

Portsmouth Safeguarding Adults Board

Safeguarding Adults Review 'Mrs E'

Executive Summary

1. Introduction

- 1.1. This is a summary of a Safeguarding Adults Review commissioned by Portsmouth Safeguarding Adults Board (PSAB) to review the circumstances that led to Mrs E's death in June 2020, which was in part due to an infected pressures sore. The Safeguarding Adults Review subgroup recommended to PSAB's Chair that the case met the criteria for a mandatory Safeguarding Adults Review because of concerns about the neglect she had experienced prior to her death and the lack of effectiveness of agency involvement with Mrs E and her family. Safeguarding Adults Boards are required by the Care Act 2014 to carry out a Safeguarding Adult Review when an adult at risk in their area has been seriously harmed or has died, and abuse or neglect is suspected, and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future.
- 1.2. A Review Panel was established, and an Independent Reviewer was commissioned to lead the process and to write the report. Terms of Reference for the review were agreed. Initial scoping chronologies were used to inform the Review, supplemented by additional information as required, with a Practitioner Event based on a 'Strengths, Weaknesses, Opportunities, Barriers' analysis. The methodology used focused on systems and how the different parts of it work together, rather than individual practice. It is not about blame but about learning from experience to protect vulnerable people in future. It is desirable in reviews to involve the family. Mr E's husband and son acted as her main carers and were invited by letter to participate in a way that suited them; however unfortunately no response was received.
- 1.3. This report is an executive summary produced by the SAR subgroup, based on the full report produced by the Independent Reviewer. The Board decided not to publish the full report to protect Mrs E and her family's anonymity.
- 1.4. The Panel carried out its work between March 2021 and January 2022. The Final Report has been delayed by several months due to the impact of the pandemic.

2. Background to the Review

- 2.1. Mrs E was a frail older woman in her eighties with a diagnosis of dementia and complex physical and mental health needs. She lacked mental capacity in relation to decisions about her care and support needs. Her main carers were her son and her husband.
- 2.2. Little is known of Mrs E's earlier life. She had a son and a daughter, and was formerly a hairdresser in Portsmouth. Prior to her dementia diagnosis, Mrs E was described as a happy person, very keen on animals and football, supporting her local team enthusiastically.
- 2.3. Several incidents occurred in 2016 and 2017 to raise concerns about her care and support needs and her poor living conditions. In May 2019, a safeguarding concern was raised about neglect and acts of omission and Mrs E was admitted to hospital, where it was noted she was dirty and had matted hair. She was discharged with a four times a day package of care. The family requested that this be cancelled saying they had concerns about the carers and about the cost of the care. This was done following a Best Interests decision.
- 2.4. Mrs E did not receive visits from any service after December 2019. The onset of the pandemic meant that many face-to-face services ceased after March 2020 and Mrs E did not get her prescribed injections. Welfare checks were made by telephone but family reported no concerns. The pandemic meant there were delays to the planned home adaptations and these were not completed before she died, a year after the need for improved washing and toilet facilities was identified.
- 2.5. Mrs E died at home in June 2020. When the ambulance service responded, Mrs E's husband reported that she had been unwell and in a comatose state for three days prior to calling for help from services. Mrs E was found in a poor state and covered in dried faeces. Her death was found to be partly due to an infected pressure sore.

3. The Panel's discussion and analysis

3.1. The Review addressed the following key questions:

- How did professionals engage with Mrs E and her family?
- Were expectations from agencies that family members would provide personal care reasonable?
- How effectively was Mrs E's voice heard by professionals, and her views and wishes considered?
- How effectively were risks of harm to Mrs E recognised and managed by professionals and how were the appropriate risk management/neglect tools used?
- How was the Mental Capacity Act applied?

- How effective was communication and multi-agency working?

4. Conclusions

- 4.1. This SAR found that Mrs E was very frail, with complex and deteriorating physical and mental health, living in poor accommodation which lacked adequate hygiene facilities. Her family were known to have neglected her needs in the recent past and refused a care package to support her. They would accept help with installing washing and toilet facilities. The plans for home adaptations did not materialise before she died, a year after the need was identified.
- 4.2. Visits were made by practitioners from different organisations but there is no evidence of co-ordination between them, or a holistic or comprehensive assessment and care plan as required by the Care Act 2014. She was discharged from the Virtual Ward in June 2019 on the erroneous understanding that she had a care package in place.
- 4.3. The family were left to their own devices for the last six months of Mrs E's life with no visits from any service after December 2019. The onset of the Pandemic meant that many face-to-face services ceased after March 2020 and Mrs E did not get her prescribed injections. Welfare checks were made by 'telehealth', but family reported no concerns. Clinical guidance on the use of telehealth consultations were not available until September 2020 but these do now provide guidance on the risks of relying on it in some situations, including safeguarding. Whilst this was usual practice during the 'lockdown', it may be unwise to rely on a family's account of the home situation. In this case, the risk would not be known to the caller.
- 4.4. Mrs E had advanced dementia and her life expectancy may not have been long. However, she died from causes which were almost certainly avoidable. It has been shown that a lack of communication and co-ordination led to missed opportunities to intervene and to put a robust monitoring plan in place and thereby keep her safe.

5. Findings

- 5.1. **Mental Capacity.** There was no doubt that Mrs E lacked capacity to make informed decisions about her care. Whilst a Best Interests Determination was made appropriately, there was no review or monitoring of this, despite a high risk of neglect arising from the outcome of the determination. It may be considered that Mrs E was being deprived of her liberty as she met the 'acid test' but Community Deprivation of Liberty Safeguards, or other statutory mechanisms, were not considered as a means of ensuring a care package was in place when 'the less restrictive' option failed. It is also important to

review individuals without capacity who live at home and are known to be at risk of neglect regularly to ensure their situation remains safe.

- 5.2. **Financial Misuse and cost considerations.** Mr E stated his concern about paying full cost for the care package, cancelling as a result, which increased the potential risk of harm to his wife. Mrs E had made allegations that her family were misusing her money. Some safeguards needed to be put in place to ensure that this did not happen. If this could not be done by negotiation, application could be made to the Court of Protection. Other options may also be available, such as writing off debt for financial contributions or applying for funding from other sources, including NHS Continuing Care.
- 5.3. **Advocacy.** Mrs E was unable to make her own views known but it may have been possible to facilitate this through use of a skilled advocate.
- 5.4. **Multi-Agency Communication and Information Sharing.** There is little evidence of effective multi-agency co-ordination in this case. There was also a lack of continuity in practitioner involvement which may have obscured the risks.
- 5.5. **End of Life.** It was known that Mrs E had advanced dementia, which is a life limiting condition, often requiring highly skilled care in the end stages. Contact was not made with the palliative care service.
- 5.6. **Carer's Allowance Concerns.** Payment of Carer's Allowance is not based on a person's suitability for the role of carer and is not monitored to ensure that 35 hours of care per week is given to an acceptable standard by an appropriate person.
- 5.7. **Covid-19.** The pandemic has caused immense disruption to health and care services, due to extra demand and to the need to protect staff and patients from contracting the virus. The most vulnerable people were checked by telephone. However, when Mrs E received her calls in April 2020, her daughter reassured that all was well although clearly it was not as Mrs E had a pressure sore. It is known that Mr E told the ambulance service that he had not wanted to inform the GP and did not want his wife to go to hospital due to Covid-19. There has been concern nationally that fears around the pandemic prevented people from seeking help when it was needed, and this may be an example of this issue. There needs to be a clear message that health and care services are available when genuinely needed.

6. Good practice identified

- 6.1. The Mental Capacity Assessment was carried out and recorded according to the legislation, with attempted engagement with Mrs E.
- 6.2. Guidance was issued in September 2020 on the use of telehealth during the pandemic. This describes risks associated with safeguarding assessments and where insufficient information can be obtained. It states when a face-to-face meeting is appropriate.

7. Recommendations

- 7.1. It is recommended that PSAB use the opportunity afforded by the launch of the new Mental Capacity Act/Liberty Protection Safeguards in April 2022 to increase awareness and confidence in implementing the requirements of the law.
- 7.2. It is recommended that there is a review of the use of Community Deprivation of Liberty Orders to ensure that they are put in place appropriately to safeguard individuals without capacity, with care needs, who are living at home.
- 7.3. It is recommended that regular reviews are put in place for individuals without capacity, with care needs, living at home to ensure their ongoing safety.
- 7.4. It is recommended that clear guidance is in place regarding the management of high-risk situations where the Multi-Agency Risk Management Framework does not apply.
- 7.5. It is recommended that PSAB request partners to draw up simple guidance on financial abuse and misuse of funds together with information about the solutions available in different circumstances and how to action them. Practitioners should know how to protect individuals without capacity in finance decisions where their best interests may not be met by those in control.
- 7.6. It is recommended that PSAB request that the Local Authority ensures that practitioners are informed about the advocacy services provided under the Care Act 2014 and the Mental Capacity Act 2005 and that they know how to refer appropriately.
- 7.7. It is recommended that the PSAB request that partners put in place improved guidance around Risk identification and Management in cases where an individual lacks capacity and a high level of risk exists. It is also recommended that a keyworker is allocated to maintain continuity and provide a focus for communication.
- 7.8. It is recommended that PSAB ensure that the role of palliative care at home and how to access it is understood by practitioners.
- 7.9. It is recommended that PSAB pass these concerns to the Department of Work and Pensions for their consideration.
- 7.10. It is recommended that PSAB seeks assurance that a clear public message goes out to assure people that services remain available in cases of serious need during the pandemic.