwell to undergo the assessment, on other occasions it was deemed obvious that Person F did not have capacity, and at times discussions were had regarding who might be the most appropriate person to complete the assessment which caused delay. At the practitioners' event some professionals indicated they did not do MCA's but would call on a senior colleague if one was required. On one occasion when Person F was believed by some professionals not to have capacity but when assessed, he did. Consideration of mental capacity should be part of routine practice and it is important that the assessor does not predict the outcome of the assessment before it is undertaken.

8.2.5 When Person F was found to have capacity and was able to articulate that the decision not to take medication was his own, and his belief that FW was acting in his best interests; this did not alleviate health staffs concerns that Person F was being unduly influenced by his FW.

Learning point 2: Assessments of mental capacity are not routinely being recorded unless there is a formal assessment. A consistent, Sheffield wide approach needs to be agreed and adopted by all services which ensures capacity is considered and evidenced at all points were decisions are being made in patients who are demonstrating fluctuating capacity.

Recommendation 2: SASP and its partners to ensure all professional's consider the need for a formal mental capacity assessment that is then recorded and that systems contain a prompt to staff to consider and record a client's mental capacity where this is possible.

8.3 Multi-agency working

8.3.1 The underlying issue for professionals working with Person F was whether Person F was being harmed by his FW omitting medications, whether Person F was being unduly influenced and whether this constituted wilful neglect. Health professionals were looking to their ASC colleagues to determine whether Person F needed safeguarding. Although a concern had been raised to safeguarding and safeguarding had become involved, the timing of this coincided with a decline in Person F's condition and it was felt that it was not appropriate to invoke safeguarding procedures at that time. This decision was not well communicated and although ASC indicated at the practitioners' event, that they had a plan to become involved if Person F's condition improved, this was not part of a multi-agency plan, and not the understanding of partner agencies.

8.3.2 It is unusual in cases where professional anxiety is high amongst a number of health disciplines to find that there was only one multi-agency meeting during the review period. This meeting occurred by chance as the meeting was arranged as a family meeting instigated by the couple's niece. The SW and manager were in attendance as a result of visiting Person F that day. Whilst in one way this was fortuitous, as the SW was present to learn of the discharge plans and had an opportunity to add some safeguarding measures, in another this impacted negatively as normal processes were not followed and there wasn't a full multi-agency response. This meeting was pivotal; it tried to fulfil multiple disparate roles. It became a discharge meeting, a safeguarding/best interests meeting, and a family meeting all in one. The unintended consequence was that key professionals who would have been invited/present at a safeguarding/best interests meeting, were not invited, not in attendance and had not provided information that they would usually provide to a safeguarding meeting. Those professionals present were not aware prior to attendance at the meeting of

the full nature of the meeting and were therefore not in a position to share all the information which would have been useful to all parties. In a previous local SAR[13] it was noted that, individual services did not know enough about the concerns and risks due to a lack of information sharing, and felt powerless to bring about positive changes; there are similarities within this review.

8.3.3 There were alternative forums that might have been useful in this case. Sheffield has adopted the Vulnerable Adults Risk Management Model (VARMM) which is a multi-agency process, managed by SCC or health professionals, that helps manage high risk safeguarding adults' cases where the person makes informed choices (in accordance with the Mental Capacity legislation) that may put them at significant risk of harm. VARMM was found to have been an effective way to achieve multi agency working in a previous local SAR.[14] Guidance indicates that when it is felt that the decision is unwise, the VARMM can be used to show the reasons why, and to demonstrate that SSC has clearly explained these to the person and stated why other solutions are being advised. By doing this, SCC accepts that the person can make unwise decisions, but SCC can fulfil their responsibilities in maintaining their duty of care to the person and offering protection to SSC representatives. The same process is operated within health via the Safeguarding Team in Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) in cases where only health concerns exist as in this case. The Safeguarding Team had been involved by ward staff and could have called a VARMM meeting however they were concerned that when Person F went home, they would not be able to protect him in the community and felt that safeguarding rather than VARMM was more appropriate. The clinical support workers (RAs) who would be supporting Person F in the home were from an integrated health and social care team.

8.3.4 This was a complex case with multiple disciplines involved. What was required was for agencies to work cohesively and share information effectively as they moved forward. In this case there was no one taking the lead as the case was not being managed in any particular forum.

8.3.5 Had the GP been present at either meeting the following information could have been shared. The couple were registered with different GP practices having moved around practices following disagreements with the practice or a GP. Person F had been known to the GP for a number of years. The GP had seen Person F on a number of occasions on his own, prior to becoming increasingly unwell, and the GP was well aware of Person F's beliefs regarding medication, and his belief that he did not fully metabolise medications. Person F believed these medications would remain in his system and become toxic. This highlights the importance of capturing and using historical information to inform current practice.

8.3.6 Had all professionals been made aware that these were longstanding beliefs, and that Person F had a history of ceasing to take prescribed medication, they may have considered that FW was merely following Person F's wishes, thus alleviating some of the professionals anxieties.

8.3.7 At the practitioner event it was highlighted that communication from acute hospital services to the GP was impeded by the knowledge FW would receive a copy of the discharge letter. Medical staff try to keep the letters brief, highlighting any particular areas of concern relating to the patient's condition. Whilst the letters were

[13] Person C SAR (2020)
[14] Person C SAR (2020)

extremely informative around Person F's condition and treatment there was little information regarding the safeguarding/social concerns and risks if Person F were not to receive his medication.

Learning point 3: Currently a case of this nature falls outside of existing meeting terms of reference. When issues of a safeguarding nature are raised a multi-agency meeting, either complex case management, VARMM, a safeguarding or best interests meeting needs to be convened with representation from all involved agencies and clarity on whom is leading the process. Where aspects of the individual's behaviours are impeding professionals a professionals only section of the meeting should be held.

Recommendation 3: SASP and its partners to review and clarify the remit of all meetings with a safeguarding element, to ensure there is an appropriate forum for cases of a complex nature.

8.4 Professional curiosity

8.4.1 Person F and FW would provide professionals with information about themselves and each other. On one occasion FW suggested she was autistic and on another she stated she was a nurse. These statements were accepted but none of the professionals sought to gain any additional information, either to establish what field of nursing or to ascertain if FW had a clear diagnosis of Autism and what, if any, support she was receiving.

8.4.2 As a consequence of the couple being registered with different GP practices, Person F's GP's knowledge of Adult FW was limited to their contact around Person F's care needs. Professionals were too accepting of information without exercising professional curiosity to establish the facts. Had they enquired further they would have discovered that although FW had qualified as State Registered Nurse she was not a practicing nurse but a chiropodist. This is important as it is recorded that as a nurse there was an expectation she would have greater knowledge than a layperson. Whilst FW would undoubtedly have greater knowledge than a lay person, as with every skill, if it is unused for a significant period it diminishes or is lost.

8.4.3 Although this was a complex case and multiple health disciplines raised concerns what was absent was discussion of the case within safeguarding supervision. The reviewer learned that frontline professionals felt supported by their line managers however there is currently no opportunity to discuss cases in multi-agency supervision

Learning point 4: Professionals need to become more curious, ask more questions and establish the facts. Use of multi-agency supervision for such cases would support professionals across Sheffield to develop professional curiosity and challenge assumptions based on scant information.

Recommendation 4: SASP and it partners to introduce a multi-agency supervision model for complex cases.

8.5 Professional challenge

8.5.1 There are two areas of challenge that the reviewer has considered. Challenge by professionals of Person F and FW and challenge of fellow professionals.

8.5.2 Person F and FW had some belief systems that were at odds with those of the professionals involved in Person F's care. At the practitioner's event it was discussed that there is a presumption that patients will do as their doctor instructs. Doctors

have been paternalistic in the past therefore a patient who does not follow a doctor's instructions is unusual and can be seen as difficult. In this case there was a lack of understanding as to whether the belief that Person F was unable to metabolise medication was Person F's belief or FW's.

8.5.3 Professionals were concerned that it may have been a belief that was imposed on him as he presented as placid. In contrast professionals indicated they had found FW's personality challenging. FW was described as 'forceful', 'demanding but not complaining', 'pedantic and in control' and she would speak in an angry tone.

8.5.4 Some professionals had been accepting of these behaviours, others had lacked the confidence to challenge the behaviours and reflected their own behaviours had been defensive, not wanting to provoke an angry response from FW. Professionals indicated that in general having factual information and being well prepared helped them to challenge more effectively.

8.5.5 Some described visiting the family home as 'anxiety provoking', needing to be on their 'A game' and 'taking a deep breath before entering' as they were anticipating confrontation. Professionals described how difficult it is to challenge when they are essentially a guest in the family home. FW was requesting some professional worked outside of the parameters of their role and this proved particularly difficult to challenge.

8.5.6 The issue for all professionals was not that FW was uncaring towards Person F, it was solely regarding administration of medication. In addition, FW seemed to have greater knowledge regarding drug interactions than most of the professionals which professionals found unsettling.

8.5.7 No one had given sufficient consideration to the origins of the behaviours although some had pondered whether these might have stemmed from FW's autism. Had additional information been sought via a multi-agency forum, Person F's GP would have been able to confirm that it was Person F's long held belief that he was unable to metabolise medication and therefore likely FW was representing Person F's beliefs. An unintended consequence of labelling people as difficult, fixated or a nuisance can lead to things being unintentionally missed.

8.5.8 In respect to challenge of each other's practice, there is evidence that professionals did challenge each other when they did not feel Person F's case was being dealt with appropriately. The decision not to take the case into safeguarding was challenged a number of weeks later when Person F had been readmitted in an acute state. What was never challenged was the lack of a best interests meeting. The reviewer is of the opinion that had the case been managed in any of the multi-agency forums this would have increased information sharing, provided an opportunity to conduct a thorough assessment of risk and given greater clarity regarding the concerns.

Learning point 5: A culture of respectful challenge needs to be developed, promoted and supported across professionals in Sheffield.

Recommendation 5: SASP and its partners to ensure that within all training, supervision, policies and procedures, professionals challenge is promoted.

8.6 Carer's assessments

8.6.1 FW was acting as a carer for both Person F and FS who had a mental illness and lived with the couple. At the point of discharge home FW was placed in the position of being Person F's carer at the same time as being considered as a potential source of harm to Person F; this disparity should have been addressed prior to discharge. FW

was signposted to the Carers' Centre for support, but this was declined. Because this was declined FW never had a carers assessment.

8.6.2 There is no evidence of wider thinking regarding whether FW had capacity to care for and meet the needs of both her husband and adult son. Whilst it was FW's choice to reject carer support, this was never revisited. There were further opportunities to offer carer support once Person F had been discharged home, particularly when FW was seeking advice. The reviewer would have liked an opportunity to discuss this further with FW but this has not proven possible.

Learning point 6: Carer's assessments should be offered to all carers and the offer revisited whenever there is an increase in need or when a carer is seeking advice or support. When carers refuse a carers assessment, practitioners should consider whether, in their opinion, the carer has capacity to undertake all the care needs of those they are caring for. Any concerns regarding capacity to meet needs should be escalated to line managers.

Recommendation 6: SASP to seek assurance from ASC that wider thinking, regarding a carers capacity to meet those in receipt of cares' needs, has been demonstrated.

8.7 Involving the Office of Public Guardian

8.7.1 Professionals did not involve the Office of Public Guardian (OPG) in this case however, in hindsight there was thought that this might have been an avenue open to professionals to help them manage this case. There were three occasions where professionals sought to confirm that FW did have power of attorney for health and welfare (POA). On these occasions the professional requesting the information did not feel Person F lacked capacity to make his own decisions. On two occasions the enquirer felt FW, might not understand the full remit of having POA and, was making decisions that were not in Person F's best interest when he had mental capacity to make his own decisions. The SW indicated the POA did not have any impact as Person F had capacity and therefore it was never invoked. An option not explored was the use of mediation to make sure FW was fully cited on the parameters of the POA and the impact of the decisions Person F and she were making.

8.7.2 Some senior professionals did have the difficult conversations with Person F and FW, however it might have been useful to have an independent advocate or mediator present. The outcome of those difficult conversations was not fully shared with other professionals working with the family.

8.7.3 If anyone had concerns that FW was not acting in Person F's best interests, there is a process for reporting those concerns.[15] Practitioners felt it would be a bold move to say that in their professional opinion they were going to check with the OPG whether someone was the appropriate person to have POA; the fear cited was that this could negatively impact on the maintenance of relationships.

8.7.4 Had the professionals involved known of Person F's beliefs and had the right questions been asked the reviewer believes that in this case there would have been no need to involve the OPG. The reviewer is concerned that in cases where someone with POA is not acting in the persons best interests, professionals would not alert the OPG for fear this might harm relationships; this has the potential for someone with POA to abuse their position of power.

Learning point: When there is a difference of opinion between professionals and a person with lasting power of attorney, advocates or mediators should be used to

[15] https://www.gov.uk/report-concern-about-attorney-deputy-guardian

help resolve the situation. A lack of confidence to report concerns has the potential to leave vulnerable adults in risky situations. Professionals need to be supported by senior staff to escalate their concerns. Recommendation 4 addresses this learning point.

8.8 Examples of Good Practice

The SW's decision making was well evidenced and in line with Making Safeguarding Personal

All professionals had Person F at the centre of his care.

All professional groups were responsive to FW'S requests for information and changes.

9 Conclusion

10.1 Person F was a 73 year old gentleman with multiple health conditions and deteriorating physical health.

10.2 Health staff were right to raise their concerns regarding the possibility that Person F was being wilfully neglected with the LA safeguarding team. All the professionals wanted to sustain Person F's life and worked hard to this end.

10.3 This case has been proved anxiety provoking for all the professionals involved. Professionals' anxieties could have been significantly reduced had they known that Person F had historically chosen not to take medication of his own free will, and that both Person F and FW had held the same belief (that he was not metabolising his medication which was building up to toxic levels) for many years. The coroner found no evidence that this was the case. Although this belief is unusual, it was firmly held and it appears FW was acting upon Person F's wishes during periods when he lacked mental capacity.

10.4 What health professionals required was greater clarity on whether Person F was making a choice not to take his medication or whether FW was coercing and controlling him. Increased partnership working and a dedicated meeting where information could be shared, risks discussed, and a clear plan of action developed, was required. This did not happen, leaving professionals anxious that Person F's health was being intentionally, adversely affected.

10.5 An added dimension in this case was professionals' reactions to FW's behaviours. Professionals reported finding her intimidating and, as a result, this impacted on their thinking, and their practice. It resulted in reticence to converse with or challenge FW.

10.6 A key element to this review was establishing mental capacity; once established, all patients are able to express a contrary view to professional opinion and this should be supported. All staff needed to reach a place where they could be clear Person F was making a lifestyle choice to refuse medication from an informed position.

10 Recommendations

1: SASP to seek assurance that the status of all cases referred to safeguarding is clear and that no case is left in suspension.

2: SASP and its partners to ensure all professional's consider the need for a formal mental capacity assessment that is then recorded and that systems contain a prompt to staff to consider and record a client's mental capacity where this is possible.

3: SASP and its partners to review and clarify the remit of all meetings with a safeguarding element, to ensure there is an appropriate forum for cases of a complex nature.

4: SASP and it partners to introduce a multi-agency supervision model for complex cases.

5: SASP and its partners to ensure that within all training, supervision, policies and procedures, professionals challenge is promoted.

6: SASP to seek assurance from ASC that wider thinking, regarding a carers capacity to meet those in receipt of cares' needs, has been demonstrated.

Appendix ii – key to acronyms/ abbreviations

CAB	Citizens Advice Bureau
CVA	Cerebrovascular Accident
DNAR	Do not attempt resuscitation
GP	General Practitioner
LA	Local Authority
MAR	Medication Administration Record
MCA	Mental Capacity Assessment
OOH	Out of Hours
OPA	Out-Patients Appointment
OPG	Office of Public Guardians
POA	Power of Attorney
RA's	Clinical Support Workers
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
SASP	Sheffield Adult Safeguarding Partnership
SOB	Shortness of Breath
SW	Social Worker
TIA	Transient Ischaemic Attack
VARMM	Vulnerable Adults Risk Management Model