Newcastle Safeguarding Adults Board

ADULT L

A Safeguarding Adults Review (SAR)

FINAL

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1. INTRODUCTION

1.1. Adult L was a lady of white British origin who died at the age of 75 years in hospital following a positive test for COVID-19. In the four months before she died, Adult L had increasing care and support needs with several agencies involved to meet those needs. Adult L sometimes refused care which created concerns for agencies.

1.2. Adult L spent periods in hospital and respite within the four-month period.

1.3. Adult L lived at home with her husband who was her carer. There was a previous history of domestic abuse recorded, with two referrals to the Multi-Agency Risk Assessment Conference (MARAC)[1] three years previously. There were concerns raised regarding clutter, hoarding and self-neglect. Adult L and her husband were also noted by police to be intoxicated when they had been called to domestic abuse incidents. Adult L was latterly known to be alcohol dependent.

1.4. Several safeguarding alerts were raised by agencies; safeguarding procedures and plans were ongoing at the time of Adult L's death.

2. PROCESS, SCOPE AND REVIEWER

2.1. The Terms of Reference, scope and methodology for the SAR can be found in Appendix 1. The review set out to cover a four-month period prior to the death of Adult L. NSAB commissioned an independent reviewer to chair and author this SAR[2].

3. FAMILY INVOLVEMNT IN THE REVIEW

3.1. Contact was made with Adult L's husband to invite him to be involved in the review. Adult L's husband agreed to be involved and face to face contact was made under strict COVID-19 Safe guidelines. Adult L's husband was supported by an advocate to prepare and accompany him to meetings. Adult L's husband's views are included throughout the report as appropriate to the learning.

4. ADULT L and RELEVANT HISTORY

4.1. The brief information presented in this section will aid the review to understand the background and context with which Adult L came to the attention of services within the timeframe.

4.2. Adult L lived with her husband in an owner-occupied house. The couple had been married for 27 years; Adult L's husband told the author that they had known each other for 40 years after meeting in the cemetery where he worked and where Adult L walked her dog. Adult L had been a store detective; the

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[1] **MARAC** A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children, and perpetrator.

[2] **Karen Rees** is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of NSAB and its partner agencies.

couple had no children together and no relatives that they kept in touch with other than a brother that Adult L's husband visited occasionally. Adult L's husband told the author that Adult L had always told him that there were just the two of them in this world, professionals involved in the review agreed with this, observing that they did not have any other support and appeared to be very co-dependent.

4.3. Adult L's husband used descriptions about her that lead the author to believe that she was a formidable character, again this view was also observed by those professionals that worked with her.

4.4. At the point at which Adult L's health deteriorated, her husband retired from work to become her main carer. Adult L had multiple chronic medical conditions; these were lymphoedema, osteoporosis, leaky heart valve, atrial fibrillation, alcohol dependency and asthma, all for which she received various treatments and medication.

4.5. History in records raised attention to the fact that the couple were subject to reports regarding domestic abuse, often with Adult L's husband as alleged perpetrator. Two of these occasions led to the couple being discussed at a MARAC with Adult L as the victim and her husband as perpetrator. At the time these events appear to have been managed well with information sharing happening between agencies. It is of note however that the GP was not aware of this situation, and this will be subject to further analysis later within this report.

4.6. Both Adult L and her husband drank large amounts of alcohol that appeared to feature as factors when police were called to the property. In later years Adult L appeared to drink far more than her husband; professionals stated that she drank whiskey mixed with water. There were some elements of relationship difficulties noted by professionals; Adult L's husband agreed that they had problems but does dispute the nature of some of the incidents that occurred.

4.7. Adult L was prone to falls from her osteoarthritis and had requested a personal alarm that would alert services if she fell. This remained within the property for two years and appeared to have had good effect at getting attention promptly. Adult L asked for this to be removed; it was not clear why at the time, but it is now thought by review participants, to be linked to the incident that led to the MARAC as it was the alarm company who had reported seeing abuse taking place. Adult L had decided that she did not want the alarm following that incident. This would add to the history of Adult L's preference for privacy.

4.8. Records show that Adult L had several hospital admissions prior to the timeframe of the review with district nurses visiting to care for her lymphoedema and reportedly knew her well. Adult L and her husband lived in cluttered surroundings, this was described as not particularly dirty environment but that they had a lot of personal possessions that they kept around them, sometimes making caring for Adult L difficult.

4.9. By the time of the review period Adult L had been suffering from significant health concerns for many years. Professionals showed empathy for the issues that Adult L was facing and tried to work with her to reduce some of the impact of this.

5. ADULT L KEY EVENTS/TIMELINE

5.1. For the purposes of analysing and understanding practice and systems, professional interactions with Adult L during the timeframe of the review will be briefly summarised in this section. It is not the intention of this section to review or analyse, but to provide some detail of the factual situation as it unfolded.

5.2. For purposes of a timeline and to keep Adult L's story anonymous, the timeframe will be referred to by month number e.g., month 1 being the start of the review period etc.

Phase One- month one and two

5.3. At the start of the review period Adult L was in hospital having been admitted a week previously. The admission was related to gastrointestinal issues and alcohol dependence. Adult L had originally refused hospital attendance but was persuaded by the social worker to accept admission. It was noted that Adult L's husband was her main carer, supporting her in all activities of daily living[3]. There was a great deal of work done during this admission to try and address the clutter reported in the home and to ensure that there could be a safe discharge. Alcohol issues were discussed with the alcohol specialist nurse resulting in Adult L stating that her intention was to abstain. Adult L also disclosed the previous domestic abuse and relationship issues. Adult L later denied this when she realised that safeguarding action should be considered.

5.4. Although not everything was in place for a planned discharge date 12 days later, Adult L was insistent that she was discharged on that date. Adult L's husband agreed to Adult L's discharge to support her wishes. Adult L stated that she would restart her carers and Adult L's husband stated that he had cleared a pathway of clutter. Adult L was informed that carers could not start until 14 days later; Adult L agreed to the Community Response and Rehabilitation Team (CRRT)[4] visiting to ease the gap until carers could start.

5.5. As soon as Adult L was discharged there were immediate concerns with Adult L's living environment. Adult L was offered various additional elements of care to support her, but these were all declined. Adult L was felt to have fluctuating capacity associated with her alcohol consumption. Adult L was also largely non-compliant with her care plan. The social worker and GP were made aware of the situation. District Nurses were visiting once a week to dress Adult L's legs.

5.6. 17 days after Adult L's discharge, her husband collapsed, and an ambulance was called. The ambulance crew recognised that Adult L was at risk and could not be left at home by herself. A further crew attended and conveyed Adult L to hospital after a considerable amount of persuasion. Adult L's husband was well enough to be sent home and was not formally admitted to hospital.

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[3] **Activities of daily living (ADLs)** are basic tasks that must be accomplished every day for an individual to thrive. generally, ADLS can be broken down into the following categories: personal hygiene, continence management, dressing, feeding, and ambulating.

[4] **The Community Response and Rehabilitation Team** are a community-based team of health and social care professionals. The team works with adults who live in the Newcastle area or who have a Newcastle GP. The aim of the team is to provide treatment, rehabilitation, and support, working with you to increase independence and safety within the home environment.

5.7. On admission Adult L was found to be significantly unwell with a chest infection and sepsis; mobility had decreased considerably from her last admission. Two days after admission, Adult L deteriorated further, and it was agreed with Adult L's husband and the care team that Adult L would not benefit from active resuscitation due to her considerable co morbidities[5]. Adult L then started to improve, and plans switched to supporting a safe discharge and ensuring inclusion of social worker in these plans. Adult L was very keen to be discharged and was pressing for an earlier discharge than the care team felt was appropriate.

5.8. Adult L expressed that she was low in mood and had disclosed some suicidal ideation, expressing a wish that she had died when she was very ill. Adult L was subsequently referred to the Psychiatric Liaison Team for assessment.

5.9. The mental health assessment concluded that Adult L was reacting to trauma from pain and the experience of coming close to death. It was noted that Adult L had deficits in time, place, and recall. It was agreed that Adult L had mental capacity to decide on her discharge. Adult L was discharged following a multi-disciplinary decision that there were no grounds for being able to keep Adult L in hospital against her wishes.

5.10. Adult L had an existing care package in place, but due to the expedited discharge that Adult L wanted, the days of those visits did not coincide with Adult L's discharge. Two days later Adult L was readmitted. Adult L had again deteriorated, and her husband was unable to cope. The ambulance service reported that Adult L was very confused and that there were verbal arguments between the couple. Adult L's husband had called the police as he stated that he could not cope any more. The ambulance service sent a safeguarding adult referral to adult social care.

5.11. The social worker, on receipt of the safeguarding referral, planned a strategy meeting four weeks later. This meeting should have been sooner; a delay in the meeting date was due to manager and staff availability to attend.

5.12. On admission, Adult L's pressure damage to her sacral area had increased significantly; the hospital staff made a safeguarding adult referral. The hospital staff did not note any concerns regarding Adult L's mental capacity to decide on her care and treatment. Adult L was again pressing for a discharge and had refused alcohol support services on this admission.

5.13. Adult L was seen on the ward by the social worker who assessed Adult L as not having capacity to decide on her ongoing care and support needs. A package of care was arranged for four calls a day on discharge on a least restrictive best interest's principle.

5.14. Adult L was discharged two weeks after admission with the carers commencing their package of care the next morning.

[5] **Comorbidities:** -the simultaneous presence of two or more diseases or medical conditions in a patient.

5.15. During the initial assessment by the carers, Adult L cancelled the next visit stating that she could manage her own care and support needs. On the next visit Adult L agreed for support. Only one carer was attending as that was all that Adult L agreed to. This was quickly increased to two. Carers reported that Adult L's compliance and concordance with being cared for was very variable and that she would often refuse care. It was noted that that refusal of care was linked to her consumption of alcohol. Adult L spent day and night in her chair.

5.16. The social worker visited the day after discharge. Adult L disclosed that her husband had hit her on the arm. The social worker submitted a safeguarding referral.

5.17. The district nurses who were visiting to treat and manage Adult L's legs found that Adult L's concordance was difficult to manage. Adult L's legs would show improvement from being bandaged, when the time was right to move to compression stockings, Adult L would remove these and her legs would immediately break down again.

5.18. The strategy meeting that had been planned did not go ahead due to staff sickness. The social worker undertook several phone calls gathering information as a means of undertaking a strategy discussion. Adult L was involved in the strategy discussion and although she felt that she did not require help, she agreed to continue with the four calls a day and the district nurse visits. The domestic abuse was discussed with Adult L being aware of how she could get help and support if she needed it.

5.19. A few days later Adult L fell from her chair. The carers who visited called NHS 111 to seek help but are not allowed to lift clients from the floor. At the request of the NHS 111 service, a community response falls team attended to lift Adult L from the floor. A clinician was requested to attend; paramedics advised Adult L that she needed to be taken to hospital, Adult L refused. The GP visited the next day and planned to monitor Adult L closely and to review correspondence related to her.

Phase Two- months three and four

5.20. At the start of this phase Adult L fell and sprained her ankle. Adult L told the carers that she would let the GP know; there is no record of any agency knowing about this fall other than the carers. Two days later the carers reported that Adult L had a bruise to her right wrist. Adult L's husband told the author that this had happened because Adult L had slept on her watch and the GP had told them that Adult L would bruise easily because of the inhaler that she was using. On the same day the social worker phoned to check in on Adult L and arranged a home visit for four days later. Adult L cancelled the visit on the day stating that she was unwell and thought that she had COVID-19. The social worker advised Adult L to contact the GP. The next day the carers reported that Adult L was pale and unwell and refused care.

5.21. Over the next three weeks there was a general deterioration in Adult L's presentation. Adult L was largely non concordant with care advice at this time. She was sleeping in the chair, not changing her position, or elevating her legs. This led to further pressure damage to her skin and worsening of her lymphoedema.

5.22. Within that period the carers made a safeguarding referral over ongoing concerns regarding the arguments between Adult L and her husband and that Adult L had refused to contact her GP regarding her current illness. The carers contacted the GP due to their concerns. This was the day after the country went into the first national lockdown due to the COVID 19- pandemic. The GP took a history from the carers and tried on several occasions to contact Adult L by telephone and succeeded on the third attempt. Adult L was triaged over telephone, prescribed antibiotics with a possible diagnosis of COVID-19 infection. This was the same day as the strategy discussion. The GP did not know of this discussion, those involved in the strategy discussion were not aware that the GP had been trying to contact Adult L.

5.23. Over the next couple of days, the situation deteriorated further, Adult L's chest infection worsened. Carers again contacted the social worker regarding their concerns for Adult L's well-being; the social worker contacted the GP to share concerns. The next day, the care package was increased to six times a day. The district nurses also visited and made an emergency referral to the physiotherapist who visited later that day. The physiotherapist contacted the GP the next morning and requested a visit. The GP contacted Adult L over the phone, as was required by the COVID-19 rules in place at the time. The GP stated at this time that they did not suspect COVID-19. The GP assessed that a home visit was not required. The GP deemed that Adult L had mental capacity, was not intoxicated and able to make her own decisions so took the opportunity to discuss her advanced care planning wishes. Adult L already had an order that she would not be for active resuscitation in place from a previous hospital admission; Adult L asked to avoid hospital admission during the pandemic but receive other available treatment.

5.24. Later the same day, the social worker contacted the GP who agreed to visit that evening. Arrangements were discussed regarding 24-hour care for respite for a period to try and get Adult L's condition stable. The social worker needed clarity that Adult L did not require admission to hospital. Adult L was admitted to a care home for nursing care the next day. There were difficulties arranging transport due to the COVID-19 pandemic; a receptionist at the GP practice identified a private volunteer transport for that day. Adult L requested to be transferred the following afternoon; her wishes were respected. The GP visit did not take place as the nursing care placement had been arranged.

5.25. At the same time the social worker was having several conversations with legal services and the manager regarding options for managing Adult L's care needs by using the Mental Capacity Act and Court of Protection[6]. Adult L was deemed at times to lack capacity to make some care needs decisions and to understand the risk she was placing herself at by her refusal to follow advice and accept care.

5.26. Adult L did not settle at the home as she wanted to be with her husband. Adult L was unwell and anxious at the time as noted by carers in the community, (hence reason for OT and social worker requesting GP assessment,) and was nursed in bed at her request. Adult L constantly stated that she wanted to go home. Adult L refused much of the care in the care home and although was encouraged to mobilise she declined to get out of bed. Adult L was advised that she would not be able to go home unless she was able to mobilise. This encouraged Adult L to be more compliant and concordant with what she was being asked to do. As she had been in bed for so many days, her legs had healed well, and

[6] **The Court of Protection (COP**) makes decisions on financial, or welfare matters for people who can't make decisions at the time they need to be made (they 'lack mental capacity'). https://www.gov.uk/courts-tribunals/court-of-protection

her mobility then improved. Although care home staff and the social worker wanted Adult L to stay for longer in the home, Adult L was adamant that she wanted to go home. The social worker assessed Adult L over the phone (due to COVID-19 Restrictions) as not having capacity to make these decisions and therefore a Best Interest decision was made. The decision was that the least restrictive option was for Adult L to go home with a package of care for six calls a day and for a bed to be delivered so that Adult L did not sleep in the chair. Adult L's husband was going to move the clutter to allow this to happen. Adult L was discharged before any of this was in place as Adult L stated she would not stay and there was felt to be no grounds for a Deprivation of Liberty Safeguards DoLS[7] application in that situation.

5.27. As soon as Adult L went home things deteriorated very quickly, Adult L was refusing care and medical attention; four days later Adult L was admitted to hospital where she died six days later.

6. AREAS FOR LEARNING AND IMPROVEMENT

6.1. The analysis section takes a strengths-based approach identifying what went well and then building a picture of areas where learning has occurred, identifying further steps that should be taken to achieve stronger systems. Systems and services that worked with Adult L have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this review.

Management of Alcohol Dependency and decision making

6.2. Adult L had been a heavy drinker for many years. In the latter part of her life this had increased, and it was not unusual for professionals to find that Adult L was under the influence of alcohol when they visited to deliver her care. It appears that most professionals understood that it was more likely that Adult L would refuse care on the occasions where she was under the influence of alcohol and that the more that she drank, the less likely that she would be to accept care. This was an indicator that alcohol may have been impacting on the decision making of Adult L.

6.3. By analysing this issue, it has been possible to understand how this affected every other theme to be discussed below. Adult L's intoxication influenced her ability to make decisions, her reactions to professionals, her response to stated risks that she needed to consider and her response to her husband and those that were caring for her. It was noted in the history that alcohol featured in the domestic abuse incidents that were reported to the Police, and it is likely that this continued to be an issue in the relationship albeit that there were no reports of significant physical abuse, there was evidence of difficulties and arguments.

6.4. Long term use of alcohol can impact on the body's systems significantly. One of the issues can be the impact on cognitive functioning therefore a potential to affect mental capacity and decision making. It is therefore necessary to apply the Mental Capacity Act if there is a disturbance of the mind or brain of

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[7] **Deprivation of Liberty Safeguards (DoLS)** ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. https://www.scie.org.uk/mca/dols/at-a-glance

that nature. Adult L had several CT head scans, none of them showed any significant changes to the brain that would account for permanent damage that would affect cognitive functioning.

6.5. Despite the fact there were no brain changes seen on scans, research points to the fact that those who are alcohol dependent over many years will show memory impairment and lack of understanding of risks[8,9]. Intoxication from alcohol use causes fluctuating capacity; when a person is intoxicated, they may not be able to make decisions that they usually would when sober. The law regarding mental capacity and alcohol dependence is not clear and there are many examples of case law that identify different elements in legal considerations. This includes whether alcohol dependence in itself is a disturbance of the mind and brain in the first instance and then how the Mental Capacity Act applies in cases of alcohol dependence when a person is often under the influence of alcohol.

6.6. For the purposes of this review, it is important to understand the complexities of this area of work and identify what practitioners did well.

6.7. On the first hospital admission just prior to the review period, the influence that alcohol may have been having on Adult L's life was recognised and she was seen by the specialist nurse. This was strong practice and led to a clearer understanding of the impact of Adult L's drinking. There were signs of withdrawal when in hospital. The opinion of the specialist nurse was that there was no evidence of brain injury when they saw Adult L.

6.8. It is noted that withdrawal symptoms can include hallucinations and memory issues. There was evidence of some stories told by Adult L to her husband that indicated that these were possibly due to withdrawal both in hospital and within the care home. Adult L was not treated for withdrawal in further hospital admissions or the care home admission.

6.9. The specialist nurse informed the review that it takes time to build relationships when working with people who are potentially alcohol dependant. Adult L declined any further input from alcohol services. On the next admissions there was no referral back to alcohol services and this will lead to consideration for strengthening practice in the hospital setting. Adult L was screened for alcohol consumption on the following two admissions and neither of these indicated that referral to the alcohol team was needed but could have been offered based on history. There was a constant recognition by community health and social care services working with Adult L of her dependency on alcohol, again strong practice. To further improve that practice, consideration to take all opportunities to address alcohol consumption with offers of support services may be useful.

6.10. This review would therefore suggest that mental capacity and decision making in those who are alcohol dependent is extremely complex. Professionals need additional support and guidance in these situations. Many organisations have access to safeguarding lead professionals and mental capacity experts as well as legal advisors who would be able to offer this type of support. A shared understanding by all agencies is also helpful in situations of this nature.

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[8] No.l X, et al.. Alcoholism and the Loss of Willpower: A Neurocognitive Perspective. J Psychophysiol. 2010; 24:240–248. [PubMed: 21765575]
[9] Breversa,D, et al. (2014) Impaired decision-making under risk in individuals with alcohol dependence. Alcohol Clin Exp Res. 2014 July; 38(7): 1924–1931. doi:10.1111/acer.12447.

Points for strengthening practice:

- A deeper understanding of the impact of alcohol on decision making may support robust application of the Mental Capacity Act.
- Use of experts in substance misuse and Mental Capacity Act can support professionals in working in this complex area.
- Legal advisers may be able to offer support and guidance in this complex area of law where each case is different.
- An understanding by professionals of the services available to those with alcohol dependency could lead to a wider range of support.
- Organisations that have an ability to tailor services to the needs of the individual may encourage more service take up.

Safeguarding: Domestic abuse and the cared for/carer relationship

6.11. The history that the review has had access to indicates that, prior to the time frame, domestic abuse was a feature in this relationship. History would suggest that Adult L's husband was sometimes the perceived victim but more often it was Adult L that was the perceived victim.

6.12. The domestic abuse that had caused Police intervention was considered as an historic issue with last reports dating back three years previously. There were some reports of domestic abuse (verbal arguments, allegation that she was hit on the arm), but none related to significant physical injuries to Adult L or her husband during the time frame of the review. It is of note and identified as strong practice that most agencies had flags for MARAC on their electronic record keeping systems. It was also noted that some professionals were not aware of the history of domestic abuse despite evidence suggesting that there was information in the records. The GP surgery received a notification that was wrongly coded; the review heard how the surgery has since improved the system. There are more complexities by new guidance issued by the Royal college of GPs that is being worked through to assess its impact on local and regional systems. The NHS Foundation Trust have identified a need to ensure that all practitioners are aware of where information relating to safeguarding can be found and are progressing work to collate all safeguarding information in electronic records.

6.13. As stated above, Adult L's drinking often influenced her mood, and she showed her frustration to professionals by refusing care. Professionals would often note that Adult L appeared to be the dominant partner in the relationship and was observed to be the decision maker. It seems that although this was observed, it did not lead to a greater understanding of the dynamics in the relationship.

6.14. Adult L's husband often left the room whilst Adult L was being cared for, this may have given opportunity for Adult L to disclose any abuse ensuring that this was conducted safely with knowledge of Adult L's husband still being in the house. There were elements of what Adult L said, indicating that she did not want her husband to know things that might create arguments. Once these were explored further, Adult L denied that there were any issues of violence or abuse. When Adult L needed emergency care, Adult L's husband stated that he could not cope any longer with the demands placed on him by Adult L; this led to a referral for a carers assessment that he had agreed to. When the

allocated social worker rang to arrange the carers assessment, Adult L answered the phone and stated that her husband did not need support. The social worker rightly asked to speak to Adult L's husband at which point, with Adult L in the room, he declined support and stated he was alright.

6.15. When this information was discussed in the review, Adult L's husband's GP commented that he could not have been Adult L's carer due to his own health care needs. Whilst the GP did not disclose what these conditions were, there was a clear dichotomy given that Adult L's husband had given up work to be his wife's carer and all agencies apart from the GP practice recorded him as Adult L's carer who supported her with all her activities of daily living. Adult L's husband confirmed with the author that he did everything for his wife; evidence of the strain that this was putting on him was noted in his call to police and ambulance stating that he could no longer cope with caring for his wife.

6.16. Further evidence of this was that Adult L, when trying to limit the number of times paid carers were to call, was adamant that her husband would help her. At the time, the social worker was newly allocated and was in the process of building a relationship with Adult L so decided not to challenge this. This was understandable as in cases where people are more challenging to work with, there is a dilemma for professionals between challenge and relationship building.

6.17. Adult L was noted to be neglecting her health and care needs in wishing to discharge herself home on each hospital admission. Adult L stated that she missed her husband and that was the reason for her requesting early discharge. Professionals observed that, when at home, Adult L's husband would leave the house to do some shopping and within minutes Adult L would phone him to see where he was. Adult L had been known to phone the local pub seeking her husband's whereabouts. Care home staff stated that when she was being cared for by them, that Adult L was extremely anxious and worried at being separated from her husband; comments suggested that she appeared to be worried about what he would be doing. It is of note that when Adult L was in the care home, Adult L's husband was not able to visit due to COVID-19 restrictions.

6.18. Adult L did have opportunities to disclose abuse, and this was certainly discussed with her as evidence suggests that she responded that she would get help if needed. This was not the case for Adult L's husband who was not seen on his own to discuss his needs and ask him how he felt about the stress and demand placed on him and about any relationship issues. The social worker contacted Adult L's husband, but he stated at the time that he did not need support; that was a time when Adult L was in the care home, and he was not under the stress of caring for his wife. He stated that he was preparing for her returning home. Other professionals that were visiting, observing, and forming opinions regarding the relationship were not able to put this into the context of a possibly controlling relationship and explore this any further. This was a difficult and complex situation that changed regularly; time was not afforded to professionals to undertake more work due to the limitations of visits that Adult L placed on professionals as well as knowing that this couple were very private and did not share very much about their life.

6.19. Recent research indicates that there is still generally a lack of recognition for male victims of domestic abuse, and probably less recognition of controlling relationships[10],[11]. This may explain that whilst there was known evidence that Adult L was a dominant partner, it was not explored further to discern whether in fact there was any control or coercion by Adult L.

6.20. It is clear from police reports that Adult L was mostly perceived as the alleged victim and on one occasion there was a significant assault on Adult L by her husband observed three years previously that led to a MARAC referral. Evidence that Adult L was always desperate to get home was not seen in any other context. Adult L indicated that she was worried about what her husband would be doing. Research [IBID] would suggest that this type of behaviour is often experienced by men who have not disclosed abuse.

6.21. There was further evidence of the difficulties working with Adult L that some professionals found challenging to manage. Adult L was known to make complaints of a serious nature about some professionals that, on investigation, were not founded. This made caring for Adult L stressful for some professionals who found the allegations distressing. This may be a further indicator of a person who is struggling with losing function through poor health, had nearly died, and feeling as though they are losing control.

6.22. It shows strength of practice that all of this was recorded and was evident in discussions at the workshops. To strengthen practice there needs to be a focus on carer stress that shows insight into why a carer might change their mind in terms of requirement for support and ensuring that relationship dynamics are included in assessments and safeguarding meetings.

6.23. The Care Act (2014)[12] states that carers need to be offered assessments and that carer abuse should also fall into section 42[13]. Carer stress coupled with domestic abuse could make a relationship very difficult. When alcohol misuse is added to this situation, the lived experience of Adult L and her husband would make managing the day-to-day physical health care needs of them both very challenging. The risks facing Adult L were understood at some level. To ensure safety concerns regarding abuse are fully considered, an assessment of risk contributed to by all agencies is required. By considering the full picture a stronger package of support and alternative methods of offering that support may be considered.

6.24. More recently, a research publication related to the 'confronting a looming crises'[14] identifies key findings from interviews with older parents who care for middle aged and older adults. Although not specifically related to older couples in carer/cared for relationships, it identifies some key learning that

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[10] Bates, E. A. (2020). "Walking on eggshells": A qualitative examination of men's experiences of intimate partner violence. *Psychology of Men & Masculinities, 21*(1), 13–24. https://doi.org/10.1037/men0000203

[11] Philippa Laskey, Elizabeth A. Bates, Julie C. Taylor, **A systematic literature review of intimate partner violence victimisation: An inclusive review across gender and sexuality,** Aggression and Violent Behavior, Volume 47 2019, Pages 1-11,

[12] 2014 HM Government **Care Act 2014**; https://www.legislation.gov.uk/ukpga/2014/23/resources

[13] **The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

[14] Forester-Jones., R. (2019) People with learning disabilities and/or autism and their carers getting older: confronting a looming crisis. Mencap. https://www.bath.ac.uk/publications/report-confronting-a-looming-crisis/attachments/Final_FullDocument.pdf

can nevertheless be applied.

- *Combined carer and cared-for assessments which acknowledge mutuality and interdependence, and which are more family-oriented in approach; with assessors who understand and consider the ageing process.*

6.25. The key learning for this review is to consider taking a whole family approach when undertaking assessments. By gaining understanding of the nature of co-dependency, personalities and the narrative of a couple may help to break down any barriers.

Points for strengthening practice:

- Knowing the history of domestic abuse is important; systems can support this.
- Opportunities for disclosure and selective enquiry can support further discussions regarding experiences of domestic abuse
- Understanding the dynamics of a relationship can lead to a deeper understanding of the lived experience of each person.
- Being persistent in offering carers assessments and using a whole family approach, can support the full application of carers rights under the Care Act.
- Multi agency working can elicit information that may change pathways and plans.

Safeguarding: Self Neglect

6.26. This section will consider how effective the safeguarding system worked to safeguard Adult L and her husband as carer regarding self-neglect.

6.27. Self-neglect is defined in the Care and Support Statutory Guidance[15] as:

> 'a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.

This can therefore include:

- Lack of self-care (e.g., neglecting personal care, hygiene, and health; poor diet and nutrition) and/or,
- Lack of care of their domestic environment (e.g., neglecting home environment, hoarding and excessive clutter) and/or,
- Refusal of services that could mitigate the risk to safety and well-being (e.g., lack of engagement with health and/or social care staff and other services/agencies)

6.28. Adult L displayed a lot of these issues and therefore met the criteria for consideration of a safeguarding response which was evident in information gathered by the review process.

[15] **Care Act Guidance: Care and Support Statutory Guidance** (2016) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance Updated 2018 with no changes to Chapter 14 Safeguarding

6.29. When the author spoke to Adult L's husband, he indicated that as a couple they had always had a lot of belongings that accumulated. Professionals had stated that when they first visited Adult L, that they had to deliver care in the hallway at the request of Adult L as she was embarrassed by the clutter in the living room.

6.30. Adult L's husband indicated to the author that most of the possessions were not related to saving up items of importance to them, they just seemed to accumulate. The first element of safeguarding here therefore was clutter and hoarding and the risk that it posed to delivering safe and effective care to Adult L. Professionals did not describe the home as being one of squalor, therefore, it was only when the need for external support was required that this became an issue.

6.31. Managing risks for those that collect belongings is complex. Research[16] suggests many reasons and types of personality and mental health disorders of people who might hoard belongings to a point where there are greater risks of environmental issues and fire. Research also highlights that it is not possible for people who hoard to 'just tidy up and clear things out' (author's summary). As with other forms of self-neglect, effective work to improve the issue requires time to build relationships and to understand the root of the issue before work towards change can begin. The author would suggest that Adult L's recognition of the issues was an opportunity to consider further exportation of this, with a view to working towards an environment that did not cause embarrassment to Adult L. The self-awareness displayed by Adult L could have been key in promoting some change to the environment.

6.32. Other elements of self-neglect related to Adult L was her refusal of care and not being concordant with treatment and self-care that was prescribed/advised.

6.33. Some of this is linked to whether Adult L had 'executive capacity' to use and weigh information to make capacitous decisions and then carry out what she had agreed to. On many occasions Adult L was assessed as having capacity. Adult L appeared, on assessment, to understand the information that was being delivered to her regarding her care and on the face of it appeared to understand the risks posed if she did not carry out actions that she stated that she would e.g. contacting the GP when asked to by carers, keeping compression stockings on to prevent breakdown of leg ulceration and more worryingly staying in hospital and care home until professionals had deemed her fit for discharge. Adult L appeared to understand the risks and agreed to certain elements of care but then either declined care or carried out actions against advice.

6.34. Professionals appeared to not really understand why Adult L might act in this way. Professionals could see what was happening but felt powerless to change things. Executive capacity may have been an issue related to long term alcohol use or for other reasons not understood. Professionals did comment that Adult L always seemed very plausible when assessing her capacity, but then later would not follow instructions that she agreed to in her best interests. As discussed above in the section related to alcohol dependency, the legal view regarding mental capacity and decision making in those who are alcohol dependent is very complex and not easily understood. It is therefore suggested that early legal

[16] Braye, S. Orr, D. & Preston-Shoot, M. (2015) Self-neglect policy and practice: key research messages. Social Care Institute for Excellence available at https://www.scie.org.uk/publications/reports/report46.pdf

advice should be sought to ensure that practitioners are supported to consider the legal implications of assessing capacity in complex situations and dynamics.

6.35. In best practice guidance produced by several researchers [IBID] and displayed in many guidance documents and briefings[17] the key elements to working effectively with adults who self-neglect are:

- based on a relationship of trust built over time, at the individual's own pace
- finding the whole person and to understand their life history rather than just the particular need that might fit into an organisation's specific role
- takes account of the individual's mental capacity to make self-care decisions
- informed by an in-depth understanding of legal options
- honest and open about risks and options
- makes use of creative and flexible interventions
- draws on effective multi-agency working.

6.36. The link with safeguarding processes and self-neglect are dependent upon the level of risk and concern. When working with Adult L, these risks were effectively recognised with several professionals making safeguarding referrals to the local authority. It is of note that there had been 21 Safeguarding referrals over the 9 years prior to the review period. Most of these were related to documented domestic abuse.

6.37. The widest form of safeguarding is protecting the wellbeing of a person. There are often single agency responses to crisis points that safeguard a person from coming to harm. The second admission to hospital is an example of strong practice related to this principle. The ambulance had been called for Adult L's husband who had fallen. The attending crew recognised that Adult L would be at risk of harm if she was left at home without her husband there. Another crew was sent as there were two people needing support. Adult L initially refused to go to hospital but was persuaded by the crews that she needed to be safe and that they could not leave her at home. Adult L agreed then to go to hospital. It is of note that Adult L's husband was discharged the next day whilst Adult L became extremely unwell following admission.

6.38. The first safeguarding referrals in the review period came from the ambulance service and the hospital related to the second hospital admission in month two. The paid carers made several safeguarding referrals based on their concerns as Adult L's health was deteriorating and there were concerns about self-neglect and domestic abuse. The social worker raised an alert due to a disclosure that Adult L's husband had hit her arm.

6.39. On receipt of the first referral, the social worker planned for a strategy meeting as per the process. The social worker was not able to coordinate a timely meeting due to the availability of the chair and other professionals to attend. This did not stop the social worker from gathering information from other professionals, meeting with Adult L to assess her capacity and to identify a package of care as part of a best interest decision. There were multiple conversations at this point between professionals as

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[17] Braye, S., Orr, D. and Preston-Shoot, M. (2014) Self-neglect policy and practice: Building an evidence base for adult social care, London: Social Care Institute for Excellence (available at www.scie.org.uk/publications/reports/69-self-neglect-policypractice-building-an-evidence-base-for-adult-social-care/files/report69.pdf)

concerns were escalating.

6.40. It was disappointing for those professionals that were due to attend the strategy meeting, that due to staff sickness, the meeting was cancelled and was continued as a discussion separately with various professionals over the phone. Whilst this was a reasonable and sensible decision in the circumstances, making that a multi-agency discussion would have been beneficial. Cancelling the meeting should have been a last resort, further attempts could have been made to source an alternative chair for the meeting within the Social Work Team or failing that from the Safeguarding Adults Unit. Telephone conference calling facilities could have been used for multi-agency meetings. The review heard that this was not generally used at that time. Since the COVID-19 pandemic, this is no longer an issue as professionals have become very used to using video meeting technology; it is now widely used for strategy meetings. This not only enables multi agency discussion but is less time consuming and resource intensive for the social worker and other professionals. The decision from the strategy discussion was to ensure a safe discharge on this occasion and increase the care and support package.

There were some elements of the process that could have been stronger. On the social care record system, most of the recording of the information gathering from professionals that informed the strategy discussion was in the general contact notes. The record of the strategy outcomes was recorded in the appropriate forms in the safeguarding module/pathway. This meant that the two elements were not linked on the system. It was also noted that the GP and the police had not been part of strategy discussions. The district nurses were involved; however, the NHS Foundation Trust Safeguarding Team were not contacted by either their district nurses or the social worker. The NHS Foundation Trust are continuing to work to widen the knowledge of the support that the Safeguarding Team and Mental Capacity Act Lead can offer to their practitioners in safeguarding cases. The local authority social work teams will be reminded of the need to include the NHS Foundation Trust Safeguarding Team when strategy meetings or discussions are being convened. NHS Foundation Trust have made appropriate recommendations in their single agency report to address these issues.

6.41. There was an impact on the safeguarding of Adult L by not having all the information to make safeguarding decisions and alert all services to concerns; it also falls into the next section regarding multi agency working.

6.42. It is possibly for this reason that the GP was not aware of heightening concerns and/or reminded of the domestic abuse that was not recorded on the GP system. From a police perspective it was important that they gave a view from the domestic abuse perspective as there were indicators of some ongoing issues. It might also have highlighted the issue that the GP had regarding Adult L’s husband as her carer. It appears that there was an assumption that the district nursing team would be providing feedback to the GP. There were conversations between the GP and the district nurses but not from the safeguarding process perspective.

6.43. The further strategy meeting, as issues were again escalating, was set for the day after the country went into lockdown during the COVID-19 pandemic. The meeting therefore did not go ahead but became a discussion again.

6.44. It was recognised by professionals during the review process that there was a lot of strong practice in recognising self-neglect but also there was recognition for areas where the system requires strengthening.

6.45. The information at the start of this section identifies where best practice lies. The North of Tyne SABs have excellent guidance related to self-neglect and hoarding. Barriers to implementing its use are not wholly clear. There is no evidence that any visiting professional used the clutter image rating tool to aid risk assessment in relation to the level of clutter and collection of belongings. Self-neglect within the environment tends to have more focus when it is related to squalor and significant hoarding. Use of the self-neglect guidance and clutter rating tool can have several benefits. It can help to rate the risk and the level of clutter. This can then provide a baseline to identify if the situation is improving or declining and may provide for some preventative work. It can also support professionals to take an objective view and match it against national indicators rather than a subjective view of 'well it is not too bad'. For some professionals working in areas where they may see a lot of self-neglect, it again can ensure that there is no desensitisation and present a more objective approach when many households visited may appear to be similar.

6.46. Adult L had been known to services for many years, but it was only in the later years, and particularly in the time frame of the review that the self-neglect due to her refusal of services and non-concordance with care was getting to the point where Adult L was at serious risk of harm. There is a need to apply time and patience and relationship building to effect change; issues were escalating very quickly meaning that best practice was difficult to apply. This points towards learning regarding oversight and supervision from senior managers, safeguarding leads and seeking legal advice, not just from the local authority but from each agencies' legal advisors. The availability of safeguarding leads in NHS Foundation Trust has been discussed previously in this report and is being more widely promoted. Likewise, the local authority safeguarding team provides a valuable resource where team mangers can seek advice regarding cases of concern. This too needs further promotion to encourage managers to seek early advice where cases are complex.

6.47. Safeguarding plans need to be formal and shared and regularly reviewed from a multi-agency perspective. The use of core groups of key professionals meeting regularly to review these in more recent cases in the locality has proved to be very beneficial to the outcomes for those at risk and the professionals working with them. There has very recently been the development of a framework for meeting within the MASH on a weekly basis where referrals and other cases can be discussed in the multiagency forum. This process is in its infancy, but appears to have all the characteristics of a system that would benefit professionals working with cases of a similar complexity to Adult L's.

6.48. A further element for strengthening practice would have been to use an element of Section 42 Care Act that enables the local authority to 'cause others to make enquires'. This does not mean that the local authority does not coordinate the safeguarding enquiry but asks the most appropriate agency to carry it out. The author would suggest from experience that nationally, and certainly regionally, this element is not used as it could be. In this case it was self-neglect of Adult L's healthcare needs that were the main concern and therefore it could have been the district nurses that carried out part of the investigation. This would almost certainly have involved the GP and both the Safeguarding Teams for the NHS

Hospitals Trust and the Clinical Commissioning Group.

Points for strengthening practice:

- Clarity on executive capacity can be crucial in understanding if a person can use and weigh information based on seemingly capacitous decisions.
- Use of practice guidance can remind professionals how to apply policies, procedures and legislation to specific situations e.g. Self-Neglect Guidance.
- Clarity for all agencies on any safeguarding process underway and sharing of strategy action and safeguarding plans can provide a vehicle for multi-agency working and information sharing.
- A team around the person approach such as Core Groups can enhance multi agency working and improve outcomes for people in receipt of services where there are safeguarding enquiries underway.
- Ensuring that safeguarding processes include all relevant agencies ensures that information is shared by and to all involved.
- Use of organisational safeguarding leads can support professionals in their safeguarding work.

Multi Agency Working, Communication and Pandemic Impact

6.49. There were very few agencies involved in the everyday care of Adult L. There were the paid carers, one social work team, one GP practice. There was also one NHS Foundation Trust albeit that had multiple services, it was only the district nurses and the hospital wards that had ongoing input.

6.50. These main services communicated well together at points where there were concerns, particularly when those concerns were escalating. Services were quick to recognise where other services could step in to support with the CRRT being contacted to provide appropriate services when required. Generally, each agency was aware of what the other was doing, and it was Adult L's refusal of some of that care that caused most concern.

6.51. Professionals concluded at the workshops that, despite this, there could have been a more coordinated approach, and this has provided them with some points for stronger practice discussed further below.

6.52. One area that could have been stronger were some of the relationships and understanding of roles and what was needed at various points. There was a definite point of debate throughout the review process particularly related to whether a home visit from a GP was required. The details of these conversations do not add to the learning but the themes that emerged were clear from the author's perspective.

6.53. The social worker felt that Adult L's needs were related to her health conditions. Needs were escalating, the care agency was increasingly concerned that they were not able to deliver the care expected, and Adult L's health was deteriorating with possible COVID-19 infection. Physiotherapists and district nurses were also concerned with the deterioration. The GP assessment indicated that Adult L was clinically stable, was under treatment for her conditions and antibiotics had been prescribed for a chest infection.

6.54. It seems that the legal advice to the social work team was that being able to identify a diagnosis would be helpful if an application to the Court of Protection was made. However, it appears that this was recorded, and therefore perhaps understood, to mean that the court would be unlikely to accept an application without a formal diagnosis. What the court would need, is evidence of the reason to believe impairment of the mind or brain that leads to the possibility there is a lack of capacity. This information does not need to come directly from a medical person or report at that time and could arise from other records and information recorded about the person. In the case of Adult L, there was evidence of the alcohol dependency that could have had an impact on her mental capacity, specifically her executive capacity. There appeared to be a misunderstanding in what had been advised.

6.55. The social worker also requested a medical opinion to help discern what type of care bed was needed for Adult L as her admission was for healthcare reasons. The GP agreed that Adult L needed nursing care in a verbal telephone conversation. The social worker ultimately found a bed in a nursing home.

6.56. There were tensions between services exacerbated by the onset of new working rules related to the pandemic. GP practices had been told at that point not to undertake any home visits unless clinically necessary, social workers were advised only to undertake face to face contact when absolutely necessary. District nurses and carers continued to visit Adult L. COVID-19 restrictions added increasing complexities to an already difficult situation that was escalating by the hour.

6.57. The review process considered these communication difficulties and how the system might be improved. Clarity in communication is important. Conversations (discussed in the above paragraphs) would be stronger if each person involved were able to be clear about what they were specifically asking for but also checking back on understanding of actions at the end of the conversation. These principles can help when tensions and concerns are heightened. A model of 'ASK-DO-SHARE-CHECK BACK- RECORD (see appendix two) can be helpful.

6.58. One of the main issues was that the key coordinator in this case was the social worker; many of Adult L's needs related to her poor physical health and alcohol dependency. The author has suggested that there could have been more of a role for the district nurses to work in a coordinating role with the social worker. There is evidence that the district nurses often take a more active role, but in this case, the district nurses believed that Adult L's primary need was related to her mobility, therefore it was social care that was the priority need. A joint approach from social work and health, including the GP, may have led to better understanding of both areas of concerns to understand the broader picture. As stated in the above section this could have been brought about by S42 element of 'causing others to make enquiries'.

6.59. The review panel discussed this as being a longstanding issue regarding who should take the lead in cases. The author considers that this may be the case far and wide but should be addressed in core groups and escalated internally in organisations if it is causing a debate. Joint coordination should be possible.

6.60. At the point that the timeframe for this review covers, the situation regarding COVID-19 was causing increasing concern with services being altered to try and keep staff and people safe. This ultimately led to the first national lockdown where many services changed the way they worked and removed all but

essential face to face contact.

6.61. This was a situation that no one had ever been in before with many services' guidance changing daily based on information from government sources. This was an extremely difficult situation for both practitioners and people in receipt of services. The ending or change to services had a significant impact on some service users/patients/clients nationally as the rapidly changing situation was confusing.

6.62. What this meant in practice was that the social worker and GP were no longer able to visit unless very critical. The district nurses and carers continued to visit. This was at the time that Adult L was deteriorating and increased the complexities of communicating. Face to face meetings were also not possible and, as stated previously, it took some agencies quite a period to be able to use secure video meeting technology.

6.63. Given the unique nature of the pandemic it appears that organisations had to adapt and change rapidly. The issues are well documented regionally and nationally and are still being debated. What is clear, however is that there has been a lot of learning from the early stages of the pandemic and many services and agencies were able to find effective and innovative ways to feel confident to prevent such issues in the future.

6.64. The most important issue for this review is that community COVID-19 testing was not available at the most concerning point for Adult L. The symptoms of COVID-19 were described quite specifically at that point whereas now it is known that people may contract COVID-19 with no apparent symptoms. The GP had diagnosed a chest infection when Adult L was at home. At the point of admission to the care home, residents and new admissions were not being tested for COVID-19. At some point Adult L contracted COVID-19 infection; this was not known until admission to hospital where tests were being carried out. Adult L subsequently died from COVID-19 infection. The pandemic therefore had a direct impact on Adult L and the ability of professionals to know that she had COVID-19; she was admitted to a care home at a time when no testing was being carried out and went home possibly having already contracted COVID-19. None of the professionals were able to have any influence on what happened as very little was known about COVID-19, professionals were following the very strict guidance in place at the time that has subsequently changed.

Points for strengthening practice:

- Clarity of what is required and requested during communication, especially via telephone can support more effective understanding of roles and responsibilities.
- Dual coordination may be required in cases where health care needs are the main concern. Use of the 'cause others to make enquiries' under Section 42 Care Act, can support this way of working where a case meets the safeguarding threshold.
- Learning from responses in the early stages of the pandemic has already changed practice.

7. SUMMARY AND CONCLUSION

7.1. Adult L was reported as being a formidable character who had been a very private lady who had not had any contact with family for many years. Adult L felt that she and her husband did not need other

people in their lives; they appeared to become co-dependent through the ups and downs in their relationship.

7.2. This review has found that there were complexities of Adult L's multiple physical health needs, and it became apparent that she had difficulty in accepting support that was deemed to be needed to keep her as well as possible. Professionals tried their hardest to support her but unfortunately any recovery and improvement was not sustained.

7.3. The review identified a plethora of strong practice as mentioned throughout the report. During the workshops, practitioners reflected on their practice and along with the author, areas where practice could be strengthened.

7.4. It did not to seem as though professionals could get to understand why Adult L refused care on occasions or why she complained about services and individual professionals on several occasions. Adult L's self-neglect that manifested in refusal and non-concordance with care, led to her expedited deterioration, making her more vulnerable and in a place where she ultimately contracted COVID-19 infection. Shielding at home would have been the safest place but this was not possible due to the deterioration that had already happened. Had she not contracted COVID-19, there would have been further opportunities for agencies to build on relationships that had been established with a view to understanding the complexities of providing care for Adult L in more depth.

7.5. There were uncertainties regarding the impact of Adult L's alcohol dependency on her capacity to make decisions and carry out agreed actions.

7.6. Adult L's husband struggled to care for her, and he had needs that had not been met, possibly due to the intervention by Adult L that led her husband to change his mind regarding assessment of his needs.

7.7. There were many areas where the review found good multi agency working but this was not always as coordinated as it could have been with the pandemic having a significant impact on this area.

7.8. There was evidence of a good systems in place to safeguard and offer safe and effective care to Adult L; there was guidance that could be used to strengthen systems and support from specialists in mental capacity, safeguarding and substance misuse that could be used more effectively.

7.9. Adult L's death could not have been prevented at the time. Having had the opportunity to use Adult L's experience as a learning opportunity; individual agencies as well as the broader multi agency partnership have identified areas where practice could be strengthened.

7.10. Strengthening practice can improve the lived experience of those in receipt of services.

8. RECOMMENDATIONS

The recommendations are built around the noted areas that require consideration of stronger practice.

Alcohol Dependency and decision making

- NSAB to undertake work with public health on training and other available resources to upskill the workforce who may work with adults who use alcohol problematically. This should include the complexity of Mental Capacity Assessment in those adults.
- NSAB should work with partner agencies towards the wider use of the alcohol identification and brief advice (IBA) model, including the use of screening tools for alcohol use. This should also include work to identify and promote support services that may meet the need of individuals who use alcohol problematically, including change resistant drinkers.
- NSAB to set up a task and finish group to identify relevant elements of Safeguarding Vulnerable Dependent Drinkers, England and Wales report. NSAB should consider actions needed for implementation, that would be beneficial to adults who use alcohol problematically in Newcastle.

Safeguarding: Domestic Abuse

- NSAB should ask that providers of domestic abuse training ensure that the specific issues of domestic abuse in older couples is included in training packages.
- NSAB should develop and provide briefing on the topic that is easily accessible by the workforce who come into contact with older couples. This should include:
    - creating opportunities for selective enquiry.
    - Whole family approach to assess carer and cared for needs understanding any interdependency based on individual circumstances.
    - Multi agency working to assess risk
- NSAB to contact new Local Domestic Abuse Partnership Board to share the learning from this SAR and ensure that the needs of older couples are incorporated into their work and strategy.
- NSAB to ensure that there is a link into the Domestic Abuse Partnership Board in terms of reporting to and from.

Safeguarding: Self Neglect

- NSAB, in light of the learning from this review, should refresh and relaunch the self-neglect guidance and clutter rating tool, ensuring that there is clarity regarding the issue of executive capacity.
- NSAB should request that the Weekly Strategy Discussion started in the MASH is reviewed and audited to provide evidence of the positive impact on people with complex needs and formalised as part of multi-agency procedures if its additional value is demonstrated.
- NSAB to promote the existing mechanisms and frameworks (available within the NSAB's multi-agency safeguarding adults procedures) that assist with ensuring that Section 42 Enquiries are multi-agency in their nature and where required a key worker or dual co-ordination role is identified. This should include things such as Core Groups, investigation report templates and the Risk Assessment and Management Plan (RAMP) tool.
- NSAB should ask partner agencies to ensure that the role of Mental Capacity Act leads and safeguarding adults leads is highlighted within organisations.

Multi Agency Working, Communication and Pandemic Impact

- NSAB should consider adopting the ASK-DO-SHARE-RECORD-CHECKBACK tool as an aide memoir on effective communication. This may be shared as part of the learning briefing from this SAR and/or as part of relevant multi agency or single agency procedures.
- NSAB to produce a learning paper: Takeaways from the pandemic to strengthen future practice.

General Learning Briefing:

- NSAB should consider various methods of sharing the learning from this review e.g. podcast, video, as well as the traditional learning briefing.
- A case study should be developed to support individual and team reflection and for use in single and multi-agency training.

Appendix One: **Safeguarding Adults Review**

SUBJECT ADULT L

Terms of Reference and Scope

1. Introduction

A Safeguarding Adult Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.

- Be proportionate according to the scale and level of complexity of the issues being examined.
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within.
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened.
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case.
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels.
- Make use of relevant research and case evidence to inform the findings of the review.
- Identify what actions are required to develop practice.
- Include the publication of a SAR Report (or executive summary).
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

Adult L was 75 years old when she died in hospital following a positive test for COVID-.
In the four months before she died, Adult L had increasing care and support needs with several agencies involved to meet those needs. Adult L sometimes refused care creating concerns for agencies.

Adult L spent period in hospital and respite within the four-month period.

Adult L lived at home with her husband who was her informal carer. There was a previous history of domestic abuse recorded with a referral to MARAC 3 years before. There were also concerns raised regarding clutter, hoarding and self-neglect. Adult L and her husband were also noted to consume significant amounts of alcohol.

Several safeguarding alerts were raised by several agencies and safeguarding procedures and plans were ongoing at the time of Adult L's death.

3. Decision to hold a Safeguarding Adults Review

The Safeguarding Adults Review Committee of the Safeguarding Adults Board met on 1st July 2020 to consider the case for review. It was agreed by all members present that a formal Safeguarding Adults Review should be undertaken and made a recommendation to the NSAB Independent Chair. The Independent Chair endorsed this decision.
NSAB were in receipt of several SAR referrals at the time. NSAB therefore, undertook a robust process to identify how to manage that workload for agencies, resources available given the national pandemic impact, and then to identify a suitable reviewer. The Review commenced in January 2021.

4. Scope

The review will cover the period **1 December 2019 – 30 April 2020.** This timeframe includes the most recent safeguarding adult's concerns about Adult L. Information will also be sought from agencies regarding background information and key events prior to the scoping period.

5. Methodology

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

NSAB chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a series of workshops undertaken using virtual meeting technology (Due to pandemic restrictions). Each workshop will focus on one or two themes and be set the task of exploring the themes and answering questions. The themes will be identified from the chronologies and reports that have been undertaken by agencies. This will lead to identification of areas for learning and improvement.

6. Safeguarding Adults Review Panel Membership

A panel will be established that will oversee the Safeguarding Adults Review for Adult L. The panel's role will be to quality assure the process and products (including single agency review from their own agency and the final overview report and recommendations). Panel members need to be of sufficient seniority to be able to provide challenge as well as agree any recommendations.

The Safeguarding Adults Review Panel's membership will consist of:

- City Council

- NHS Foundation Trust
- Mental Health NHS Foundation Trust
- Police
- Ambulance Service
- Clinical Commissioning Group
- Legal Advisor to the NSAB

7. Key Lines of Enquiry to be addressed

As well as broader analysis provided within the Agency Review Reports, the following case specific key lines of enquiry will be addressed.

7.1. Assessment, Care and Review

- What assessment did your agency undertake of Adult L's holistic needs, inclusive of physical and mental health and social needs?
  - How robust was this?
  - How did this inform care planning and interventions and review?
  - Please provide analysis of what assessment policies and frameworks were in use and identify any gaps in policy and/or evidence-based practice.
  - Please comment on your agency's response to assessing and managing Adult L's alcohol use and any impact on care delivery.

7.2. Mental Capacity Act

- Was the Mental Capacity Act applied robustly at points where it should have been?
- Please evidence how the Mental Capacity Act was applied at various decision-making points. Please reference whether and how the impact of alcohol as well as Adult L's wishes, and feelings were taken into consideration.
- What part did Mental Capacity play in understanding the how Adult L understood the risks of abuse and self-neglect?

7.3. Domestic Abuse

- What did your agency understand of the relationship between Adult L and her husband both in the review period and previously?
- How did your agency assess, support, and address any ongoing impact of domestic abuse? Please consider all forms of abuse and coercion.

7.4. Safeguarding and Self-Neglect

- What was your agency's response to concerns related to abuse and neglect/self-neglect?
- What part did safeguarding procedures and guidance documents play in protecting Adult L from self-neglect?
- How did your agency engage with safeguarding procedures and meetings?
- Please analyse the overall safeguarding response to Adult L based on your understanding of the case.

7.5. Engagement

- How well did Adult L engage with your service? Please analyse any strategies used to encourage Adult L to engage. Please include any advocacy that was offered/used as a strategy to support engagement.

7.6. Informal Carer Support

- How did your agency engage with Adult L's husband?
- What carers assessment was offered/undertaken in respect of Adult L's husband for his caring role? Please comment on and analyse how carer needs were understood in relation to Adults L's illnesses and her sometimes refusal of care.

7.7. Wider family and community support

What did your agency know of the wider family, friends or community networks that supported Adult L and her husband? Was assessment of support networks robust?

7.8. Pandemic Impact

- Following the national response to the COVID-19- 19 pandemic, please analyse the impact on Adult L of any changes to services and/or practice.

7.9. Documentation

- Please identify if documentation was in line with agency requirements. If not, please analyse why this might be.

7.10. Good Practice

- Please identify examples of strong practice from your agency and others

8. Independent Reviewer

The named independent reviewer commissioned for this SAR is **Karen Rees.**

9. Organisations to be involved with the review:

The following organisations will be asked for Agency Review Reports:

- The Mental Health NHS Foundation Trust
- Council Adult Social Care
- NHS Foundation Trust
    - Hospital
    - District Nurses
    - Community Response and Rehabilitation service (CRRT)
    - Occupational Therapy
- Police
- The Ambulance Service NHS Foundation Trust
    - Emergency 999 Service
    - 111 Service
- The Clinical Commissioning Group
    - GP
    - GP Out of Hours Service

- Care Home Provider
- Home Care Services Provider

10. Family Involvement

A key part of undertaking a SAR is to gather the views of the family, involve them in the review and share findings with them prior to publication. NSAB has contacted Adult L's husband, inviting him to be involved. Adult L's husband will be fully involved in the Safeguarding Adults Review to the extent that he wishes and will supported by an independent advocate to do so.

11. Coroner and Crown Prosecution Service (CPS) considerations

The SAR Committee and Panel is not aware of any parallel reviews or investigations. The Coroner has been notified of the intention to undertake a Safeguarding Adults Review. Terms of Reference will be shared with the Coroner and any other information as requested/necessary.

12. Communications

Newcastle City Council are the lead agency in relation to communications about Safeguarding Adults Reviews. Any approaches made to other agencies should be directed to Newcastle City Council. There will be no public statements about the Safeguarding Adults Review until the review has been concluded.
Key stakeholders that will need to be updated as appropriate:

- Adult L's husband
- Staff and agencies involved in the case
- The NSAB

13. Links to other review processes

The SAR Committee considered whether this case also met the criteria for a Domestic Homicide Review (DHR). Whilst it was felt that it did not, it will be important that learning from this review is shared with the Community Safety Partnership.

Project Plan dates:
NB: the timeline allows for additional time to allow for pandemic impact on services but adjustable in respect of any lifting of COVID- restrictions.

1.	Scoping Meeting	4 Feb 2021
2.	Terms of Reference agreed	4 Feb 2021
3.	Agency Authors' briefing	11 Feb 2021
4.	Agency Review Reports submitted	9 April 2021
5.	Review of reports by Independent Author	12-14 April 2021
6.	Distribution of reports & workshop details to all workshop attendees	14 April 2021
7.	Author prepares for workshops	14 April- 3 May
8.	Learning and Reflection Workshops x4	5,7,13 & 14 May 2021

9.	First Draft Overview report to all workshop attendees	18 June 2021
10.	Comments on First Draft from workshop attendees	2 July 2021
11.	V2 Overview report circulated to panel (and attendees for info)	16 July 2021
12.	1st Panel meeting	W/C 6 September
13.	V3 to Panel & suggested areas for recommendations to panel	W/C 20 September
14.	2nd Panel meeting (agree V3 report and recommendations discussion)	W/C 27 September
15.	Recommendations circulated for virtual sign off.	W/C 4 October
16.	V4 Final version with recommendations	W/C 11 October
17.	V4 to Board Members	
18.	NSAB Meeting for final sign off	TBC End October/November

Appendix Two: Model for Effective communication