Nottinghamshire
Safeguarding
Adults Board
Stop abuse and neglect

Safeguarding Adults Review (SAR) – Executive Summary

Subject: L20

Date of Birth: 11/09/20

DRAFT

SAR Independent Author: Richard Procter

Nottinghamshire Safeguarding Adults Board wish to place on record their sincere thanks to the daughter of Adult L who worked closely with the Board and Independent reviewer and author. They provided valuable information and an insight into the life of Adult L which was used to help shape and inform this review. Unfortunately, Adult L's son who cared for Adult L was unable to contribute to this review. This Safeguarding Adult Review would not have been possible to undertake without the co-operation, open reflection and information supplied by those agencies who provided care and support for Adult L. This contributed significantly to the production of the final report and helped to identify recommendations for improvement. The input and professional support provided by the Safeguarding Adults Board Managers and support staff have been invaluable throughout this process.

Contents	Page
Overview	2 - 4
Themes	5 - 7
Recommendations	7 - 8

Appendix A: Terms of Reference

Introduction

The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

The purpose of the Review is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

Overview

This Learning Review has been commissioned by Nottinghamshire Safeguarding Adults Board in response to concerns around multi-agency working and missed opportunities to support and engage with Adult L.

Adult L was the mother of 3 children and had 3 grandchildren. One of her sons Paul (not his real name but the name will be used throughout this report to protect his identity) lived with Adult L for all his life. Paul has been described as caring deeply for his mother and undertook the role as her carer for several years and exclusively for the timeline period of this review. It was suggested that Paul made decisions on his mother’s behalf, including prior to her diagnosis which involved professional, family, and social contacts she was allowed to see. This resulted in long standing, limited contact with her daughter and partner prior to his death.

DRAFT

She had previously been married and following a divorce formed a relationship with another man with whom she enjoyed holidaying with until he sadly lost his life. Adult L loved to dance and was a keen ballroom dancer. She enjoyed knitting, sowing and baking at home.

Adult L worked previously as a pharmacy dispenser and also as a school dinner lady where through this role she became well known within her local community.

Adult L was described by her daughter as a “lovely bubbly person who would do anything for you, a great Mum, a fantastic Mum”.

Adult L was admitted to Hospital after arriving by ambulance on 11th September 2020 following a fall at home. She was found to have extensive bruising and there were concerns raised that this may have been as a result of abuse or neglect. She died a short time later after arrival at hospital. A Forensic Post-mortem found evidence of cancer and that Adult L had died as a result of a blood clot on her lung (natural causes). The bruising/injuries did not contribute to her death and could not be attributed to one event. Paul informed the Police that Adult L had suffered a number of recent falls, and he had cared for her and dressed any cuts she sustained. He stated that he had been worried about the Covid19 pandemic and was embarrassed about his hoarding behaviour at the home address. He informed the Police that the doctor was aware of a lump in his mother’s stomach which may have been cancer but due to her frailty it was not thought to be a good idea to put her through treatment. He also stated that he had told the doctor about a lump in his mother’s breast.

In November 2015 it was confirmed that Adult L had a diagnosis of mixed type dementia and required a further assessment. Adult L was allocated a Community Psychiatric Nurse (CPN) to provide her with support for her condition. Following a reported fall in February 2016 attempts from the CPN to access the Adult L’s home proved unsuccessful where it was identified concerns existed that Paul was unwilling to allow visits to the home. After multiple unsuccessful attempts by the CPN to access Adult L the case was referred back to Adult L’s general practitioner (GP). From the information provided there were reports of Adult L falling whilst at home and in March 2016 following such an episode she was hospitalised with a fractured right femur after falling over a bag in her kitchen. Following discharge, she was provided support by a Falls team. This team at the time supported individuals who may have fallen or felt at risk of falls so as to provide interventions to help maintain independence and prevent hospital admissions. It was recorded by the falls service that Adult L declined to work with their therapists. Following an assessment, the falls team devised a care plan to promote Adult L’s independence however, over subsequent visits Adult L was found to be in bed and declined all offers of support and therapy from the service. In response to Adult L declining interventions the falls team completed a number of cognitive assessments to

DRAFT

ascertain how they could support Adult L and they liaised with the GP. The records indicate that Adult L had the mental capacity to make informed decisions around her care and treatment and she declined a number of interventions offered resulting in her being ultimately discharged from the Falls Team in April 2016.

It was reported by agencies that it was suspected that Paul had a mental health illness and suffered from depression. Information provided to inform the review demonstrate that he may have had a hoarding disorder which resulted in the home on occasions being cluttered. Whist multi-agency responses to the hoarding concerns did take place and management of the issue was supported by a District Council Hoarders Panel, considerations of the support Paul may have required in supporting Adult L as her carer and the impact of doing so were not always evidently considered. It was apparent from the information provided to inform this review that tensions existed between Adult L's daughter and Paul and her perception of a lack of quality of care and support he was providing for Adult L. Several safeguarding referrals were raised with Adult Social Care (ASC) which included concerns regarding financial abuse, physical abuse, neglect, hoarding, concerns regarding nutritional intake and that Paul was preventing multi-agency professionals from entering the home address so professionals may engage with Adult L. All the referrals were investigated by ASC and the majority found to be unsubstantiated with the exception of one regarding Paul preventing professionals having access to the premises in August 2017.

Concerns regarding Pauls hoarding behaviour in this referral featured heavily. On this occasion a multi-agency meeting involving ASC, a District Council Housing Officer, District Nursing Team, Adult L's General Practitioner and the Fire Service resulted in action being taken to work with Paul. This resulted in a clear pathway being established both in and out of the property, so as to provide safe egress from the property in an event of fire or other emergency, together with facilitating the ASC Safeguarding Officer regular access to the property and subsequently Adult L. There are references from the information provided regarding Adult L and considerations relating her mental capacity and ability to make informed decisions regarding her care and support and home living conditions. The last recorded assessment of her mental capacity took place in December 2019 when visited at home by ASC. It was recorded on this occasion that she demonstrated capacity and was happy with Paul providing her with care. She declined any sort of a package of care at this time. It was observed as previously agreed the pathway to the stairs and entry to property remained clear allowing Adult L to leave the premises in case of an emergency should this be required. On the 23rd January 2020, the case was closed to ASC as no new needs had been identified, the situation appeared stable and that no further action was required at that time.

Key themes and events

The role and support for Paul as Adult L's carer.

a) What worked well?

It was believed that multi-agency joint working and communication worked well with strong evidence in particular of District Council Housing and Fire and Rescue working closely regarding the management of risk regarding Paul's hoarding activity. Participants identified that there was good awareness regarding the requirement of when to raise safeguarding concerns where abuse or neglect may have been suspected with a number of referrals being made to highlight the concerns practitioners had. It was considered that record keeping was comprehensive and of a high standard.

b) What could we have done better?

It was apparent that Paul had both physical and mental health concerns. Whilst it was recommended to Paul by housing that he should seek support through his GP for these concerns, it was unclear how these additional needs were being met or whether it was considered how these issues may have impacted upon his ability to care for Adult L. It was commented upon that whilst undertaking a Carers assessment as per the Care Act was the responsibility of Adult Social Care it was felt there was a requirement to increase awareness across the Nottinghamshire safeguarding partnership of the circumstances as to when a carers assessment should be required to be considered and how the process is facilitated. It was recognised that it would have been beneficial for Paul to have been offered a carers assessment by ASC so as to help identify and record the impact caring for Adult L may have had upon Paul's life and what additional support, he may have required in fulfilling this role.

Responses to Adult L's falls.

a) What worked well?

It was recognised that there had been considerable efforts made to ensure Paul kept the landing clear and that a route out of the house in case of an emergency was clear and accessible.

Additional checks were made in relation to electrical systems at the properties together with fire alarms being provided in the case of fire.

The involvement of the Falls Team was deemed to be appropriate and offers of physiotherapy made albeit Adult L declined any such support.

DRAFT

Risk assessments were undertaken in relation to the hoarding issues which were a potential contributory factor regarding future falls.

b) What could we have done better?

The fact that Adult L was the tenancy holder of the property and not Paul was not always considered by Housing. This resulted in communications regarding the living conditions being predominantly targeted at Paul rather than Adult L, who may have been in breach of her tenancy agreement. Housing identified this as learning issue for their agency.

Responses to Hoarding and Access Issues.

a) What worked well?

It was recognised that the referral by housing to the Hoarders panel was good practice. This enabled a multi-agency approach to be considered and promoted information sharing between housing and fire and rescue.

There had been actions taken in particular by Housing to work with Paul to clear the landing and provided a safe route out of the house in the case of an emergency.

ASC had referred the case to the complex case panel which allows an opportunity for multi-agency professionals to meet together and discuss challenging cases so as to work towards finding a multi-agency problem solving solution.

b) What could we have done better?

Agency representatives all identified the challenges practitioners had encountered in accessing the home address and how this on occasions had frustrated their ability to provide support for Adult L. There was a lack of clarity in relation to what powers of entry could be considered to secure entry to the premises and in particular the extent of police powers.

The potential that Paul may have on occasions displayed "Disguised Compliance Behaviour" in relation to hoarding and access issues at the home address was discussed with participants. Whilst there was an awareness of this behaviour from a number of the agencies represented a small number were unfamiliar with it and how as best to respond for example undertaking unannounced visits and joint multi-agency visits.

Mental Capacity and responses to Adult L's wishes and feeling.

a) What worked well?

Agency representatives identified that Adult L had lived with Paul for several years and she appeared to be happy with that situation when agencies engaged with her. It was

DRAFT

commented by participants it was apparent they “loved each other deeply”. It was felt by practitioners present who had direct contact with Adult L that she was a capacitated adult, who had the mental capacity to make informed decisions, albeit some of those may have been seen as unwise decisions, for example her decision to decline support from professional carers.

b) What could we have done better?

It was considered that there was an over reliance in using Paul as Adult L’s advocate and that by asking Adult L more questions directly regarding her ongoing care, it would have ensured that her wishes, and feelings were always fully considered in the care and support that was provided. This would have protected against any coercive control which may have been applied by Paul in controlling Adult L’s life.

It was identified that in this case there were occasions when Mental Capacity was not appropriately assessed, or the outcome recorded. It was identified that the Nottinghamshire Safeguarding Adults Board is in the process of launching several resources on its website in relation to the application of the Mental Capacity Act. This will supplement the significant amount of agency training and guidance already provided to practitioners.

The accountability, governance, and reporting arrangements for the Hoarders Panel.

The review was asked to consider the accountability, governance, and reporting arrangements for the Hoarders Panel, where Paul’s hoarding concerns were being managed. Currently in situate is a multi-agency hoarding framework which is endorsed by the Nottinghamshire Safeguarding Adults Board. Whilst the hoarding framework is comprehensive providing a problem-solving approach for agencies in assessing and managing hoarding behaviour, the framework, or the terms of reference for the hoarders panel are non-specific as to where the impact of the work undertaken reports to, or how the Nottinghamshire Safeguarding Adults Board is assured the risks to this potentially vulnerable cohort of individuals are managed, reduced and where possible mitigated.

Recommendations.

Recommendation 1.

Drawing upon learning from this case Nottinghamshire Safeguarding Adults Board should raise awareness across the safeguarding partnership of the circumstances as to when as per the Care Act 2014 a carers assessment should be required to be considered and how the process is facilitated.

DRAFT

Recommendation 2.

Nottinghamshire Safeguarding Adults Board should seek assurance that Nottinghamshire County Council Adult Social Care are offering assessments to Carers who may have needs for support and where eligible those needs are being met, as per the Care Act 2014.

Recommendation 3.

Nottinghamshire Safeguarding Adults Board drawing upon learning from this case should develop a toolkit detailing the relevant legislative powers of entry to premises which could be utilised to access premises in order to safeguard an "Adult who may be at Risk of Abuse or Neglect" as defined in the Care Act 2014.

Recommendation 4.

Nottinghamshire Safeguarding Adults Board drawing upon learning from this case should develop guidance for practitioners to assist in the identification and response to disguised compliance behaviour.

Recommendation 5.

Nottinghamshire Safeguarding Adults Board drawing upon learning from this case should develop guidance for practitioners to assist in identifying and responding to concerns of Carers applying coercive control to "Adults who may be at Risk of Abuse or Neglect" as defined in the Care Act 2015.

Recommendation 6.

Nottinghamshire Safeguarding Adults Board should seek assurance as to the extent that the Mental Capacity Act 2005 is being applied across the Nottinghamshire Safeguarding Partnership.

Recommendation 7.

Nottinghamshire Safeguarding Adults Board should through the utilization of their quality assurance processes assure itself as to the effectiveness of the application of the Nottingham City and Nottinghamshire multi-agency hoarding framework, in managing the risks posed by these potentially vulnerable cohort of individuals who display such hoarding behaviour.

DRAFT

Appendix A: Terms of Reference

Scope

Scoping Period: 14th October 2015 – 24th Sept 2020

Methodology

This Review will be conducted using a blended approach of action learning with a more in-depth analysis of agency involvement. Through a structured process of reflection this will allow practitioners to participate fully in the case group, providing a balanced view with a reduced burden on individual agencies to provide lengthy individual management reviews; particularly as this is not a SAR. The independent reviewer will identify key questions and themes for those agencies and practitioners involved. Following their responses an in-depth discussion will be undertaken with the case group to identify key themes, practise episodes and recommendations.

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those practitioners involved at the time as well as key family members. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

This blended approach will help ensure that consideration is given to systems as well as practice to determine both what happened and what should have happened, helping to minimize the reoccurrence of similar case findings.

The principles and benefits of using this model are:

• A structured process of reflection.

• A reduced burden on individual agencies to produce management reports.

• Analysis from a team of reviewers and case group may provide more balanced view.

• Staff and volunteers participate fully in case group to provide information and test findings.

• It enables identification of multiple causes/ contributory factors and multiple causes.

Details of the Independent Reviewer / Chair

Richard Proctor – Proctor Consultancy ltd

Details of whether the final report will be published or whether an executive summary will be produced

DRAFT

Executive Summary to be published.

Organisational Contributions

Ashfield District Council, Nottinghamshire Fire and Rescue Service, Nottinghamshire County Council (Adult Social Care), East Midlands Ambulance Service, Nottinghamshire and Nottingham CCG, Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire Police, Sherwood Forest Hospitals NHS Trust.

Board Over-sight

The SAR sub-group will report to the Board. The Board will have final sign-off on this Review

Agreed format of report for agency information

Not applicable – individuals' agencies will be sent question prior to the case group convening.

Timescales for completion

August 2nd, 2021

Ownership of agency information submitted as part of the review

Ownership of any information provided as part of this Review lies with the Nottinghamshire Safeguarding Adults Board.

If a request for this information is subsequently made by a third party, there should be a discussion between the agency who provided the information and the Independent Chair to agree if the information should be shared.

Level of involvement of practitioners involved in the case

Practitioners may be asked to complete written submissions in response to specific questions for their agency, prior to the case group convening.

The involvement of family members in the SAR

It is the intent of the Independent Reviewer to engage with family members, in order that their views can be sought and integrated into the process and the learning.

How legal advice will be provided to the Case Group, (in addition to agencies own internal legal advice)

The Board will utilise the services of Nottinghamshire County Council's legal services.

DRAFT