Safeguarding Adult Review

Overview Report

Adult A

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Lancashire Safeguarding Adult Board
Safeguarding Adult Review Report

Re: Adult A

Concise Review	√

Review Process

This safeguarding adult review was commissioned by the Independent Chair of Lancashire Safeguarding Adult Board (LSAB) on the 5th May 2016 in agreement with the recommendation of the LSAB Safeguarding Adult Review Sub Group that the circumstances surrounding the death of a vulnerable adult met the criteria for a safeguarding adult review.

Circumstances and history resulting in the review

Subject of the review: Adult A: **Aged 88 years**

Adult A lived with her husband for 60 years, they will be referred to as Mrs and Mr A throughout the remainder of the report. Mrs A had one child, a son called Mr D, who Mr A was step-father to from a very young age. Mr and Mrs A had two grandchildren, and their relationship with Mrs A was good however there was a strain with the relationship with Mr A as he distanced himself from the grandparent relationship. Mrs A was described as non-confrontational to others and would find herself reducing conflict as she referred to this as an 'easy life'.

Mr A was described by his close family as a 'difficult' man, who could be

argumentative and difficult to engage. His relationship with his son (Mr D) was often tense and challenging, but as a family they had always maintained contact and visited regularly. Mrs A had described her husband to external agencies as being very dominant and a rude man and that they fell out at times and always had done.

Mr and Mrs A began to show signs of deterioration in their mental well-being around 2011. This manifested itself as odd behaviours and comments. From 2011 to 2015, the frequency and intensity of these behaviours increased, and the family directed them to seek support. In April 2015 Mr and Mrs A both attended their GP and both were referred on for further exploration of their mental health.

From April onwards both Mr and Mrs A's behaviours deteriorated with agencies becoming involved in their care. In September 2015 there was an incident where it was alleged that Mr A assaulted Mrs A which directly contributed to her death.

The Safeguarding Adult Review Panel identified the review timeframe as between 01/04/15 and 23/09/15. The timeframe and methodology used will be explained later, and the service provision and involvement analysed.

There was involvement with a variety of adult services at this time and the focus of the analysis is on the agency involvement and how these services worked together. The panel recognised that this was a short time frame but this was reflective of the quick deterioration in Mrs and Mr A's well-being and engagement with services.

The circumstances which resulted in the review being agreed are summarised here:

In the four years leading up to the start of the review timeframe, both Mr and Mrs A were described as developing 'unusual' behaviours. Incidents were described by the family which included receiving phone calls during the night from both parents stating that they believed that they were being spied on, or that there were unknown people in the house and at times that they did not recognise one another.

The family described these incidents as low in frequency and they were able to resolve them over the phone, therefore the family did not feel the need to seek further support.

Mr D reported that the family became significantly more concerned following an incident in April 2015. The incident occurred as a result of Mr D and family attending his parents' home to show them their new car. On arriving at the property the family suggested going for a drive, however Mr A was adamant that he would not get into the car with Mrs A as he felt she was an 'imposter'. The family spent time trying to provide assurance to Mr A, however he would not cooperate and the drive was abandoned. This led to Mr D encouraging them both to attend multiple GP appointments. Following attendance at the GP, referrals to the memory clinic for both Mr and Mrs A were processed in July 2015.

Mr A's assessment occurred on the 10th August, 2015. He was diagnosed with Alzheimer's at this assessment meeting. Mrs A was present to support her husband, and the clinician noted she had a low mood and delusions that others were locking her and her husband in the bedroom. Based on this observation, a memory assessment was carried out at the same appointment to explore further. This identified that Mrs A's memory and level of need was even higher than her husband's, leading to an immediate referral to the Rapid Intervention and Treatment Team (RITT) for her. This was allocated to a care coordinator and an appointment arranged for the 14th August 2015.

During this period, a referral was made by son to adult social care, requesting allocation for a social worker to assess any social care needs.

RITT and adult social care visited Mr and Mrs A on the 19th August 2015, and discussed options and support that could be provided. Mr A was adamant that they did not require any support and declined assessment. Mrs A had agreed to have the support with some daily tasks and both parties agreed to discuss this and think about it further. There was assumption at this point around both Mr and Mrs A

having capacity to make this decision. With the memory and cognitive challenges already identified for both, assessing capacity at this point would have been appropriate.

Over the next three weeks there was good inter-agency communication and it was clear professionals involved were working together. However Mr D reported that he was often not aware of outcomes or decisions. The professionals involved stated this was due to them respecting that Mr A had asked professionals not to share any information about himself with his son and they were confident that Mr A had capacity at the time around this decision.

Mrs and Mr A continued to show signs of confusion and having what was described as hallucinations. The allocated social care professional raised the case in supervision requesting a second person to be involved, or a qualified social worker. It was agreed that as there was already a good working relationship it would be more appropriate to continue with the allocated worker and adding new professionals could cause some confusion or distress to Mr and Mrs A.

Mr D described an event on the 6th September in which he and his wife visited his parents. During this visit it was identified that an appointment letter for a magnetic resonance imaging (MRI) scan had arrived, however Mr A refused to let his son view the letter. Mrs A was willing to show them the letter, however Mr A threatened his wife with the words “You will be sorry” if she did. When Mr D asked his mother whether she was worried by the threat, she replied that she was. At this point Mr D did discuss with his mother the offer of staying with him, however she refused stating she wanted to remain with her husband.

On the 11th September, when the RITT worker attended the property, Mrs A reported a small graze on her leg. She did not appear distressed and described banging it on the table. The worker took Mrs A to the GP where the minor wound was dressed, but no concerns were noted. Due to it being considered a minor injury the son was not informed as the professional believed Mrs A had capacity to inform

who she chose about the incident, however this was never fully explored or assessed. Planned visits to the house were increased with daily visits and prompts for Mrs A to attend appointments.

On the 12th September, Mrs A had contacted her son on the phone and told him that the injury had been caused by her husband “throwing a letter knife”. Mr D shared this information with adult social care out of hours Emergency Duty Team (EDT) as it was a Saturday. EDT made the decision not to visit, though it was noted they had no access to some of the historical information referred to above as it had not been recorded on their system.

This incident was picked up on Monday 14th September by adult social care for further investigation. The social care team spoke to Mrs A on the phone, and she described herself as safe and not wanting to leave the home. Mrs A stated to adult social care that the injury had been caused when her husband had ‘dropped a knife’ on her leg, but she described this as an accident. There does not appear to have been any consideration around a referral to the police for this incident. RITT practitioner discussed the incident with Mr A however he could not recall the incident occurring.

A joint visit was undertaken by social care and the RITT on the 15th September. The couple were both relaxed during the visit and Mrs A stated that she felt safe in the home. She advised at this time the knife incident was an accident. Both felt that there was no evidence of immediate risk to Mrs A; however it was not explored why Mrs A had given a different account of the injury initially. This exploration would have again looked at capacity for Mrs A in her understanding and memory of the incident and whether the multiple accounts were as a result of confusion or intentional hiding of information.

There was agreed ongoing monitoring and visits to be undertaken on the 18th and 21st of September by the RITT. There was further discussion about a package of care, but again Mr A refused this.

On the 16th September, Mr D contacted social care again due to him becoming increasingly concerned that agencies did not appear to be taking any action. Mr D was concerned that he was seeing a different presentation to the one professionals were seeing. This was potentially linked to the time of the visits from professionals, which had all been during the day. Mr D was receiving a lot of contact in the evening and overnight from his parents.

On the 21st September, a specific safeguarding social worker was allocated to the case, however they took emergency leave. A decision was made by the local authority Safeguarding Team Manager that this could await their return rather than re-allocate as the leave was a short term agreement and was for less than a week.

On the night of the 23rd September, during a telephone discussion with his father, Mr D became increasingly anxious about his mother's welfare so made a 999 call to request an ambulance. Mrs A was found with a head injury. Mr A was unable to describe to the ambulance crew what had happened. At the hospital Mrs A indicated to staff that her husband had caused the injuries by throwing her over a table. The lead clinician indicated there were multiple bleeds and expressed to the police that the likely cause was a repeat trauma to the head, and that it was unlikely to be caused as a result of a single fall.

A subsequent forensic post mortem examination and examination of the brain by a Consultant Neuropathologist was undertaken which confirmed she had suffered traumatic brain injury which in combination with her advanced dementia and cerebrovascular disease had left her susceptible to developing a significant kidney infection which proved fatal. From the available evidence it could not be established how the traumatic brain injury was received.

Mr A was initially placed in a specialist hospital and is now living in a specialist care centre.

Legal Context:

A Safeguarding Adult Review was commissioned by Lancashire Safeguarding Adult Board, following agreement at Lancashire Safeguarding Adult Review Sub Group in accordance with the Care Act (2015).

Section 14 of the Care Act Guidance sets out the functions for LSABs. This includes the requirement for LSABs to undertake reviews of serious cases in specified circumstances.

The Care Act states 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:-

> *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,*
>
> ***One of the below:-***
>
> *Either*
> *the adult has died, and 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)*
>
> *Or*
> *the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect*
>
> *Or*
> *We believe that there would significant value and learning from 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)*

The Safeguarding Adult Review group agreed that the known facts in relation to this

case met this criteria and this decision was supported by the Safeguarding Adult Board Independent chair.

The methodology used was based on an adapted version of the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Reviewing the history of the adult and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Adult Boards to use where it is more important to consider how agencies worked together. Because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice.

The role of a Safeguarding Board is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final review report or in an action plan as appropriate.

Methodology:

Following notification of the circumstances of Mrs A in this case, and agreement by the chair of the Lancashire Safeguarding Adult Board to undertake a Safeguarding Adult Review, a Review Panel was established in accordance with guidance. This was Chaired by the Associate Director Safety and Governance at Lancashire Teaching Hospitals and included representation from relevant organisations within Adult Social Care, Health, and the Police. Peter Chapman, Head of Safeguarding Adults from East Lancashire CCG agreed to undertake the review with support from the County Safeguarding Manager for the local authority. The time period for this review is between 01/04/2015 and 23/09/2015 to reflect the point at which Mr and

Mrs A became known to wider agencies, leading up to when the incident occurred. Full terms of reference for the review are included in Annex 1.

All relevant agencies reviewed their records and provided timelines of significant events and a brief analysis of their involvement. These were considered by the panel and provided opportunity for panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the reviewer with the panel and informed the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case.

The reviewer and panel chair met with son Mr D and his wife in July 2016 to gain an understanding of their experiences of the services provided. This valuable insight into the families' experiences was shared with the panel and with practitioners attending the learning event. Account was taken of the views when writing the report and recommendations, and the reviewer is grateful for their contribution.

A decision was made by the panel following information received not to contact Mr A due to his significant cognitive deterioration and lack of capacity to effectively or meaningfully engage in the process.

The practitioner event was held in September 2016 and was attended by 11 professionals who had had direct involvement with either Mrs A or Mr A. The chair facilitated the session assisted by the reviewer of the Panel and the LSAB team. The learning event was organised in line with Welsh Government guidance (Child Practice Reviews: Organising and Facilitating Learning Events, December 2012) and minutes were recorded.

Following the learning event, the Reviewer collated and analysed the learning to

date for discussion with the Panel. Practice issues originally identified by the panel were re-examined in the light of the findings of the practitioner event. In reviewing the findings, the panel gave consideration to what could be done differently to further improve future practice. A draft report was provided to the panel in advance of the panel meeting in March 2017

The reviewer and chair will offer to meet again with Mr D to provide an opportunity to see a copy of the report when agreed by the Lancashire Safeguarding Adult Board. Learning from the full report will only be made publically available after consideration by the Lancashire Safeguarding Adult Board.

ANALYSIS: Practice & Organisational Issues Identified

Both Mr and Mrs A were engaged with a number of services during the period of this review, including the GP, Adult Social Care, Adult Safeguarding team and Community Mental Health Services. Scrutiny of the timeline, information shared and reflections at the panel meetings and the learning event have highlighted some areas of good practice and also provided an opportunity for wider learning to emerge about the ways in which services work together. The following is an analysis of the issues identified:

1. Assessments of Capacity

The Mental Capacity Act (2005) defines the framework around how professionals work with people who may be unable to make decisions for themselves. It provides the statutory powers to intervene where it is believed individuals lack capacity around specific decisions.

The review highlighted multiple opportunities where it would have been appropriate for professionals to have completed mental capacity assessments in relation to specific decisions that were being made.

The key opportunity was after the incident where the letter opener / knife hit Mrs A on the leg. Mrs A had expressed some fear of husband, though made the decision to stay in the house. She had also given varying accounts of what had occurred, which could imply either further confusion or fear of disclosing information which may have had repercussions for herself or her husband.

Although the practitioners believed Mrs A did have capacity to make the decision to stay in the house at this point, with all of the concerns around her mental well-being and confusion, it would have been appropriate to have thoroughly assessed her ability to make the decision and for this to be documented. The views of her son could also have been taken into consideration. This would also have allowed further exploration of whether there was any coercive behaviour, and to what level, from Mr A over Mrs A.

It was reflected that as professionals were only in attendance for relative short periods of time, and these were always during the day, they potentially had a limited picture of the household dynamics. This could explain why they did not see the same level of confusion or distress as that witnessed by family. Had they seen this, it may have prompted further consideration and challenge to the assumption that both Mr and Mrs A had capacity. Research shows that assessment of capacity is found to be largely undertaken when assessing the capacity to make higher risk decisions. Dilemmas in best interest decisions were primarily due to contradictions between views of the patients and the wishes of relatives. (Jenkins, K. 2012)

The lack of clearly documented, decision specific, capacity assessments places professionals in a challenging positon to evidence that they have fully explored the risks around individuals with them, and that they are making an informed choice when choosing to accept those risks. Particularly when concerns are at a point where service users are being asked if they feel safe and are happy to remain at home, it would be imperative for practitioners to feel confident that the service user is able to make a fully informed decision and has the appropriate understanding of any risks and available options open to them.

2. Challenges for Professionals Working with Couples

An area of challenge for services working with Mr and Mrs A was the inherent conflict evident in that they had separate views on a range of issues. Within the timeframe this was a recurring issue with both the acceptance and refusal of a care package, as well as sharing of confidential information.

Adult social care had a single worker who was allocated to the couple. It must be stated that there were advantages in one worker getting to know them as a single unit and family found it much easier to communicate with one person. However due to the conflicting views and the need to work towards both individuals desired outcomes, it became increasingly difficult for the worker to effectively work with them both and manage potential conflict of interest. Due to Mr A's more dominating personality, it appears that his decision was often then the overriding decision for the couple.

It is important that when there are potentially differing outcomes that services are able to work in a way that does not create a conflict for practitioners. Although both Mrs and Mr A were spoken to on their own at multiple times, professionals still appeared to consider them as a couple for the purpose of choice and control and meeting care and support needs. The voice of individual service users is at risk of being missed when they are viewed as a couple rather than as individuals.

Compounding the challenge of working with this couple was the relationship between father and son. Mr A was clear with professionals that he did not wish for his information to be shared with his son, Mr D. However Mrs A was happy for her son to be involved in her care and to be fully informed.

This led to some confusion by professionals around what information could and could not be shared, as well as frustration on behalf of Mr D around feeling he was not being kept informed and had no overall single point of contact. As nearly all of

the interventions occurring with Mrs and Mr A impacted on them both, it would have been beneficial to have explored the issue of confidentiality with the whole family together, agreeing what information could and would be shared and what would not.

Practitioners reported that their training addressed the importance of maintaining confidentiality but was less helpful in relation to situations where it might be necessary to share information without consent.

Mr A's expressed view also impacted on the family in being able to share information with professionals effectively. The family reported being unsure on who was the right person to speak to about each concern and did not feel there was a joined up approach to the care. Mr D found this most frustrating when trying to raise his concerns around their deteriorating well-being.

Research tells us that failure to engage effectively with carers carries many risks, and withholding information compromises carers' ability to care and support and impacts on the effectiveness of relationships between professionals and the people who often know the person best (Gray et al, 2008). This was clearly evidenced within this case.

Although Mrs and Mr A were both in receipt of services from community mental health, they were open to two different teams. This caused delays in some information sharing, and added some confusion for family as they were not always aware of who to contact about what. Although the two mental health teams have slightly different functions, it would have been possible for both of them to be supported by the same team which could have aided the agency engagement.

3. Risk Assessment and Effective Use of Family Views

A risk management approach was used in deciding the level and type of intervention most appropriate to meet Mrs and Mr A's needs. It is really important to note that neither Mrs nor Mr A were seen as high risk by any of the professionals involved.

Although there was evidence of confusion in both of their presentation and some support needs identified around medication, professionals were presented with a well-kept home, with food in the cupboards and no significant distress from either person. On visits the interactions were appropriate and the level of need was not at a point where there was a belief that more direct or intense intervention was required.

The only indicator of any note was the incident involving the letter opener / knife. Again, professional judgements and risk assessments were based on the presentation of Mrs and Mr A when they were visited. During the review it was clear that Mrs A had given a different account to how the injury had been caused to different professionals and to her son. This should have been a trigger for further exploration and a level of professional curiosity was required. This could then have potentially given agencies a more robust understanding of any risks and whether there was a need for more direct safeguarding intervention at this point.

As the risk had been assessed as low by professionals, when the incident which resulted in Mrs A being immediately admitted to hospital occurred, there was genuine shock amongst professionals and they described this as being highly unexpected. The couple were viewed as not unlike many people the teams support on a regular basis with similar conditions. This was mostly clearly evidenced when the dynamic risk assessment supported the decision not to reallocate the safeguarding case when the allocated worker took emergency leave.

This was in direct conflict to how family had viewed risk. Mr D talked about seeing increased confusion, especially in the evening and late night. He talked about increased hostility from his father, and becoming more concerned about his mother's welfare. Mr D had stated that he had asked his mother to come and live with his family for a period as he was so concerned. Chung et al (2008) identified that carers' views were often marginalised and their voices frequently unheard and it could be argued that this had occurred here when viewing risk.

No comprehensive guidelines exist on the assessment of risk to others posed by

patients with dementia and aggression. Hindely and Gordon (2000) identify certain specific factors should be taken into consideration particularly during assessment of the risk of harm to others. The risk of aggression towards others may be increased if the following clinical features are present, including presence of psychosis in particular paranoid symptoms or depression and evidence of conflict with others. This case would appear to contain both of these indicators.

When Mrs A had described the letter opener / knife incident to her son, this had caused Mr D genuine concern. He repeatedly contacted agencies and could not understand why they were not sharing his level of concern or seeing the risk as he was.

Interactions between professionals and Mr D throughout this timeframe were inconsistent, compounded by the challenges already highlighted in relation to confidentiality. As a result, it was not clear what level of weight was given to his concerns or his views on the level of risk.

As already mentioned, contact from professionals was generally for relatively short periods and during the day. The majority of concerns raised by family, especially relating to moments of confusion and distress, were during the evening and at night. There does not seem to have been any recognition that people's presentation can be different at different times of the day and night.

Professionals appear to have given significantly more weight to their own observations and did not give the same value to the views of the family. It is of course important that assessments are based on professional judgement, however part of making an informed judgement is about understanding all of the information and using that effectively. Research suggests that "…involvement of, and assessment of, the views of the people closest to the person has frequently been overlooked without such information it is not possible to accurately assess risk." (p14) – Littlechild & Hawley 2010.

This risk management process by professionals was also compromised by the number of agencies involved, limited access to each other records, and understanding around their specific roles and remits. Part of effective safeguarding relies on robust protection planning, which includes being clear on how each area of risk is being managed. The fact that there were two Community Psychiatric Nurses (CPN's) and a social care worker involved with the family, provided a false picture of support as these agencies were involved under a service specific remit.

The Local Authority safeguarding service were unable to access the records in respect of work being undertaken by the community mental health teams which compounded the risk of relying on services being engaged as part of their risk formulation.

Further to this, Mr D described contacting lots of agencies to raise his concerns. There was limited information sharing across all agencies, particularly for the adult safeguarding service and this appears to have affected agencies' ability to risk assess the level of concerns as they were only getting one piece of the puzzle.

Practitioners did not respond to this as a high risk safeguarding case and a decision was never made to call a meeting where the level of risk was examined jointly by agencies with or without the family. The local authority safeguarding team commented that they could have co-ordinated a multi-disciplinary meeting (MDT) around the concerns that were being raised, but this did not happen. This was due to a combination of the low level of risk identified and the short period of time from the initial knife incident to the significant deterioration in Mr A's presentation. Had the level of concern been higher, agencies were confident that an MDT would have been arranged.

4. Resourcing of Care as Safeguard Against Risk

The review has touched on the issue of the repeated discussions with the couple around the instigation of a package of care.

On three separate occasions professionals strongly suggested to Mrs and Mr A that a package of care would be beneficial, and that it would help with areas such as medication. Mrs A had appeared open to the idea and willing to accept the support, however Mr A had repeatedly refused this, predominantly on the basis of cost. The level of risk around this or potential impact was not explored further. Had this been looked at in more detail, including involving family, it is possible that this would have identified wider concerns or given services a better understanding of whether there was further risk to explore.

Those attending the learning event agreed that had a package of care been in place, it may have supported agencies in having a better understanding of the risks and thereby provided direct relief and support to both Mrs and Mr A. Clearly individuals have a right to make choices and professionals are bound to work within this framework, however it was unclear if cost was a genuine reason to refuse the package. It was agreed that had cost not been an issue, then refusal of this package of care may have been an indicator of concern.

Although the local authority does have access to a crisis service, this is predominantly a very short term service, up to 72 hours, and is very task focussed intervention. It was agreed that this would not have been an appropriate approach to supporting Mrs and Mr A.

Local Authorities are public bodies with a need to spend resources in a fair and equitable way, and this includes means testing people's finance to fund their own support. There does not appear to be any available mechanism where a care package can be put in place, even for a time limited period, which could be provided free of charge as a result of risk.

From the information presented to them, agencies did not see this case as high risk and the support needs were not openly apparent. The house was clean and well stocked with food and there was limited need for direct care other than medication. It

is therefore possible that if such a service was available, it may not have been accessed for Mr and Mrs A, and they may have refused this support even if it was free, though all agreed this was less likely.

5. Information Sharing, Multi-Agency Working and Referrals.

There was evidence of some good communication between individual professionals in this case, especially between the adult social care officer and the community mental health team practitioner. There was clear evidence of these practitioners working together, including joint visits and numerous telephone discussions. Although information sharing with family appears to have been challenging for the agencies involved, this does not appear to have been an issue between these two specific agencies. However the communication between the safeguarding team, the out of hours service and family were not as robust or effective.

It was apparent that there was a range of issues which were a barrier to effective communication with family, with confidentiality a key issue and understanding around when information can be shared. Alongside this, the concerns that the son voiced to each agency were not shared or viewed in their totality.

Professionals stated Mr A had asked professionals not to share any information about himself with his son and they were confident that he had capacity at the time around this decision. However best practice usually involves health and social care professionals developing plans and making decisions together with carers. NICE clinical guideline advises that health and social care staff should take into account the views of carers and relatives who describe behaviour that could be in keeping with dementia. This information, in conjunction with an assessment of the person concerned, helps with diagnosis and deciding on care arrangements. It also helps in the estimation of the person's capacity to make decisions.

The Adult Safeguarding team and the out of hours Emergency Duty Team (EDT) did not have the same access to information. As the agencies use different computer

systems, information sharing was reliant on professional communication. When this case was passed to the adult safeguarding service, they were unable to access mental health data, and therefore based their own assessments and decision making on the limited information available to them at the time.

The review has touched upon the confusion over remits and roles and this was something explored through the practitioner event. One of the mental health teams involved was a relatively new team (less than 12 months old) and this team's role was an area of confusion for some agencies. It was clear that since the review, systems have since been implemented to support the relationship between services and understanding of their involvement. However it is worth noting that the specific remits of the teams and where responsibilities for specific actions sits was still unclear to some of the practitioners at the event. The dispersed nature of health and social care services, as well as constant changes in structure and team roles was described as consistently challenging for professionals and this was evidenced here.

Referrals to other agencies throughout the review timeframe were all appropriate, and the correct referral mechanisms were used. The exception to this was that there was no consideration of contacting the police in relation to the first incident with the letter opener / knife. Had this gone through to the police they may have put additional support, scrutiny or challenge in to the process, including potentially requesting a multi-agency review, which could have impacted on decision making.

6. Consideration of Domestic Abuse

Although there was a view from both family and professionals that Mr A was a difficult man to engage with, there was no belief or evidence that there was a history of domestic abuse.

During the review there was reference to an incident involving a letter from the local hospital to Mrs A about an appointment for an MRI scan. Family had asked to see

the letter and witnessed Mr A refusing this. When Mrs A did show it to them, Mr A was heard to say to his wife “You will be sorry”. Mrs A did state that this threat did worry her, but that she did not want to leave.

Alongside this, there were repeated incidents where Mr A clearly made overriding decisions on the care and welfare for them both, in particular around access to care and support for his wife.

This could potentially have caused professionals to give consideration to whether there was potential domestic abuse in the wider context, as controlling and coercive behaviour or whether this was more symptomatic of his deteriorating condition. This could have then had an impact on their assessment of risk and their decision making, particularly in relation to allowing Mr A to refuse a care package on behalf of them both.

A review of the impact of domestic abuse for older women in Health and Social Care in the Community in 2011 highlighted that health and social care professionals often fail to recognise domestic abuse between older couples. This is reflected in the practice of the professionals here.

It is worth noting that routine enquiry is not normal practice within Adult services where there are no risks around children.

Practice issues

Practice issues were highlighted for individual organisations as a result of the review. These issues are not subject to separate recommendations as practice improvement and/or action is already in place or planned but the organisation’s own governance arrangements will need to monitor that issues have been, or continue to be resolved:

Practice issue - Consideration of how the Mental Capacity Act was implemented by

practitioners in their service.
Services affected - LCFT and LCC

Practice issue – Information sharing between practitioners and families.
Services affected - LCFT and LCC

Practice Issue – The need to ensure professionals are able and to understand specific team roles and remits and accountability of multi-agency partners.
Services affected - LCFT and LCC

Practice Issue - Due consideration for all referrals to safeguarding with potential injury to be discussed with the police.
Services affected - LCC

Practice issue – Awareness of wider domestic issues and potential for this to exist in all settings.
Services affected – All agencies

Good Practice Identified

Some good practice was identified during the review, by the Panel, by professionals at the learning event and by son Mr D, where professional commitment, persistence and professional curiosity resulted in an enhanced service;

- One Community Mental Health Team and Adult Social Care officer had strong communication and completed multiple joint visits.
- The decision by the consultant at the memory assessment clinic to undertake

an assessment on Mrs A when diagnosing Mr A as part of the initial screening appointment.

- On visits, professionals assessed environmental factors, for example the house cleanliness was checked and fridges and cupboards looked in.

Conclusion

While the findings of this safeguarding adult review do not indicate that the outcome of the case could have been predicted by any individual or organisation involved at the time, there were missed opportunities to fully explore the level of risk especially the aspect of family views, albeit under difficult circumstances.

Had agencies formally met and explored all of the information and included the family in this process, they may have identified that there was a need for further direct intervention which may have made an impact.

Due to the period which has elapsed since the end of the timeframe, some systems and practice within organisations have now changed. Scrutiny of practice, however, always provides an opportunity to reflect on ways in which services can be further improved and therefore the following recommendations, based on the learning from this case, have been made:

Recommendations

In order to promote the learning from this case the review identified the following actions for Lancashire Safeguarding Adult Board and its member agencies:

1. Lancashire Safeguarding Adult Board should disseminate awareness raising materials with the key messages identified thorough this review, with particular reference to the voice of families/carers in risk assessment, effective information sharing, choice and control of the service user, and capturing the

voice of the service user.

Intended outcome: to develop a culture where the voice of service users, families and significant others is being heard and valued in Lancashire, and that time is given by professionals for this to happen.

2. Lancashire Safeguarding Adult Board should gain assurance on how well embedded the Mental Capacity Act is across professional agencies responsible for safeguarding adults with care and support needs; with specific focus on ensuring assessments are appropriately completed and done so in a timely manner, and then reviewed as circumstances change.

Intended outcome: Professionals are confident in their application of the Mental Capacity Act and any issues re the extent to which this is embedded are resolved.

3. Lancashire Safeguarding Adult Board should ensure that local current training and guidance around confidentiality across its partner agencies gives enough focus to when it may be necessary to over-ride confidentiality and the importance of exploring impacts of people not giving consent;

Intended outcome: To ensure professionals feel confident in knowing what information can and should be shared and the appropriate checks required to do so legally and safely and are able to set this out with families and significant others.

4. The Lancashire Safeguarding Adult Board via the Quality Audit group should gain assurance that professionals give consideration to domestic abuse as part of all safeguarding adult enquiries and encourage a culture of professional curiosity.

Intended outcome: To ensure that domestic abuse is recognised across all agencies among adults with care and support needs.

Acknowledgements

This review has only been possible due to the openness and willingness of the family and the professionals involved, including the work done by the panel overseeing the report. On behalf the panel chair, the LSAB and myself, I would like to extend my personal thanks and appreciation to everyone involved in what have been extremely difficult times.

References

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Statement by Reviewer

REVIEWER Peter Chapman (Head of Safeguarding, East Lancashire CCG)	
Statement of independence from the case *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the adult or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer (Signature):	**P. Chapman**
Name :	**Peter Chapman**
Date :	**19th April 2017**
Chair of Review Panel (Signature)	**J. Seed**
Name	**Julie seed**
Date	**19th April 2017**

Annex 1 Terms of Reference Safeguarding Adult Review - Adult A

Introduction
This Review has been commissioned by the Chair of Lancashire Local Safeguarding Adult Board (LSAB) in accordance with the Care Act (2014). The Safeguarding Adult Review will be undertaken as a concise Practice Review, utilising the principles of Child Practice Reviews in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

A multi-agency panel established by Lancashire LSAB will conduct the review and report progress to the Board through its Chair. Membership will include an independent Lead Reviewer and Chair and representatives from key agencies with involvement.

Role	Organisation
Independent Chair	Lancashire Teaching Hospitals NHS Foundation Trust
Independent Reviewer	East Lancashire CCG
Area Operations Safeguarding Manager	Lancashire County Council
Designated Lead Nurse for Safeguarding Adults & Mental Capacity Act	Chorley & South Ribble CCG
Safeguarding Adult Lead Nurse	Fylde and Wyre CCG
Adult Safeguarding Practitioner	Blackpool Teaching Hospitals
Named Nurse Safeguarding	Lancashire Care Foundation Trust
Review Officer	Lancashire Constabulary
Business Manager	Lancashire Safeguarding Adults Board
Business Support Officer	Lancashire Safeguarding Adults Board
Business Co-ordinator	Lancashire Safeguarding Adults Board

Timeframe for the review
The review will cover the timeframe of 01/04/2015 – 23/09/15. Any significant incident relevant to the case but prior to the start date of the timeframe may be included in the analysis completed by each agency.

Subject(s) of the review
Adult A – Aged 88 at time of death

Significant others
Mr A – Husband of Adult A and Step-father to Mr D
Mr D – Son of Adult A

The purpose of the review is to:
1. Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSAB;
2. Examine inter-agency working and service provision for the adult and family;
3. Determine the extent to which decisions and actions were adult focused;
4. Examine the effectiveness of information sharing and working relationships between agencies and within agencies;

5. Examine the involvement of other significant family members in the life of the Adult A, the impact of other significant family members on the care offered/ provided to Adult A and whether family members views were considered during assessments of Adult A;
6. Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;
7. Identify any actions required by the LSAB to promote learning to support and improve systems and practice;

Tasks specific to the review panel:

1. To set the time frame for the review, see above;
2. Agencies that have been involved with the adult and family will provide information of significant contacts by preparing an agency timeline with a focus on the purpose and scope of the review, see above;
3. Other agencies/services may be asked to provide a timeline following review of the information provided;
4. Agency timelines will include a brief analysis of relevant context, issues or events, and an indication of any conclusions reached. Information about action already undertaken or recommendations for future improvements in systems or practice may be included if appropriate. A case summary may include any relevant additional background information from significant events outside the timeframe for the review;
5. Agency timelines will be merged to create a composite timeline and used by the Panel to undertake an initial analysis of the case and form hypotheses of themes;
6. The Panel, through the Chair and Lead Reviewer will seek contributions to the review from appropriate family members and provide feedback to the relevant family members at the conclusion of the review process;
7. The Panel will plan with the Lead Reviewer a learning event for practitioners' to include identifying attendees and the arrangements for preparing and supporting them prior to the learning event and feedback following the event;
8. The learning event will explore hypotheses, draw out themes, good practice and key learning from the case including any recommendations for the development or improvement to systems or practice;
9. The Panel will receive and consider the draft SAR report prepared by the Lead Reviewer, to ensure that the terms of reference for the review have been met, initial hypotheses addressed and any additional learning is identified and included in the final report;
10. The Panel will agree conclusions from the review and an outline action plan and make arrangements with the Lead reviewer for presentation to the LSAB for consideration and agreement;
11. The Panel, through the Chair and Lead Reviewer will plan arrangements for feedback to the family following the conclusion of the review but before publication;
12. The Panel will make arrangements for feedback to the practitioners in attendance at the learning event and share the learning from the review;
13. The Panel will take account of any criminal investigations or proceedings related to the case;
14. The Chair of the LSAB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed. It is anticipated that there will be no public disclosure of information other than the SAR report for publication;