Safeguarding Adult Review Overview Report

(SAR Alice)

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1. Foreword

1.1. Not applicable.

2. Legal Context

2.1. The Care Act 2014, Section 44[i], requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when certain criteria are met.

2.2. These are:

- When an adult with care and support needs has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, including self-neglect whether known or suspected, and;

- There is a concern that partner agencies could have worked more effectively to protect the adult.

2.3. Safeguarding Adult Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

2.4. The aim of a Safeguarding Adults Review is to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

2.5. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

3. Introduction

3.1. Alice was a 93-year-old lady who died in Fairfield hospital in November 2021.

3.2. The post-mortem examination concluded that she died as a result of:

1a) Peritonism
1b) Spontaneous large bowel perforation
2) Frailty, Dementia

3.3. Alice lived at home with her 70-year-old son Richard[ii]. Richard did have his own residency but there was a general understanding by agencies that they resided together during the timeframe of this review. Alice had a diagnosis of dementia in October 2019.

3.4. There is a notable history of safeguarding concerns dating back to 2017 which did not always result in an enquiry. These concerns ranged from severe self-neglect, property potential fire risk due to 'cluttering' and the level of care Alice was receiving from Richard who was her "assumed" carer.

3.5. Richard is noted to have his own care and support needs and thus Alice had cared for him throughout his life.

3.6. The agency information demonstrated multiple concerns of Alice not managing but a reluctance to accept help or services. In contrast Richard was asking for help and finding it difficult to care for Alice.

3.7. A Safeguarding Adult Review (SAR) referral was made in January 2022 by Adult Social Care and a review was commissioned.

3.8. An independent lead reviewer[iii] was commissioned to work with a panel of local safeguarding professionals from the key agencies. The lead reviewer facilitated a practitioner event[iv], analysed agency information and reports and produced this report. The lead reviewer and the panel collaborated on identifying the learning and writing the recommendations from this SAR.

3.9. The BISP provided the reviewer with a chronology of information and agency summary reports relating to the case. Additionally progress against various initiatives, pathways and integrated ways of working were provided throughout the review process.

4. Rationale for carrying out a Safeguarding Adult Review

4.1. On initial consideration of the referral in January 2022, it was agreed that that the criteria for a SAR was met as wider consideration of safeguarding was required. The initial information indicated that agencies involved with Alice (and Richard) could have worked more effectively together with regards to safeguarding, risk assessment and care planning.

4.2. As articulated above, the BISP has a statutory duty to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, including self-neglect or an adult is still alive, and
- there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

4.3. 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.
- To explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

4.4. The purpose of the SAR is to promote effective learning and improvement 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.

4.5. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility but to identify ways of improving how agencies work, singularly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

4.6. Following appointment of the Independent Reviewer, the review commenced in November 2022.

4.7. The role of the review panel is to contribute to and scrutinise information submitted as part of this review. The review panel was made up of key representatives of the BISP:

- Independent Reviewer (panel chair)
- Safeguarding Lead Greater, Manchester Fire and Rescue Service (GMFRS)
- Deputy Designated Nurse, Adult Safeguarding, NHS Greater Manchester Integrated Care (Bury)
- Head of Adult Safeguarding, Adult Social Care, Bury Council
- Tenancy Support Lead, Six Town Housing
- Safeguarding Families Specialist Practitioner, Pennine care Foundation trust (PCFT)
- Adult Safeguarding Named Nurse, Northern Care Alliance (NCA) NHS Foundation Trust
- Case Review Development Officer, BISP Business Unit.
- Safeguarding Practitioner, North West Ambulance Service NHS Trust (NWAS)
- Greater Manchester Police (GMP) at initial panel only (no involvement in the case)

5. Review Process

5.1. **Terms of Reference**: The SAR Subgroup identified several key lines of enquiry for the review, these were then discussed and finalised following the first panel meeting:

- Multi-agency approach and complex case management
- Legal literacy and risk formulation management including professional curiosity and indictors of concern
- Health oversight
- Capacity to understand, and application of the principles of the Mental Capacity Act
- Understanding the interdependency of the “carer” and how they were supported by agencies

Taking into account:

- Any changes to system practice since the timeframe of this review and how current policy and procedures may have an impact in a similar situation in 2022
- The principles of Making Safeguarding personal which will be applied through exploration of each of the terms of reference

5.2. A methodology was agreed that would recognise good practice and strengths that can be built on, as well as areas that require improvements. The process was agreed to be proportionate, collaborative, and analytical, actively engage all agencies/organisations involved and family members.

5.3. A bespoke panel was convened to oversee the process and individual agency reports were submitted by the agencies represented on the panel

5.4. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer chaired an initial panel meeting to agree the review terms of reference, facilitated a practitioner event/ spoke to individual practitioners, conducted research by critically analysing agency learning summary reports, chronologies and relevant records held by involved agencies and additionally, by interviewing representatives of agencies and contacting family members for their contribution.

5.5. Subsequent panel meetings were held culminating in a planned Safeguarding Adults Case Review Group meeting (ACRG) and presentation to the Safeguarding Adult Board.

6. Family Involvement:

6.1. The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively[v].

6.2. Alice's son Richard was integral to the circumstances explored within this SAR and therefore he was contacted by the BISP case review development officer. Richard was fully informed of the statutory requirement for the review and the process. He did take the opportunity to ask questions and clarify several points about the process, however after consideration he declined to be involved in the review

6.3. Alice also has a sister who raised concerns about her in the months before her death, unfortunately attempts to contact her have been unsuccessful.

6.4. Therefore, this review does have a missing context in terms of family insight and views.

7. About Alice

7.1. Alice was aged 93 when she died and had lived independently until approximately 2018 when she required help and support due to deteriorating physical health and likely dementia.

7.2. Alice had a 70-year-old son Ricard who had care and support needs, he was diagnosed with schizophrenia and has had periods of relapse over the years manifesting as self-neglect, financial issues, cluttering/ hoarding and at times, difficulty in caring for himself. Alice was therefore Richard's carer over a long period of time, although he previously lived in his own residency, he was dependent on her.

7.3. There is little known or reflected in agency reports or practitioner views about Alices life, her views, likes or dislikes.

7.4. There were several factors evident in the last 4 years of Alices life that significantly affected her quality of life, independence, and happiness:

- Her physical health significantly deteriorated, she suffered from headaches, her mobility was reduced, and she had poor eyesight.
- She was described as “vague”, confused and with poor memory.
- Agencies suspected that she may have been living with dementia but were unclear if a formal assessment or diagnosis had occurred.
- The conditions of her home were not of an acceptable standard.
- She lived in a cold, unheated house and her nutritional intake was raised as a concern by her sister.
- She was no longer able to care for her son which must have been a great worry to her.
- She was fearful of having to live in a care/ residential home.
- She had periods of time in hospital and each time she was discharged, her situation seemed to worsen.
- She declined the support of agencies and was reluctant to engage with services.

8. Background and Narrative

8.1. Alice was aged 93 when she was taken to Fairfield hospital via ambulance with suspected sepsis. She subsequently died as a result of peritonitis and a ruptured large bowel.

8.2. Although there were previous concerns about the family functioning and caring responsibilities prior to 2017, the period of time between 2017 until she died, presents several concerns and incidents which will be considered throughout this review. Namely there were risk factors and concerns that emerged during this time that presented an opportunity for agencies to work more effectively with Alice and her son.

8.3. Prior to 2017 Alice was generally concordant with her health appointments and attended the GP regularly. There is evidence of a “carer health check” being done in recognition of her role in caring for Richard which is positive practice.

8.4. From 2018 there was a distinct change in her presentation, she was suffering with headaches and a reported “vagueness”. Richard was reporting that he was worried about her memory, but this often conflicted with Alices own reports.

8.5. There is evidence of good GP monitoring throughout 2018 and 2019 due to continued reports of headaches and vagueness, and there were referrals made for clinical investigations (CT and MRI scans). Alice was diagnosed with dementia by her GP (in accordance with dementia pathway in Bury) in October 2019. There is evidence of dementia and medication monitoring, annual review and care planning however it is not evidenced to what extent this was shared with any other agency to inform the overall picture.

8.6. There is less contact and oversight throughout 2020 which can likely be attributed to the changes in processes due to the COVID-19 pandemic. However, during this time, the GP did conduct home visits and telephone consultations, and thus there was adaptability to her needs. There were some missed appointments with

reminders sent via SMS text message which likely didn't reach Alice as there is no evidence that she had a mobile phone. From 2021 onwards the contact with the GP was almost entirely via Richard which may have offered an opportunity to explore the overall situation.

8.7. There is a pattern from thereon of difficulties, with several Emergency Department (ED) attendances via the North West Ambulance service (NWAS) where concerns were noted about the state of the property which was described as cluttered and neglected with an absence of heating or hot water.

8.8. Within the few months leading to Alices death there was a safeguarding referral made by Healthwatch after Alice's sister raised significant concern about the conditions that she was living in, the lack of support, her caring responsibilities and her overall wellbeing. This was closed as a safeguarding concern and referred on for a Care Act Assessment which was never completed before her death two months later.

8.9. It is helpful to consider the first-hand description of the home. When NWAS attended the home in November 2021 shortly prior to Alices death, they reported that the property was cluttered and unkempt and they struggled to gain access thus there was a fire risk. NWAS reported that Alice was *"dirty, very unkempt and had faeces on her clothes, dirty underwear, and something sticky in her hair. Her bed was downstairs, bedding very dirty, no bed sheet present. Son was also present, very dirty & unkempt".*

8.10. On the occasions where services raised concerns there were sporadically some offers of support, consideration of carers assessments and some respite and home care packages offered all of which Alice declined.

8.11. It is helpful to consider a summary of key episodes/ timeline crucial to the learning:

Episodes:	Key Points:
2017/2018	- Safeguarding concern raised by Greater Manchester Police (GMP) after Alice was found wandering in the street and confused. - Notable change in circumstances, concerns raised by Richard that Alice was confused - Reports of headaches and vagueness - March 2018- hospital social work team arranged for period of respite - March 2018- Alice declined Keysafe and Carelink information - March 2018- reablement declined, believed she was independent **Key Findings:** There is little evidence of consideration of mental capacity There is little evidence of application of professional curiosity to explore carer responsibilities- who was caring for whom.
2019	- March 2019- carers assessment for Alice (as she was recognised as a carer for Richard), she stated she wanted a break from caring, eligibility criteria met - October 2019- diagnosis of dementia- treatment commenced - October 2019- declined respite, home care and community meals - November 2019- hospital social work team deemed Alice to lack capacity, discharged from hospital with arrangements to sleep downstairs and reablement support. - November 2019- Reablement declined - December 2019- Reablement cancelled, referral to disability OT declined, Alice believed she didn't need any support **Key Findings:** There is little evidence of consideration of mental capacity There is little evidence of application of professional curiosity to explore carer responsibilities- who was caring for whom.
2020	- January 2020- declined home care package, declined referral to Staying Well Team - Reduced contact with GP (the consistent service in Alices life) - Methods of contact such as SMS or virtual consultations did not seem to work for Alice **Key Findings:** There is limited documented contact throughout 2020 during the COVID 19 period
2021	- April 2021- Greater Manchester Fire and Rescue Service (GMFRS) attended the home whilst responding to an incident in the area. There were concerned about state of property, no safeguarding referral made, follow-ups unsuccessful in June and July - May 2021- declined home care package - May 2021- declined equipment at home

	- June 2021-short term crisis intervention provided, no long-term needs identified, Alice would not consent to assessment, no capacity assessment - July 2021- Richard, crisis mental health assessment done, referred to the Later Life Mental health Team. Significant concerns noted about the living accommodation - July 2021- Richard, assessment by the Older Persons Mental Health Community Team (OPMHCT), referred back to the GP, self-neglect identified and caring responsibilities. - July 2021- short term crisis intervention, long term needs identified, referral for care act assessment - Early August 2021- declined respite - Late August 2021- declined respite again - Sept 2021- Safeguarding referral made by Healthwatch due to concerns that sister had- closed to safeguarding, signposted for care Act assessment - September 2021- home visit done but no assessment found, awaiting allocation up until the time of Alices death - November 2021- Safeguarding referral made by North West Ambulance Service (NWAS)- significant concerns about the state of the property and the presentation of Alice. Alice admitted to hospital where she subsequently died. **Key Findings:** There are several opportunities where incidents could have been considered as a safeguarding concern and raised as such (in respect of Alice and Richard) There are several opportunities to have facilitated a carers assessment for Richard that were missed. There is a significant escalation of concerns/ episodes/ incidents where Alice and Richard came to the attention of services There is an absence of coordinated risk assessment and response There is no evidence of consideration of mental capacity There is little evidence of application of professional curiosity to explore carer responsibilities- who was caring for whom. There is a close family member providing information, but little weight given to her concerns There is no evidence that the Multi Agency Risk Management Protocol (MARM) was considered

9. Analysis of Practice

9.1. Multi-agency Approach and the Lead Professional Role

9.1.1. This review has found that prior to 2017 Alice had been able to manage her home, her own health needs and support her son who had ongoing care and support needs relating to mental health. However, in 2017 there became a point where risks escalated, Alice's overall health significantly deteriorated and multiagency responses were required.

9.1.2. Considering the agency reports, the practitioner views and the panel discussion there is little evidence of a multi-agency approach to Alice. This was the view of Alice's sister when she raised concerns in late 2021. The lack of a shared

perspective led to agencies responding in different ways and a lack of overarching coordination and planning. Panel members agree that this was the case.

9.1.3. Practitioners and panel members reflected on practice to understand why this was the case and there was a view that each agency viewed Alice with a limited scope which did not prompt a wider viewpoint and they did not see themselves in a lead professional role. Often agencies viewed their own role in a narrow way. They were not all cited on the same information.

9.1.4. Panel members considered who may have been the most appropriate person to coordinate an initial multi agency meeting. Whilst there was not a definitive conclusion to that, it was agreed that there was a need to do this due to the general deterioration and increasing risk factors. However, there were also several distinct issues and episodes that could have triggered a Team around the Adult meeting when there was clear indication and opportunity to bring agencies together. These are:

- Alice was a recognised carer for Richard and the roles had been reversed
- Alice was becoming confused, poor memory reported, health investigations instigated
- Richard reported multiple times that his mother was deteriorating
- Poor mobility
- Eyesight problems
- Headaches and “vagueness”
- Several hospital admissions
- Multiple reports of poor conditions in house (dirty, cluttered)
- Reports of no heating in the house, bills not paid
- Richard asking for help and saying he couldn’t cope
- Richard presenting in crisis- mental health assessment conducted
- Alice declining help, saying she didn’t need it (on several occasions)
- Alice reported to be not eating properly or washing
- X2 safeguarding referrals due to multitude of escalating issues (September 2021 from Healthwatch and November 2021 from NWAS, shortly prior to her death)

9.1.5. These arising concerns were all opportunities where agencies could have come together with Alice and Richard to understand what was happening for them both and how they could be supported with their respective overall care and support needs. This would also have afforded the opportunity to discuss risk, capacity and safeguarding.

9.1.6. The absence of Alice’s voice in the evidence indicates a lack of person-centred planning, and challenges in communication between the services which negatively impacted on identifying the appropriate practitioners to include in multi-agency care planning and coordination. The six principles of Adult Safeguarding are therefore not apparently evidenced in a collective way[vi].

9.1.7. Similarly, the findings in this review are also aligned to the thematic areas identified in the National SAR analysis[vii]:

- Information sharing and communication
- Coordination of complex, multiagency cases
- Hospital admission and discharge arrangements
- Professional roles and responsibilities.

9.1.8. Considered in the context of multi-agency coordination and identification of a lead professional, is the question of safeguarding action. Individually, practitioners did have worries and concerns about Alice and about Richard, but the opportunity for collective consideration was missed.

9.1.9. A key question related to risk is whether safeguarding procedures were appropriately used. In this case the risk was around self-neglect as Alice's physical health was significantly deteriorating, the home conditions had flagged concern on several occasion, her carer was someone with care and support needs and whom Alice had always been the carer for, and thus a safeguarding referral may have been warranted on more than one occasion.

9.1.10. It should be noted that a safeguarding referral was made in September 2021 from Healthwatch Bury due to a family member raising concern. This was screened out as a safeguarding concern fairly quickly with a referral made for a Care Act Assessment which did not occur prior to Alice's death.

9.1.11. This safeguarding referral was made after Alices sister contacted HealthWatch with concerns for Alices wellbeing. She reported that Alice was living in a house with no heating or hot water, she described the conditions of the house to be poor, unclean with Alice having to sleep of the sofa due to clutter in the house. She said that Richard was smoking and throwing cigarette ends around the home and she was worried that Alice had not been washed due to the state of the bathroom. This was closed from a safeguarding perspective and signposted for a Care Act assessment to consider support needs, there was a recommendation that a capacity assessment should be carried out but there was no progress on either of these actions prior to Alice's death.

9.1.12. Another example may be the mental health crisis referral that was made in respect of Richard in July 2021, this assessment at the home identified significant concerns about the home environment and noted that Richard was the carer for his elderly Mother, it was noted that the *"home was not suitable for living accommodation. The home was very cluttered, dirty with faeces and flies"* however there was no safeguarding action taken on that occasion, no consideration of a carers assessment and little professional curiosity to consider the whole situation. The outcome of this assessment was for a referral to be made to the Older Persons Community Mental Health Team (OPCMHT) who noted the similar issues during their assessment but did not proactively take any action to explore what was happening for both Richard and Alice and subsequently discharged Richard back to his GP.

9.1.13. A further example was an opportunistic call by the Greater Manchester Fire and Rescue Service (GMFRS) who identified concerns about the state of the property and attempted to revisit on three occasions unsuccessfully but did not proactively take action to share concerns or raise them as a safeguarding concern.

9.1.14. Therefore, the ongoing situation as well as some of individual key practice episodes were simply not seen collectively through a 'safeguarding lens'.

9.1.15. There was opportunity for agencies to come together much earlier. In November 2019 Alice had a period of time in hospitalisation for suspected sepsis. Her capacity was assessed at this time and the conclusion was that Alice lacked capacity and thus arrangements were made for reablement services to support her at home. Handover from the hospital based social worker to the enablement team appears limited, especially with regards to the wider safeguarding concerns and

context, for example the understanding of carers responsibilities, confirmation of dementia, robust review of all agency concerns and overall support. This may have been an opportunity to get under the skin of the full picture and plan care accordingly especially when Alice declined all support, and the issue of capacity was not revisited.

9.1.16. This may have been a timely opportunity to have called a 'Team around the Adult' meeting with all agencies involved. This would have facilitated an MDT risk assessment and identification of a lead professional. This is important in this case as we know that Alice frequently declined services and support.

9.1.17. Additionally, and not related to hospital discharge, there is a regular "MDT" meeting within each Primary Care Network (PCN) in Bury that may have also facilitated a system wide response. The GP has described how this has recently been strengthened to ensure a good flow of communication between GPs and the wider system coordination.

9.1.18. In terms of Alices case, consideration at the MDT may have facilitated a wider range of services, a wider lens of the reality of her life and could have promoted better professional curiosity.

9.1.19. At that time there was not a shared process for risk assessment and management and the approaches to "risk" whilst contained in the Safeguarding Adult procedures, were not as collaborative as the current approaches which are articulated in section 11 of this report (MARM protocol). At this point of time, the different MDT opportunities described above may have triggered the use of the MARM.

9.1.20. The question of capacity and family involvement are also pertinent to the multi-agency discussion and will be picked up in subsequent terms of reference.

9.1.21. To conclude, there is little evidence of multi-agency working or risk formulation despite evidence that this should have been facilitated. This is a finding of other reviews and a thematic review in Bury. **This is key finding 1.**

9.2. **Legal Literacy and Risk Formulation Management capturing Professional Curiosity and Indictors of Concern (home conditions and indicators of self-neglect).**

9.2.1. Effective adult safeguarding involves all agencies and staff involved having a clear understanding of when legal rules may have a contribution to make towards prevention of protection from abuse and neglect. Recommendations therefore focus on understanding and application of legal rules involving, for instance, mental capacity, information-sharing, care and support assessments, and provider concerns.

9.2.2. In Alice's case there were concerns about deteriorating health, indications of non-concordance with treatment (missing appointments), reports of hoarding/ cluttering and refusal of assessments and services that were there to support her even though her son was persistently asking for help and telling services that he could not cope.

9.2.3. The most common type of abuse identified in the National SAR analysis was self-neglect[viii].

9.2.4. A coherent view of the distinct changes to Alices functioning from 2017 onwards was required however each agency only ever had their own snapshot of information. It is noted by panel members and within the agency reports that there was a definite recognition of indicators of self-neglect in respect of Alice and Richard, but it was little understood and not fully explored.

9.2.5. Examples may be the absence of more safeguarding referrals, multi-agency discussion, detailed personal history and exploration of Alices home conditions, health status and caring responsibilities. Refusal of services was not fully explored or understood and there was an assumption of capacity which will be fully explored later.

9.2.6. Professional curiosity was not always evident and assessments (that were offered and not offered completed) were viewed through a narrow lens and relied heavily on self-report.

9.2.7. There is little evidence of risk assessment and on the basis of this it can be observed at that time, there may not have been assurance that agencies were able to recognise and understand the risks related to self-neglect, the legislative frameworks available to use in these circumstances should engagement fail, or their duty to report concerns to the local authority under the provisions of the Care Act 2014. Partnership progressions relating to this area will be outlined in section 11.

9.2.8. There were local self-neglect policies and procedures available at that time but they were not effectively applied in Alice's case, this could be because professionals were not aware of them, or they didn't recognise that they needed to use them. That meant that self-neglect was not referred as a safeguarding concern.

9.2.9. A Care Act assessment (section 9)[ix] was planned in 2021, just 2 months prior to Alice's death, unfortunately this was never conducted and thus there is not an outcome. This may have been one of the key opportunities to capture a picture of Alices anxieties, needs and wishes.

9.2.10. Knowing and using legal powers and duties in the pursuit of practitioner goals is a central element of practice. Utilising these as tools could have facilitated several different outcomes for Alice. Considering the available information, Alice lived-in sub-standard conditions for at least 4 years with deteriorating health.

9.2.11. For example, needs were not considered holistically through observation of prevention and wellbeing principles. A timely Care Act assessment could have been reviewed or reassessed over the period of time in response to the changing circumstances and increasing concerns that multiple episodes or incidents indicated.

9.2.12. Consideration of Making Safeguarding Personal (MSP) should mean "No decision about me, without me." MSP means that the process of safeguarding adults at risk should be person-led and outcome focussed; it engages the person in a conversation about how best to respond to his/her safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety[x].

9.2.13. Considering Alice's situation against MSP and the 6 principles of adult safeguarding, contrary to the view that Alice was deciding and had capacity to decide what she needed and wanted, she was not supported to take control of her

own life and there was not an appropriate response to the concerns that were arising.

9.2.14. One may question the reason for Alice's persistent refusal of services and the reviewer has consider this carefully. Evidence of her voice, perspectives and reasons did not come across strongly in agency actions or decision making. However, there was information that did provide insight, for example Alice felt that her sister and nieces interfered too much in her life and they just wanted her to go into a home. She also expressed concern about "putting too much" on Richard due to his own care and support needs. Alice had also expressed anxiety about finances and how any support would be funded.

9.2.15. Therefore, a hypothesis is that Alice was refusing services/ assessment and support based on anxiety about her son, her finances and her home and consideration of all these factors would have provided some insight into her decision making.

9.2.16. The panel considered professional curiosity which when used effectively can unlock reasons for refusal of care and support or healthcare, for the neglected state of a home, or the impact that an individual's life experience might have on their current decisions. In Alice's case we know that her deteriorating physical and mental health was affecting her quality of life considerably and put her at risk.

9.2.17. This review found limited evidence of professional curiosity in relation to risk assessment, carers' needs, rapidly escalating health needs, increased hospital admission, refusal of services and poor concordance with medical management.

9.2.18. Effective professional curiosity is a crucial part of safeguarding practice and is developed through regular and effective reflective supervision both formally and informally.

9.2.19. Panel members identified the need for robust communication and information sharing and the need to "join the dots" and have "the right conversations and ask the right questions".

9.2.20. In conclusion, the review finds that there was inadequate recognition of triggers and steps that could have led to the right legal tools being used such as professional curiosity and sharing of information to collectively lead to a meaningful understanding of Alice's risk factors and needs. **This is key finding 2.**

9.3. Capacity to Understand and Application of the Principles of the Mental Capacity Act

9.3.1. The review has identified that professional curiosity, collective risk assessment and assessment of need was not often evident in Alice's case. Although capacity was considered earlier in the timeframe (2019), there is no evidence of ongoing consideration. Therefore, we are not able to definitively conclude whether Alice had capacity to refuse assessments and support.

9.3.2. It appears that Alice's capacity to make decisions about care and support was not explored regularly and there is no evidence of how professionals communicated with her to ensure she understood the risks and consequences of unwise decisions.

9.3.3. Relating to these occasions, there did not appear to be consistent discussions about the risks/concerns with her son who provided significant support and was also known to require significant support himself.

9.3.4. Considering the points above, there is lots of evidence that there were known risks factors across the agencies and with more robust professional curiosity should have led to questions about Alice's ability to make certain decisions at certain times.

9.3.5. Therefore, there was escalating risk without a risk-aware responses from agencies. Examples include the risk implications of not attending health appointments, escalating frequency of hospital admission, deterioration in physical and mental health, and refusing support at home especially in the context of hoarding/cluttering and other self-neglect indicators.

9.3.6. The panel considered the issue of assumption of capacity. The correct application of the presumption of capacity in s.1(2) MCA[xi] is a difficult question and often misunderstood by those involved in care. It is sometimes used to support non-intervention, lack of engagement or non-concordance with treatment but this can leave people with care and support needs exposed to risk of harm.

9.3.7. There was enough evidence in Alice's case that agencies had concerns that provided enough opportunity to think about capacity for example multiple occasions of decisions such as declining support.

9.3.8. Considering the assumption of capacity for Alice served to close down awareness of the need to monitor decision making ability in the face of escalating risk. It raised the question of how concerned agencies should be before an assessment is warranted. There is evidence in Alices case that the question of capacity was not considered enough despite contrary messages coming from her son about their home situation and Alices deteriorating presentation.

9.3.9. The GP has reflected on the occasions where they saw or spoke to Alice during the timeframe of this review and felt that it was likely that Alice had fluctuating capacity as she did not present consistently, for example during her medication reviews. This is not unusual for someone with a dementia diagnosis and these occasions may have prompted consideration of capacity and facilitation of assessment. The GP would have been a good point of contact for services/ agencies to liaise with and gain a better insight into Alice's functioning generally.

9.3.10. A mental capacity assessment was completed in hospital in 2019 when Alice was acutely unwell. There were many occasions after that date when she declined assessments and support, which would have provided opportunity for the question of capacity to be revisited. There was opportunity to consider her decisions and self-neglect in the context of mental health as Alice was thought to have dementia albeit without a confirmed diagnosis.

9.3.11. In conclusion there was a lack of risk assessment and an inconsistency about application of the Mental Capacity Act. There was no evidence that it was considered or assessed regularly. **This is Key finding 3.**

9.4. **Health oversight:**

9.4.1. It is unclear even with the benefit of the review process, how Alices health needs were being coordinated or addressed and more professional curiosity could have

led to a more coherent approach. This meant that on the occasions where she was in hospital, the GP was not consulted in their capacity as her primary health care provider and thus a rich knowledge of her mobility, frailty, dementia and functioning was not understood. The discharge from hospital in 2019 and subsequent occasions may have provided an opportunity for a multi-agency discharge meeting.

9.4.2. Alice was diagnosed with dementia in October 2019 by her GP. There were several investigations carried out and she was commenced on treatment and received regular medication reviews (in the GP practice, at home and via telephone).

9.4.3. The panel were not clear if Alice had a dementia diagnosis or not, and it did not appear to be clearly documented within the GP records. The reviewer gained insight from panel discussion that the dementia pathway in Bury is perhaps not well enough understood, with a lack of awareness of how it works. This was demonstrated by an inconsistent understanding of whether Alice had a "diagnosis" and a view that she may have received a better offer if she had been referred to and assessed by mental health services.

9.4.4. The reviewer has considered the dementia pathway in Bury which enhances the specialist oversight within each GP practice by having a "GP dementia lead" who has the expertise to assess, diagnose, treat and manage people. This pathway also facilitates a referral to the Dementia Advisory Service for support and consideration of social and legal aspects. This referral was made in Alices case however there is no recorded outcome and thus it appears that this assessment was declined.

9.4.5. The reviewer has considered the dementia pathway in Bury in the context of whether Alice may have received a different or enhanced service offer had she been assessed by Mental Health services and has concluded that it is unlikely that Alice would have received a different service, additionally noted is that the pathway is compliant with the NICE dementia guidelines[xii]. However, there is not a robust understanding across services of how the pathway works.

9.4.6. The reviewer has also examined the role of the MDT meetings that sit within the Primary Care Networks (PCN). The purpose of a PCN is to form a building block of the NHS Long term plan to facilitate better access to and greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home[xiii]. Primary Care Networks (PCNs) involve general practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas. If used, this MDT would provide a coordinated approach to people presenting with Alices needs however there is no evidence that this approach was considered in this case.

9.4.7. Therefore, the review concludes that there is a disconnect across health services and a lack of assurance of the management and oversight of people with mental health difficulties who may be self-neglecting. It should be noted that the health aspects do form part of a much wider safeguarding response from all agencies.

9.4.8. To summarise, Alice's physical and mental health deteriorated rapidly over the three years prior to her death. Her dementia was of most concern and for many reasons notwithstanding the COVID-19 pandemic, the oversight of Alices needs was not managed as coherent as it could have been because the different parts of the health system did not communicate with each other as well as they could have done. **This is key finding 4**.

9.5. **Understanding the Son's Role and how he was supported by agencies:**

9.5.1. Alice's main source of support was her 70-year-old son Richard. He was identified on several occasions as her "carer". This was a complex relationship as Richard had care and support needs and prior to becoming unwell Alice was Richard's carer. This in itself raises a number of complex issues.

9.5.2. Throughout the agency reports there are a few references to "carers assessment" however it was often not clear who was being perceived as the carer and thus a carers assessment was never concluded for Alice or Richard at any point. However, there were opportunities for agencies to question and recognise this.

9.5.3. It is helpful to consider what a carers assessment is. The Care Act 2014 (section 9 and 10)[xiv] uses the term 'assessment' to refer to either a Care Act assessment of an individual's needs for care and support (in this case Alice) and/or a carer's needs for support and determination of eligibility (in this case Richard). The review recognises that the carer's role had been interchangeable at different times in this case, and it may have been good practice to have carried out both assessments in tandem.

9.5.4. In terms of the 'carers assessment; when a carer is found to have support needs following assessment under section 10 of The Care Act 2014, the local authority must determine whether those needs are at a level sufficient to meet the "eligibility criteria" under section 13 of the Act. The panel considered it likely that Richard would have been assessed to have eligible needs thus support and services may have been facilitated.

9.5.5. Richard was a person with care and support needs himself, he had a mental health diagnosis and on occasion over the years had relapsed with the indicators being signs of self-neglect. Those indicators were recognised on multiple occasions during the timeframe of this review which raises three points. Firstly, why did agencies not recognise that Richard no longer had an effective carer in place (previously Alice), secondly why did agencies not recognise that Richard was acting as the carer for his mother and needed significant support, and thirdly why did agencies not recognise that there were now two people with care and support needs trying to care for each other.

9.5.6. No assessments were completed to determine whether Richard was a suitable informal carer, or of the impact on his own health. In the context of him telling people he was struggling, the evidence of the house and the deteriorating health of Alice, this would have made a difference if conducted effectively. Although there is evidence that Richard was referred for a carers assessment in 2021, it does not appear to have concluded effectively.

9.5.7. This was a complex situation of interdependency that required some unpicking and careful thought. Consideration of a multi-agency risk process such as the MARM may have facilitated a different response. The MARM was implemented in Bury at the latter stage of the timeframe and the reviewer has explored the factors that may have prompted professionals to utilise it and concludes that the indicators and risks are present.

9.5.8. When Alice's health began to decline in 2018 (mobility, dementia), she said that she needed a break from her caring responsibility. However, what is evident from thereon is a shift in mindset that Richard was now Alices carer but with little

analysis of how he would carry out that role without support. It is evident that Richard asked for help on many occasions and said that he could not cope.

9.5.9. However, assessment and services either weren't followed through, or they stopped because Alice wouldn't consent or declined them, without application of professional curiosity, in the absence of capacity assessment and without carers assessments all of which would have provided a reality check on what was happening in the house.

9.5.10. Between 2016 and 2018 there were concerns about Richard, he had a period of hospitalisation due to a relapse of his mental health, there were concerns about self-neglect and debts. It is helpful to consider this in the context of Alice and the pressure that she would have felt between 2016 and 2018 at the time her own health was deteriorating.

9.5.11. To summarise there was a pattern of Richard asking for services and Alice declining services, there were known concerns about a number of issues that may have led agencies to consider that neither was able to care for the other but there was no exploration of capacity, insufficient attention to carers assessment and a lack of professional curiosity about the functioning and dynamics of the household.

9.5.12. This suggests that there was a lack of insight and understanding of the term "carer", and of the steps and processes to ensure that appropriate assessments were undertaken. **This is Key Finding 5.**

10. Key Findings

10.1. Key Finding 1- Multi-agency Coordination

10.1.1. There were at least 12 key practice episodes that should have prompted multi agency coordination. This could have facilitated a Team Around the Adult meeting, application of the MDT meeting within the PCN, the identification of a lead professional and collective consideration of risk, capacity, and safeguarding concerns.

10.1.2. The newly embedded Multi Agency Risk Management protocol (MARM) protocol contains practical guidance on how to coordinate this approach, however there may be agencies that may need more support in implementing this into practice. In terms of this protocol, effectiveness measures are paramount.

10.1.3. This approach would have provided the platform for Alice (and Richards) voice to be clearly heard and the 6 principles of adult safeguarding to be enacted.

10.1.4. This is not a new finding, and a recommendation will be made to the BISP.

10.2. Key Finding 2 - Professional Curiosity

10.2.1. Professional curiosity is the capacity and communication skill to explore and understand what is happening within a person's situation rather than making assumptions or accepting things at face value.

10.2.2. Curiosity is required to support practitioners to question and challenge the information they receive, identify concerns and make connections to enable a greater understanding of a person's situation[xv].

10.2.3. This review found that there was an absence of professional curiosity that resulted in inaction rather than action. There will be a recommendation to the BISP.

10.3. **Key Finding 3 - Risk Assessment and Management and Application of the Mental Capacity Act**

10.3.1. This finding relates to the absence of collective risk assessment and in turn consideration of when to apply the mental capacity act as part of that. In Alice's case there was little evidence that she was aided in decision-making and with the right risk assessment and timely application of capacity assessments, risk may have been reduced and independence promoted.

10.3.2. At this time of Alice's death there was not a collective approach to risk assessment with the newly developed MARM being implemented which is designed to support any practitioner working with adults where there is a high level of risk that would benefit from joint multi-agency management and senior oversight of risk management strategies.

10.3.3. Application of this protocol will support existing work that Bury has taken forward in promoting awareness of the Mental Capacity Act. There will be a recommendation related to this.

10.3.4. In terms of application of the Mental Capacity Act, the Author recognises the learning, training and resources that have been put into practice but notes that this is a finding from previous reviews and there is limited assurance that the workforce is consistently competent. There will be a recommendation related to this.

10.4. **Key finding 4- Health Management**

10.4.1. This review has found that the pathways for people thought to have dementia are compliant with NICE guidelines but are not well enough understood by all agencies (including other health providers). The GP as the primary health care provider in managing Alice's dementia was not consulted with as often as they could have been, and in turn was not prompted to contribute to or share information that may have assisted a more robust multi agency oversight. There will be a recommendation related to this.

10.5. **Key Finding 5 - Carer's Assessment**

10.5.1. This case highlighted a complex situation of interdependency between two people with care and support needs and a failing to provide the right level of assessment and support to despite multiple opportunities. Care Act Assessments could have been facilitated at different times. It is noted that "carers assessments" under Section 10 of the Care Act 2014 were not completed in respect of either Alice or Richard. This could have been facilitated on different occasions by any of the agencies involved. This suggests that there is a lack of awareness and there will be a recommendation relating this this finding.

11. Progress against learning

11.1. There are 6 recommendations to be made in this review against key areas of safeguarding practice. However, it is encouraging to see the areas of improvement where learning has already been taken forward and implemented. These developments are all relevant to Alice's circumstances and ongoing assurance of effectiveness should sought on a continual basic.

11.2. Progress to note is as follows:

11.3. **BISP-** implementation of a **"Multi-Agency Risk Management Strategy (MARM)** This has been implemented across all agencies via a range of learning and training.

11.4. **Primary Care Network (PCN)**- with reference to points 9.1.17 and 9.4.6, the MDT offer within the PCNs in Greater Manchester (including Bury) has been significantly enhanced and is continuing to develop; this will continue to strengthen this area of learning.

11.5. **NHS Greater Manchester Integrated Care** – development and implementation of MCA training for Primary Care Teams in Bury.

11.6. **NCA** have adapted their mandatory training offer to include professional curiosity, self-neglect and hoarding. In addition, Dementia Training is now mandatory for all patient facing staff with Bury Care Organisation (NCA) and under review for roll out across the wider NCA Trust.

11.7. **PCFT** are currently carrying out "quality walks" to explore and focus on the knowledge of care act responsibilities towards carers. This follows a seven-minute briefing; "**What is a carer? Learning from Safeguarding Adult Reviews".** Additionally, there are a series of learning events scheduled to provide learning and knowledge about carers.

12. Conclusions

12.1. This SAR Overview Report is the BISPs response to the death of Alice to share learning that will improve the way agencies work individually and together.

12.2. Alice and her son presented together as a complex and interdependent family unit, both assuming caring roles for one another whilst enduring a range of complex health needs. All agencies who contributed to this review were aware of risk factors, concerns and physical/ mental health deterioration but there was not one occasion in this case that all agencies convened to share information, consider risks and to understand how best to work effectively with Alice.

12.3. The last three years of Alice's life paint a sad, unhappy and unacceptable set of conditions for any human to have had to endure. Through the timeframe of the review Alice was aged 89 to 93 years old and was confused, worried, anxious and living in a home described as unfit to live in. There are statutory, national and local frameworks that could have been considered and facilitated in different ways by the agencies involved. This includes the support of Richard who was trying to care for Alice but asking for help on many occasions.

12.4. The review has highlighted a need for practitioners to take a deeper look into the lives of adults who self-neglect, identifying root causes, formally considering mental capacity, and drawing on tools to help them such as multi-disciplinary working, needs assessments, and mental health services.

12.5. Alice's cause of death was peritonitis and a ruptured large bowel, it is difficult without hindsight bias to reach a definitive conclusion as to whether better care and

conditions may have facilitated earlier detection of the signs and symptoms of those issues. However overall, there was insufficient weight given by agencies to her care and support needs, self-neglect indicators and mental capacity.

12.6. Considering the findings of this review, if all if the frameworks, tools and standards had been followed effectively this may have facilitated an improved quality of life or a different outcome.

12.7. It is hopeful that the outcomes from this review will enhance and sustain support for people with complex presentations. The findings and recommendations should be monitored for compliance, implementation and assurance by the BISP.

13. Recommendations to the Board

13.1. It is noted that progress has been made in areas of findings by the BISP collectively and by individual agencies. Recommendations have been made against those areas were there have been previous finding and those where deeper and continual assurance is required.

13.2. Arising from the analysis in this review the following recommendations are made to the BISP:

Recommendation 1: Multi-Agency Working and escalation:

The BISP are asked to consider its approaches to multi-agency working to include guidance for the workforce and:

- Assurance of its effectiveness
- Escalation processes both single agency and multi-agency
- Managerial and professional supervision
- Coordination and decision making
- Alignment with risk management processes and protocols
- Alignment with local self-neglect processes

Recommendation 2: Professional Curiosity:

The BISP should continue to promote professional curiosity in practice and:

- Consider its effectiveness measures to continually seeks assurance that professionals are routinely applying professional curiosity in their practice and that this is proactively informing decision making.
- Strengthen single and multi-agency supervision models and reflective practice opportunities.

Recommendation 3- Risk Assessment:

The BISP should seek ongoing assurance that the MARM protocol is effectively embedded in frontline practice and:

- Seek assurance that professional curiosity, supervision/ reflective practice and a multiagency response will trigger professionals to utilise the MARM were indicated.
- Seek assurance that the various multiagency systems and processes that form part of the MARM continuum are aligned and understood across the partnership.

Recommendation 4- Dementia Pathways

It is recommended that the BISP seeks assurance from the commissioners and providers of dementia health and social care services that there is good awareness of the Dementia pathway to facilitate a better flow of information from the GP to other services and vice versa.

Recommendation 5- Application of the Mental Capacity Act

It is recommended that the BISP adopts an MCA competency framework approach that can standardise practice and training and allow different professionals working at different levels in agencies to consistently apply the statutory requirements of the MCA in practice. In addition:

- Its effectiveness should be regularly reviewed to provide an oversight of whether practice is working

Recommendation 6- Carers Assessments:

The BISP should strengthen communication and seek assurance that agencies are aware of the process for carers assessments in Bury; how to identify need, how to apply consideration under MSP to trigger a referral, and to know how to refer this. The process for carers assessment should include a clear timescale for completion and a method of feedback to the wider agencies.

14. References

[i] Section 44, The Care Act (2014)
[ii] The names used within this report have been chosen by the BISP to maintain anonymity
[iii] The Lead Reviewer is Anna Berry and is Independent of all agencies
[iv] Via virtual meeting technology due to the impact of Covid-19
[v] Department of Health and Social Care (2020) Care and Support Statutory Guidance: Issued under the Care Act 2014. London: The Stationery Office (section 14.165)
[vi] The Care Act, 6 principles of adult safeguarding (2014)
[vii] National analysis of safeguarding adult reviews
[viii] National analysis of safeguarding adult reviews
[ix] Section 9, Care Act 2014
[x] Making Safeguarding Personal outcome measures (2018)
[xi] MCA (2005)
[xii] Overview | Dementia: assessment, management and support for people living with dementia and their carers | Guidance | NICE
[xiii]
[xiv] The Care Act (2014) sections 9 &10
[xv] Professional curiosity in safeguarding adults: Strategic Briefing (2020) (researchinpractice.org.uk)