Safeguarding Adult Review

"Louise"

Executive Summary

Lynne Phair JP - Independent Consultant Nurse

MA BSC (Hons) RGN RMN DPNS

April 2022

EXECUTIVE SUMMARY

Louise and the Background for This Review

This Safeguarding Adult Review (SAR) concerns the effectiveness of inter-agency practice in relation to engagement and care of an 87-year-old woman (Louise) from January 2012 until her death, the 6th January 2020. Her cause of death was recorded as 1a. Malnourished,1b self-neglect,1c Dementia.

Louise was an 87-year-old lady at the time of her death. She had lived in a supported housing scheme for 20 years. Louise was first noted to have cognitive problems in 2013, over the following 7 years her abilities declined, and a friend called Trevor supported her. Housing Officers visited annually and offered services and asked her to sign that she did not need them.

Louise would always say she did not need help even when observation suggested she was struggling. She came to the attention of Adult Social Care (ASC) intermittently throughout this time and various agencies were involved in her care and support. Professionals raised three safeguarding concerns during the time frame, but all cases were closed without enquiry, as there was no evidence of intentional neglect.

In 2018 the GP called an ambulance as she had grossly overgrown toenails, that were digging into her skin. Trevor was frequently offered support and services, but he declined them, even when Louise appeared to be in need of extra care. Trevor was the attorney and registered the Lasting Power of Attorney (LPA) for both health and finance in 2017. Some professionals question the legality of these, but the Office of the Public Guardian advised there was not enough evidence to demonstrate concern.

Professionals continued to try and engage with Trevor and provide care and support for Louise, but it was often rejected. In December 2019, Louise was admitted to hospital, severely malnourished and with significant pressure ulcers. She initially improved, but sadly deteriorated and died on 6th January 2021.

Positive Aspects of the Care and Support Louise Received

1. There were several agencies involved in the care of Louise.

2. Agencies frequently raised concerns with ASC about the lack of care of Louise.

3. The Older Peoples Mental Health team (OPMH) and Community Independence Service (CIS) showed tenacity and continued to visit despite Trevor trying to stop them.

4. OPMH and CIS demonstrated some professional curiosity and concern and made enquiries about the Lasting Powers of Attorney (LPA).

5. The Community services responded well at critical times and showed tenacity with trying to gain entry.

6. The hospital found a private podiatrist to treat her toenails urgently.

7. A podiatrist responded quickly and managed to treat Louise.

The Working Relationship of the Professionals Involved and Missed Opportunities

1. There were several professional agencies involved in the care and support of Louise. Some were for a short period of time and at some points, it was complicated to follow who was involved and who was not. There was consistent evidence that the GP and the OPMH referred concerns to ASC, both for assessment and as safeguarding adult referrals. From 2018, OPMH was a consistent agency as others came and went.

2. There was evidence of communication and sharing information between professionals by email and telephone, but there was no evidence of multi-agency working in the sense of consistent engagement by ASC as the coordinator of agency involvement. There was no record of a multi-agency best interest meeting, strategy meeting or meetings to discuss the implications of concerns regarding Trevor and the LPA.

3. The decision to close the case, in November 2019, was taken unilaterally by ASC with no reference back to the professionals to determine whether Louise had improved. The note recorded that as the Social Worker had not heard any concerns, it was assumed “all was well”.

4. Whilst it is acknowledged that agencies had a responsibility to keep ASC informed, ASC also had a responsibility to communicate with other agencies. Over the 7 years, there were many examples where ASC had received information from professionals, undertook a limited enquiry and determined there were no concerns. The reality of this is that professionals may become weary of referring concerns, if they are constantly not listened to. It is also important to note that between the ASC visit to Trevor in September 2019 and the decision to close the case, there had been two visits by OPMH, one of which, where Trevor had refused to let OPMH see Louise, and the Community Wellbeing Team (CWT) had been refused visits and had communicated by phone. Added to this, ASC told Trevor that OPMH would only visit 3 monthly from November, yet no information could be found to note this was discussed and agreed at a multi-agency review and OPMH have no record of this decision.

5. The Supported Housing Service appeared to sit outside all of the other agencies. They undertook an annual review, and despite evidence of cognitive impairment, Louise was asked to sign an agreement in May 2019. In 2013, the support worker (who may have been from the housing department) contacted the GP as they were worried, but apart from this, there was no engagement by either Housing to Adult Social Care (ASC), or vice versa.

6. At the very least, Supported Housing should have been informed that Trevor was living at the flat, as this may have affected Louise’s tenancy agreement.

7. Agencies were reporting the increasing dishevelled and cluttered flat, yet this was not reported by Supported Housing. This calls into question how Supported Housing undertakes annual reviews, and how they assess whether the person needs referral to other agencies.

Conclusion

It is easy with the wisdom of hindsight to question whether if certain things had been in place, the outcome for Louise would have been different. Hindsight bias describes how an incident is viewed after the event, when it is easy to reflect and say, "*why didn't they just do this"* or "*why didn't they tell him to do that"*. Hindsight is a wonderful thing but should be considered with caution and with the reality check of how people live their lives with many difficulties.

Louise was a lady who was showing signs of increasing cognitive impairment for over 6 years and her difficulties were known by various agencies. She was able to present well superficially, even when there was evidence that she was clearly suffering and unable to manage. Yet this was never challenged.

Trevor was seen by various agencies as a friend or carer, and it was accepted without question when he became her LPA for both health and finances. When some professionals showed curiosity, about the legality of this, the OPG said there was nothing to indicate concern. It is unclear whether they were given all the relevant information. Even when most professionals were concerned that Trevor was not allowing access or care services, and thus refusing care that was in her best interest, it appears that it was assumed that as he had the LPA, he had the legal right to do this.

The story of Louise and lessons to be learned, sadly reflects many SARs already published and reviewed in the literature.

Practical application of the Mental Capacity Act 2005 was a critical part of this story. There did not appear to be evidence of assessing understanding and using critical enquiry to ensure Louise was able to make the decision she was being asked. Knowledge of the legal duties of the LPA, how to challenge this, and role of the Court of Protection was lacking, together with cohesive multi-agency discussion.

Safeguarding referrals were made and agencies tried to raise concerns, but they were closed without enquiry, and a reason, not set out in the Care Act, of "neglect not being intentional", was not challenged by ASC senior managers.

There is some evidence of multi-agency communication by phone and email, but there is no evidence of "round table" professional meetings (albeit by video link). The Housing Support Team worked in isolation, despite having a central role in oversight of Louise and her changing needs. The evidence suggests that most communication was one way and decisions were made by ASC, without multi-agency involvement.

When admitted to hospital, there was no referral to safeguarding and her death certificate listed the cause of death as 1a Malnourished; 1b Self neglect 1c. Dementia. The term "self-neglect" appeared to be used without any investigation (at that time) to establish if this was correct. A report-based inquest confirmed self-neglect on the final death certificate.

The case has been reviewed by the Police as part of this SAR who have concluded that even with the information contained in this report, their opinion regarding the likelihood that a criminal offence had been committed was not identified. Notwithstanding this, all

professionals would benefit from improved knowledge regarding what constitutes neglect, self-neglect alongside the criminal offence of coercion and control.

The care, support and protection of Louise should have been better. Professional curiosity, correct application of the Care Act and better understanding and practical application of the Mental Capacity Act and Lasting Power of Attorney could have improved her life and potentially changed the outcome.

Recommendations

The SSAB should seek assurance that:

1. All organisations ensure professionals understand the principles and importance of the practical application of the concept of professional curiosity.

2. All Mental Capacity Act training includes ensuring higher skills and competence in assessment of mental capacity, the role and legal responsibilities of the LPA and the role of the Court of Protection and when to make a referral.

3. Safeguarding training includes a better understanding of how to differentiate between neglect and self-neglect. Training should include environmental factors that need to be considered for example, clutter, fire safety risks, public health issues and housing safety issues.

4. Professionals are be supported to develop skills and knowledge to respond to, overcome and manage barriers to engagement from informal carers and family members.

5. Organisations review the case load of staff who work with adults at risk and identify any risks caused because of organisational issues, such as inadequate supervision, frequent change of practitioners or pressure and complexity of the work. This could be carried out as part of routine supervision sessions and findings communicated through line manager reporting systems.

6. There is a review of ASC safeguarding pathway to ensure the requirements of the Care Act are embedded in safeguarding practice.

7. There is a review of how agencies identify safeguarding concerns and work together to implement early intervention and appropriate assessments. This should include consideration of the development of a MASH for adults.

8. All agencies ensure staff are aware of when and how to use the 4LSAB Multi-Agency Safeguarding Adults Escalation Protocol July 2018 and the SSAB should monitor its effectiveness.

9. All private and independent health & social care practitioners have access to free online training for safeguarding and the Mental Capacity Act.

10. The Housing Support Team should review their document retention policy and ensure it is within legal and best practice requirements.

11. The SSAB should ensure that HM Coroner is provided with a copy of this report and invited to consider its findings in respect of the Inquest outcome for Louise.

12. The SSAB Board should identify ways that learning from SARS nationally are determined and actioned.

13. A multi-agency education event should be planned to develop multi agency understanding of neglect, wilful neglect, and of the criminal offence of coercion and control in the context of domestic abuse.