Hampshire Safeguarding Adults Board (HSAB)

Helen Safeguarding Adults Review (SAR) – Brief Review final report

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- Submitted to Learning and Review Subgroup in February 2023

1. Introduction

This case involved themes of multiple health problems, self-neglect, possible domestic abuse and possible neglect by the main carer. Helen died in hospital (July 2021) during the initial responses of services to the coronavirus pandemic.

The referral for a SAR was raised because it was felt there may have been opportunities for more effective joint working across the agencies which were not adequately utilised. The case was referred to the Hampshire Safeguarding Adult Board (HSAB) on 05.07.21 and was discussed at the Learning and Review subgroup (LRS) on 16.09.21. The subgroup recommended to the HSAB Chair that the case met the criteria for a mandatory SAR under section 44 of the Care Act 2014. The LRS suggested consideration be given to trialling a new brief methodology workshop with an independent facilitator. The HSAB Chair agreed that a SAR should be commissioned on 25.10.21.

2. Brief review methodology

The brief review involved the following key components:

- Creation of a short summary merged chronology from the single agency chronologies and scoping data.
- Liaison with family (undertaken by the HSAB Team)
- Identification of Key Practice Episodes and emerging themes. (February/March 2022)
- Facilitation of one LRS / Practitioner Workshop to draw out further data (24th March 2022)
- Facilitation of a follow up meeting with hospital representatives to draw conclusions about the key learning that has emerged and test out how common the issues are thought to be (8th July 2022).
- Drafting the report and devising draft 'Questions for the Board' to be submitted to LRS to discuss findings and consider quality assurance. (August -September 2022)
- Further amendments were undertaken following submission of more detailed information from HHFT Safeguarding Team (November 2022).

The style of review provides a responsive brief process and similarly brief report with a focus on the findings and only a brief summary in terms of case detail.

3. Case summary

Helen had multiple physical health issues and had misused alcohol over a period of time. She was supported at home by her husband/main carer. She had two grown sons who lived elsewhere. The relationship between her partner and her sons was strained. During 2021 Helen's physical health deteriorated considerably, and she had multiple call outs (over 30) to the ambulance services and three hospital admissions.

In March 2021 a safeguarding concern in relation to domestic abuse was raised by one of her sons to nursing staff at the hospital where Helen was an inpatient. The nature of Helen's sons' safeguarding concerns also related to self-neglect and their suspicion of neglect and abuse by her main carer/ husband, whom they believed was encouraging Helen's continuing severe alcohol misuse, which was known to be life threatening. Whilst in hospital Helen denied any abuse/coercion within the relationship and declined the prospect of help in the home. The hospital team involved the specialist substance misuse team who felt that there was no reason to doubt Helen's mental capacity to decide to continue to drink and that there was "no evidence to support the concerns from the hospital perspective"[1]. The Trust hospital team advised the sons to report their concerns to the MASH ('front door' local authority safeguarding team at the call centre).

Subsequently one of Helen's sons raised a safeguarding concern to the Hampshire County Council CART ('front door' call centre) in March 2021 and the other son raised his concern to CART (and MASH) in June 2021. During this period the CART contact centre response was running remotely in response to the coronavirus pandemic and had a very high volume of referrals. No section 42 safeguarding enquiry was opened by the local authority and there is no recording by the local authority to suggest that they made contact with the hospital ward or Trust safeguarding team.

Helen died in hospital on 01/07/2021. The coroner subsequently confirmed the cause of her death as malnutrition, pneumonia, clots on the lungs and liver damage.

N.B For a detailed list of the different teams involved in the case please see appendix 1 and for a summary chronology please see appendix 2.

4. Terms of Reference and key lines of enquiry

The particular focus of the review was the period between January 2019 – July 2021.

• To explore the barriers to effective communication about potential and known safeguarding risks within and across agencies in this case.

• To understand the nature of risk assessment undertaken in hospital and in the community during this period, and to what extent the pandemic impacted on the quality of risk assessment and

• To establish how we can support a more effective person-centred approach to safeguarding work in hospital settings where the adult is likely to be at risk on return home.

5. Differences in Professional Perspectives

The review process has highlighted areas of fundamental difference in professional opinion and perspectives. This has included community and hospital teams understanding of each other's

[1] HHFT response 03.10.22

roles, responsibilities and expectations of how safeguarding concerns are managed between community and hospital settings. This case highlights this specifically when the concerns raised are about a community setting when the person is a patient in hospital. It also raises a question to consider how decisions are reached between professionals about whether concerns are substantiated. The review raises questions to the board about how to address this and seek reassurances across the wider system. The review does not seek to resolve the difference in professional perspectives**.**

6. The Findings

Findings Chart		Theme
1.	Mechanisms to support the communication of safeguarding risk did not work effectively across the agencies.	Barriers to effective communication of safeguarding concerns
2.	In this case because the adult was in hospital, the CART and MASH practitioners concluded they were in a safe setting and so the referrals did not receive a safeguarding response.	Risk assessment and Making Safeguarding Personal
3.	In this case the multi-agency system did not support an effective response to members of the public trying to raise a safeguarding concern.	Barriers to members of the public being heard
4.	Although some opportunities were taken to assess the adult's needs and risks in more depth, there were other opportunities that were not taken, reducing the overall quality of risk assessment.	Lack of professional curiosity and hidden harms

Systems finding 1.	**Mechanisms to support the communication of safeguarding risk did not work effectively across the agencies**
Theme	Barriers to effective communication of safeguarding concerns
Summary of safeguarding risks generated	In this case the information sharing across several agencies was very limited. Although social care, the hospital and the ambulance service all had part of the picture, the usual mechanisms that support multi-agency information sharing and shared risk assessment were not used. This had a knock-on impact on how far it was possible to build a more complete risk picture.
Evidence in this case	- On 15 March 2021 (during the hospital stay of 19 days) family members reported concerns to HCC CART and to the ward. The ward contacted the Trust hospital safeguarding team, however ward staff felt there was 'no evidence' to suggest there was any substance to the concerns shared by sons and did not liaise with

	social care colleagues, they advised the sons to contact the local authority. - Hospital correspondence sent to the GP did not reference the potential Domestic Abuse concerns that had been highlighted by the sons because the ward staff did not feel there was any 'evidence' to suggest there was any substance to the concerns shared by sons. - Ambulance call outs - SCAS did attend the home so had sight of the poor state of the house and physical conditions. This did not lead to a safeguarding concern being raised to the CART but appears to have been picked up in health records accessed by the Trust alcohol team. - SCAS received 38 call outs to SCAS in 9 months during the period under review but only one reached CART (in June 2020). Systemic weaknesses in the SCAS safeguarding response were highlighted by CQC report published August 2022 – an improvement plan is now in place which is being monitored by the ICB.
Improvements already achieved or in progress	- HCC CART new process and resources are now implemented - HCC CART and MASH providing a greater emphasis on feedback to referrers. An information gathering proforma used in each case includes a prompt to feedback to the referrer and the practitioner needs to confirm this has been completed. An additional quality check is completed via the Team Manager Decision for Sec 42.
Questions for the board	• How can the board be assured about the effectiveness of referral pathways and the use of information sharing agreements and duties in relation to risk information?

Systems finding 2.	**In this case because the adult was in hospital, the CART and MASH practitioners concluded she was in a safe setting and so the referrals did not receive a safeguarding response.**
Theme	Risk assessment and Making Safeguarding Personal
Context and safeguarding risks generated	Misplaced assumptions by practitioners at CART about how the different hospital teams operated in relation to safeguarding concerns contributed to their lack of response in March 2021 in this case. MASH /CART were managing high volumes of urgent work and needing to prioritise the most pressing cases over others.
Evidence in this case	- In March 2021 one son contacted CART with a safeguarding concern, but no risk assessment was undertaken by CART and no section 42 enquiry considered. There was a misplaced view that there was no need for CART to act as Helen would be safe in hospital. The concerns were not flagged by CART to other social care teams e.g., the hospital social work team or the local social work team. - On 29.06.21 Helen's other son reported a safeguarding concern to CART, this was passed to MASH where it was reviewed on the day

	but not seen as urgent as the patient was felt to be in a safe place. It was reviewed again three days later but sadly Helen had already died in hospital on 01.07.21. The coroner subsequently confirmed the cause of her death as malnutrition, pneumonia, clots on the lungs and liver damage.
Improvements already achieved or in progress	Additional staffing and staff training has been put in place at the MASH to provide an enhanced focus on cases of self-neglect needing face to face contact. The Enhanced Support project is currently funded until the end of March 2023. It consists of two providers delivering support to people at risk of self-neglect and/or hoarding behaviours, where there is suspected or evidenced high risk and difficulties engaging with the adult. MASH have a practitioner lead for the project. Each adult receiving support via the project is reviewed 2 weekly and there are no parameters set for timescales to engage. A risk escalation tool is used if the adult continues to not engage. Adults Health and Care will review the pilot.
Questions for the board	• How can the board gain assurance that new MASH arrangements are in place and working well?

Systems finding 3.	**In this case the multi-agency system did not support an effective response to members of the public trying to raise a safeguarding concern.**
Theme	Barriers to the concerns of members of the public being heard
Context and safeguarding risks generated	In this case Helen's two sons made a number of attempts to bring their safeguarding concerns to the attention of the authorities, specifically to the hospital and to the local authority, but no safeguarding enquiry under section 42 (Care Act 2014) was opened, and there is no clear record of discussions between the agencies being undertaken to inform decision making. In this case Trust safeguarding and ward teams spoke with Helen directly about the concerns raised by the sons but the Trust safeguarding team have reported[2] that they found no 'evidence' to support the concerns and so they did not liaise directly with social care colleagues or raise a safeguarding concern to the local authority and they 'signposted' the sons to the local authority to raise the concern. It is important that the safeguarding system avoids inadvertently generating any barriers to providing an effective and joined up response when a member of the public seeks to raise a safeguarding concern. It would be hoped that a member of the public should not need to make multiple attempts to raise a safeguarding concern. The 4LSAB multi-agency framework which states that where an adult has care and support needs, a concern should be raised if there is "reasonable cause to suspect that the adult is at risk of or experiencing abuse or

[2] HHFT response 03.10.22

	neglect" (Care Act 2014, section 42). Where the referrer is unsure the guidance advises that you should still raise an adult safeguarding concern because the local authority information gathering responses, under s42(1) will help to make a decision. Ultimately, the decision as to whether there is reasonable cause to believe that the concerns reflect the 3 statutory criteria, sits with the local authority.
Evidence in this case	- Following concerns raised by Helen's sons, the HHFT staff involved undertook valuable and appropriate checks while she was in hospital. Helen was reviewed (17 March 2021) by the Alcohol Nurse who noted that that Helen reported her alcohol triggers were previous domestic abuse and historic family issues. Helen was explicitly asked if there were any current Domestic Abuse issues, and Helen stated that there are no issues of Domestic Abuse with her husband. Subsequently the HHFT staff involved formed the view that despite the specific concerns of the sons, there was not "reasonable cause" to suspect abuse or neglect and so did not communicate with the local authority and advised the sons to contact the Local Authority themselves. - The Hampshire Hospitals NHS Foundation Trust Adult Safeguarding Policy (– HH(1)/CO/584/19) Section 6.3; Actions to take upon suspicion of or allegation of abuse or neglect states 'Any reasonable suspicion or allegation of abuse of neglect must be acted upon. These concerns must be reported as a safeguarding concern, to the Safeguarding Adults Team,' which refers to the internal Trust safeguarding team. The reported practice to 'signpost' a third party raising a safeguarding concern to the Local Authority is not clearly evidenced within the policy. - Page 8 of the policy states operational managers responsibilities include 'Carrying out or supervising investigations into safeguarding adults incidents as appropriate' – it is not clear about what level of investigation the Trust staff should be undertaking without first having raised it as a safeguarding concern to the Local Authority. - The 14.43 Care and Support Statutory Guidance advises that it is not advisable to rely on a third party to raise a referral if a professional thinks there is reasonable cause to be concerned. Findings from serious case reviews have sometimes stated that 'no professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. - The CART team did not undertake section 42 safeguarding enquiries or liaise with other agencies when the safeguarding concern was raised by a family member in March 2021. This response was not in line with the 4LSAB Safeguarding concerns guidance 4LSAB Safeguarding Concerns (hampshiresab.org.uk)
Improvements already achieved or in progress	CART now treat every concern raised as information gathering to support MASH decision making for a Sec 42 decision.

Questions for the board	• How can the board be assured that improvements are being made to improve the response to safeguarding concerns being raised by family or friends? • How can the board be assured that all agencies understand and are following the 4LSAB Safeguarding Concerns Guidance?

Systems finding 4	**Although some opportunities were taken to assess the adult's needs and risks in more depth, there were other opportunities that were not taken, reducing the overall quality of risk assessment.**
Theme	Lack of professional curiosity, hidden harms and impact of Covid on service provision
Context and safeguarding risks generated	Helen had multiple physical medical issues including mobility problems, however there was no package of care in place. Helen was in touch with her GP and some outpatient clinics, however in the community Helen was not visited at home (except by SCAS) and did not always manage to attend her community medical appointments. Pressures caused by the pandemic may have led to decreased opportunities for engagement between Helen and the statutory services in the community and for Helen to be assessed in her home setting. The impacts of self-neglect and of coercion and control within a situation are not always easy to detect. Victims of DA may not be easily able to talk about what is happening to them. While Helen was in hospital it was positive that Helen was asked a direct question about whether she was experiencing domestic abuse, and her expressed wishes to have continued contact with her husband were supported. However the opportunity for a more in-depth discussion with Helen about the specific safeguarding concerns raised by Helen's sons would have better supported by the involvement of the Local Authority and ideally using the overt framework of a section 42 safeguarding enquiry.
Evidence	- There were DNAs for various appointments, however the GP did positively refer Helen to the social prescriber to try to support her to access her appointments. - On 05.02.21 a welfare check by CART over the phone did not lead to a full assessment of social care needs – which highlights the difficulty in detecting level of risk over the phone. - Contact with the CART highlighting safeguarding concerns and risks posed by the unpaid carer (e.g. March 2021 when a son rang CART) did not result in the offer of an assessment of needs or a carers assessment. - Signs of neglect were recognised by ward staff (March 2021) and on admission (June 2021) nurses noted a pressure ulcer and that

	Helen appeared ‘a little unkempt’. Helen had declined the option of a care package and her deterioration in the community between the March 2021 admission and her final hospital admission in June 2021 did not seem to have been noted by any community health services. - Helen had a grade 3 pressure ulcer on her sacrum on admission (June 2021) by which time she was very ill so her skin would have been fragile.
Improvements already achieved or in progress	The enhanced support project detailed within “System Findings 2 - Improvements already achieved” include improvements within this area.
Questions for the board	• The recent Self Neglect thematic SAR has highlighted the importance of using ‘windows of opportunity’ such as hospital stays for social workers to have a conversation with adults who are reluctant to engage with services but may be at risk of self-neglect. How can the board be assured this kind of approach will be developed? • Is the board assured that post pandemic service delivery in the community is capable of identifying hidden harms?

Appendix 1

1. **Context - key teams involved**

The key teams involved were:

- **CART team**, the contact centre for initial referrals (Adult Health and Care),
- **MASH team**, the 'front door' specialist safeguarding team to manage initial referrals (multi-agency, managed by Adult Health and Care),
- **Hospital ward medical team** (Hampshire Hospital Foundation Trust),
- **Trust Hospital safeguarding Adults team** which provides safeguarding advice and support to Trust staff (Hampshire Hospital Foundation Trust),
- **Hospital social work team** which provides a social care response including safeguarding (Adult Health and Care),
- **Trust Alcohol Team** (Hampshire Hospital Foundation Trust) and the
- **Primary Care Team.**

Appendix 2

Merged summary chronology 2020 – 2021		
2019	SCAS referral to AHC – Helen taken to Winchester hospital. Helen needs help in house and with personal care and is struggling to get out of bath. She did have support from Mencap and tenancy support from Two Saints. Closed to AHC.	AHC
Jan – April 2020	4 calls by Helen to SCAS – leg pain, foot injury, blood clot, abdomen pain, chest pain.	SCAS
May 2020	10 calls by Helen to SCAS re neck and upper back pain, rash, chest pain x 2– transported to ED, unconscious – ambulance dispatched, abdomen pain x2.	SCAS
02/06/20	SCAS referral to MASH stated that patient had dirty fingernails and was generally dirty and had difficulty getting out of the bath. Currently in hospital where her health is being reviewed and she had been referred to ward OT. No further action for AHC at this point.	AHC
June 2020	9 x calls by Helen to SCAS - Abdomen pain x 4, kidney infection? chest pain - transported to ED, anal/rectal pain x 2– 02.06.20 – 111 call – Abdo pain – ambulance dispatched.	SCAS
July 2020	3 x abdomen pain calls by Helen to SCAS	SCAS
Aug 2020	5 x calls by Helen to SCAS - shoulder injury, chest pain x 3 – ambulance dispatched, swollen leg.	
Sept 2020	2 x calls by Helen to SCAS - abdominal pain	SCAS
Sep/Nov 20	Trauma and Orthopaedics as an outpatient	HHFT
Oct 20.	Known to Endocrinology. Did not attend an outpatient appt	HHFT

Oct 20	Seen as an outpatient by vascular surgery	HHFT
Oct – Dec 2020	Helen presented with faecal incontinence and weight loss of 10kg. She reported that she could not get to the appointments as she had no transport. On one occasion, she had spent £60 on a taxi to get to an appointment but she was turned away due to coughing. Due to the GP concerns, she was discussed at the weekly MDT meeting and was subsequently referred to the social prescriber to help her get to appointments.	Adelaide Medical Centre
13 - 15/1/21	Inpatient admission RHCH. Admitted with chest pain and shortness of breath. Helen self-discharged against advice.	HHFT
18/01/21	999 call by Helen – fall, unable to bend leg – ambulance dispatched, transported to ED	SCAS
25/01/21	Referral received by CART from NHS social prescriber requesting an assessment. Helen has numerous issues including mobility and other related health issues including incontinence, she has little support apart from her husband and is very isolated. Has numerous hospital appointments. Andover Advocacy who are helping to make sure she is receiving correct benefits.	AHC
05/02/21	Social prescriber makes contact with CART again requesting help re mobility, health and isolation. Husband is only her carer. Wellbeing check completed with her on the phone by CART, she reported she needs help with attending hospital appointments. Signposted to good neighbours for transport and commode and shower board ordered.	AHC
Feb 2021	2 x calls by Helen to SCAS – two falls	SCAS
Mar 2021	2 x calls by7 Helen to SCAS – confusion and a back injury	SCAS
10/3/21 – 29/3/21	Inpatient admission with reduced mobility, poor oral intake, self-neglect. Concern raised to Trust hospital safeguarding team by ward as there was concern about the state of her property(which had not been witnessed by ward) . Her son reported his mother would not be drinking if she was not with her partner. Ward was asked to discuss with Helen what her views and wishes were. Helen self-discharged against advice.	HHFT
15/03/21	Online safeguarding referral to CART by son, that his mother is in hospital and there is bad self-neglect at home, pressure sores and hoarding. He describes her as an alcoholic, but her husband keeps giving her alcohol even though she said she wanted to stop. Nurses have told her if she does not stop drinking she will die. There is mould everywhere.	AHC
17/06/21	999 call by Helen – liver failure, ascites, transported to MAU	SCAS
19.03.21	Tel call from CART made to son who confirmed that his mother is still currently in hospital and will be for at last another week, he has raised his concerns with the hospital and has been told the safeguarding team will be informed but he hasn't heard anything yet. I advised him to speak to the hospital social care team, telephone number provided by email.	AHC
May 2021	The GP managed to arrange a face-to-face post-discharge appointment in where treatment and investigations for fractured hip were discussed.	Adelaide Medical Centre
June 2021	There was then a further face to face appointment when Helen had ascites and looked very unwell – it was recommended that she be admitted that day which she declined and chose to be admitted the following day instead.	Adelaide Medical Centre
17/06/21	999 call by Helen – liver failure, ascites, transported to MAU	SCAS
17/6/21	Inpatient admission. Ascites and hyponatremia	HHFT

18/6/21	Datix report noted by Safeguarding adults' team which detailed patient admitted and very unkempt. Advice shared with reporter to share concern with Adult Services via SAT.	HHFT
29/06/21	Another son reporting to CART that his mother was in hospital and she reports feeling fearful to return home. Son reports self-neglect and that her husband forces her to drink. Son described it as domestic abuse that Helen may be experiencing from her husband who is her carer Mr CH. Son believes the abuse has been ongoing for approx. 4 years. Helen is currently safe in hospital but nurses report that she does not want to return home. Helen has bed sores, cannot walk and fluid on her stomach. Son said her medical records describe "signs of neglect". Case escalated to MASH for review.	AHC
	Adult Services contact Safeguarding Adults Team as ward have shared with them that Helen's son thinks her partner has been taking Helen off the ward to drink alcohol. Adult Services unable to identify any Safeguarding concern. Helen reportedly has mental capacity to choose to go. During this period Helen had regular contact with the Alcohol Team at HHFT.	HHFT
01/07/21	Helen passed away. Coroner subsequently advised that she died of multiple causes: 1. Malnutrition, 2. Pneumonia, 3. clots on the lungs and 4. alcohol dependency and liver damage.	AHC