SUNDERLAND SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

CONCERNING:

"ANGELA"	**born**	**1966**
"BARRY"		**1959**
"CLAIRE"		**1936**

FINAL EXECUTIVE SUMMARY

2/10/15

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1) Introduction

This overview report of a Safeguarding Adults Review (SAR) was commissioned by Sunderland Safeguarding Adults Board (SSAB). Alan Patchett (Chief Executive, Age UK Sunderland) was appointed as Independent Chair and Richard Corkhill (Independent Consultant) as Overview Report Author.

2) Events leading to the decision to hold a Safeguarding Adults Review

Angela[1] has diabetes and a long term mental illness. She needs daily insulin injections. In March 2014 there was a case conference attended by her Psychiatrist, GP, Practice Nurse, District Nurse and Social Worker. The conference had been called because Angela had been refusing insulin injections for 5 days and as a result of this, her life was in danger. The meeting agreed that Angela lacked capacity to make a decision on consent to medical treatment and on the following day she was admitted to the Emergency Department at Sunderland Royal Hospital (SRH) in accordance with a Best Interests Decision taken under the Mental Capacity Act (MCA). On admission, her blood glucose level was 33, when the normal range should be between 4 and 7.

Whilst in hospital, Angela frequently went missing from the ward. Despite this, her condition was successfully stabilised and she was discharged from hospital three weeks later. On discharge, she remained subject to the MCA. Under direction of the Court of Protection, she was accommodated in a suitable setting, where her health and social care needs could be properly met. At the time of writing, Angela remains in this setting. It is understood that her physical, mental and emotional wellbeing has improved significantly whilst resident there.

In May and June 2014, prompted by recent events affecting Angela, SSAB Learning and Improvement in Practice Sub-Committee held two scoping meetings, which reviewed histories of local agency involvement with Angela, her brother Barry and their mother Claire. It became clear that there was a history of

[1] Pseudonyms are used throughout the report, to protect confidentiality.

concerns about the health and welfare of each of the 3 family members, all of whom were "vulnerable adults"[2]. There had been previous safeguarding meetings and frequent contacts from agencies including Adult Social Care (ASC), primary and secondary health care services, Community Nursing, Police, Ambulance Service and a social housing provider[3]. The information presented to the scoping meetings raised many questions for the Learning and Improvement in Practice Sub-Committee about multi-agency working and communication, over a period of several years leading up to the previously outlined incident in March 2014, when Angela was admitted to hospital under an MCA best interests decision. It appeared that there may have been earlier opportunities, when more effective communication and joint working between the services which were variously involved with one or more of the family members, could have more effectively protected three very vulnerable people from significant harm and potentially life threatening risks. On this basis, it was concluded that the criteria (under the SSAB SAR Protocol) to undertake a Safeguarding Adult Review (SAR) were met. A recommendation that a SAR should be undertaken was made to the Independent Chair of the SSAB, who confirmed the decision for an SAR to be commissioned.

3) Individual Management Reports (IMRs)

Each of the agencies which had had significant involvement with the three family `members provided Individual Management Reviews (IMRs). These were:

- Northumberland Tyne and Wear NHS Foundation Trust (Community mental health services)
- South Tyneside NHS Foundation Trust (District Nursing services)
- Sunderland Clinical Commissioning Group (GP / primary health care)
- Northumbria Police
- North East Ambulance Service

[2] Until April 2015, the definition of "vulnerable adult" was based on No Secrets guidance (Department of Health, 2000). The 2014 Care Act (implemented in April 2015) refers to "adults at risk of abuse and neglect" All three family members meet both sets of definitions.

[3] The name of the housing provider is not included in this report, to assist in protecting confidentiality of the tenants.

- City Hospitals Sunderland NHS Foundation Trust (hospital in-patient services)
- Sunderland City Council People Directorate (Health, Housing and Adult Services)
- Sunderland City Council (Adult Safeguarding and Personalisation Services)
- Social housing provider

4) Summary of major themes and findings

The following is a summary of major themes and findings, linked to the Terms of Reference questions:

Question 1:
Was self-neglect evident in the record keeping for your agency? Did your agency ever consider self-neglect as a safeguarding issue?

Evidence of the high level and frequency of concerns about self-neglect included:

- Numerous referrals and concern notices about self-care issues received by Adult Social Care (ASC) from agencies including the Police, primary health care, mental health services, North East Ambulance Service and the social housing provider.
- Agency case notes and records of telephone conversations about self-neglect.
- Copies of letters and email correspondence about self-neglect.

There is also clear evidence to show self-neglect was considered and discussed by each of the agencies (both internally and in multi-agency fora) on numerous occasions, including within multi-agency safeguarding meetings. However, until March 2014, there was little evidence of any effective safeguarding strategies to remove or minimise risks resulting from self-neglect.

The primary reason for this was an underlying assumption that all three family members were making informed and capacitated choices to live in the conditions

which were clearly placing them at serious risk. This is evidenced, for example, by the comment from a Care Manager about not being able *to "state how people should lead their lives"* (see key learning point 7). There were attempts by some professionals to challenge this position, but these challenges were insufficiently robust.

Question 2:
Which other agencies, statutory and voluntary, were you aware of that were working with the family? Did your agency collaborate with any of these agencies to meet the needs of the family?

It has been established that the main agencies which had significant involvement with the family were:

- Adult Social Care (Sunderland City Council)
- GP Practice
- District Nursing (South Tyneside NHS Foundation Trust)
- Mental Health Team (Northumberland Tyne and Wear NHS Foundation Trust)
- Social housing provider
- Sunderland Royal Hospital (City Hospitals NHS Foundation Trust)
- Northumbria Police
- Ambulance Service (North East Ambulance NHS Foundation Trust)

There is clear and repeated evidence of professionals speaking to each other, arranging MDT meetings, attempting to formulate multi-agency plans and strategies and exchanging referrals. There were good practice examples of agencies working in collaboration. However, the more common picture was one of agencies working in silos. For example, social housing provider employees made repeated efforts to establish a partnership approach with ASC colleagues, but were advised more than once, to the effect that dealing with housing management issues was a matter for them and that there was no role for social work involvement. This was despite the fact that the social care and safeguarding

needs of three very vulnerable adults were inextricably linked to their housing situation.

Question 3:
What risk assessments were undertaken by your agency in the planning and management of the co-caring arrangements for the whole family?

Until late 2013, there was very limited evidence that agencies properly considered the co-caring arrangements within the family as whole, though there are some exceptions to this, which could be identified as good practice. For example, it is clear that the social housing provider recognised the need for two adjacent properties, so that Angela and Claire could maintain close contact with Barry who relied on them for his care and for most of his social contact. Another example was provision of a package of home care (in January 14) with the same care workers responsible for each of the 3 family members. Had this integrated approach been taken at an earlier stage, this may have helped to build trust and reduce the possibility of Claire refusing home care.

Question 4:
Do your agency's records document any forms of abuse occurring?
What category(s) of abuse was/were recorded, what action was taken and what was the outcome?

Angela made a number statements and allegations which suggested she may have been subjected to physical and sexual abuse a family friend. On those occasions when professionals followed up the allegations with Angela, she would usually retract what she had said. When the same allegations were discussed with Claire, she would dismiss this as something which was "in Angela's head". The SAR has reached the following conclusions:

- Angela repeatedly made comments to professionals which indicated that she felt uncomfortable when in the presence of Sam[4]. These included specific allegations about inappropriate sexual behaviour, one instance when she said he had force fed her and a statement that he had 'put her in a bin'.
- When Claire dismissed Angela's concerns as being "in her head", this seems to have been accepted, without any real question or challenge.
- When specific allegations were made, they did not result in joint police / ASC investigations or consideration of the need for safeguarding strategies to be put in place. (Learning point 8)
- On occasions, allegations were assessed as if they were a single isolated report, rather than as a pattern of similar reports. As a result of this the level of potential risk was under-estimated. (Learning point 9)
- On the one occasion when an allegation about Sam was considered within Adult Safeguarding procedures, this did not result in a safeguarding plan.
- There was also a suspicion of financial abuse of Barry, by Claire. The safeguarding investigation properly concluded that there was no evidence of financial abuse. However, Barry had been placed at risk because Claire was not coping well with his benefits claims, bills, and other financial matters. Appropriate safeguarding measures were put in place, including establishing the Council as Appointees for Barry's income and expenditure. This was **good practice** which resulted in significant improvements in Barry's situation and his financial security.

[4] In Dec 14 / Jan 15 there were follow up investigations into all of the allegations and concerns about 'Sam' (not his real name) including interviews with family members by the Police and ASC. The outcome was that none of the allegations against Sam were substantiated.

Question 5:
What activity was your agency involved in with the management of Angela's diabetes? Could this have been better managed to prevent hospital admission? Could her care needs have been met in another way?

The agency which had daily responsibility for management of Angela's diabetes in the community was the District Nursing Service, under the over-all direction of the GP. It is recognised that District Nurses, in conjunction with the GP practice, went to very great lengths to try and ensure that Angela's diabetes was properly managed, through daily insulin injections, monitoring of blood sugar levels and advice and support to maintain an appropriate diet. The challenges faced by District Nurses in carrying out this role should not be under-estimated and included dealing with verbal abuse and physical aggression from Angela and working in what was sometimes an unsafe physical environment.

It is undoubtedly the case that without these community based health care services, Angela could not have lived safely for any significant period, outside of a hospital or nursing care setting. It has also been recognised that District Nurses often worked well beyond their professional roles and duties, for example in helping with tasks such as cooking and cleaning.

Whilst acknowledging the very significant challenges faced by District Nurses, the evidence from the IMRs in relation primary health care services highlight a number of important lessons. Key amongst these are:

- The initial referral information received from the GP practice for District Nurse input was poor and in no way prepared the service for the complex needs and levels of risk (for both Angela and for District Nurses operating initially as lone workers) which would be present.
- Although the District Nursing Team had serious concerns about risk to themselves and to Angela, they were unable to effect change in the management of the situation, either through internal agency measures or through multi-agency work.

- District Nurses should have arranged an MDT of medical professionals or a multi-agency meeting as soon as their doubts about Angela's capacity to understand her dietary and medication needs became clear. That this did not happen was a **missed opportunity**.
- District Nurses were involved in some multi-agency meetings about Angela, but there is no record of them receiving minutes from meetings. Due to the lack of recorded information it would have been very difficult for all members of the District Nursing Team to be aware of any multi-agency risk management plan, had one existed.
- During the period in question none of the District Nurses involved would have been confident to carry out an MCA assessment.

The above factors contributed (alongside many other multi-agency failings) to the eventual outcome of Angela's life being placed in danger as a result of not receiving the treatment she needed. Possibly the most significant of these factors was that neither the District Nurses nor the GP practice appear to have properly understood their roles, responsibilities and *powers*, under the MCA. Had they done so, they could have assessed Angela's mental capacity to consent (or refuse consent) to medical treatment at a much earlier stage. This could then have resulted in best interests decisions to ensure that her diabetes was effectively treated and managed. Such action could have been considered as early as April 2011, when Angela refused hospital admission, as advised by her GP.

Certainly by February 2012 there was very strong evidence – including an MCA assessment by her Psychiatrist – that Angela did not have mental capacity to make informed decisions to accept or decline medical treatment. Even following this assessment, no best interest decisions were taken. This was a serious failure of multi-agency practice, because all of the key health and ASC services were aware of the Psychiatrist's conclusions. As the service with primary responsibility for overseeing Angela's treatment and management of diabetes, the GP practice should have been pro-active in preventing this failure from occurring.

Question 6:
Angela and Claire were both understood to have a formal caring role; at what point did your agency formally identify them as carers?
What assessment did your agency undertake to support this?
Were the interdependency of caring roles between Angela and Claire acknowledged?

It was clearly known from and recorded by all of the agencies involved with the family that both Claire and Angela acted as informal carers, for each other and for Barry. It was also well documented that both Angela and Claire struggled to perform these roles, resulting in all 3 family members often being at risk of significant harm. This is clearly evidenced throughout the chronology, from early 2011 onwards.

ASC workers correctly recognised that Claire was the key influence in the family, even though her physical health meant that her ability to directly provide “hands on” care was extremely limited. As a result she was (on five occasions) offered carer’s assessments, as part of her family’s assessments. Each of these offers was declined by Claire.

In summary, there were strong inter-dependencies within a very close family unit. Even though Claire and Angela were increasingly unable to safely care for each other and for Barry, Claire refused offers of carer’s assessments.

There was not a failure to recognise the interdependencies or to offer carer’s assessments. However, Claire’s refusals of support significantly increased the risks of all three family members coming to serious harm from self-neglect. This was not recognised and acted upon at an early enough stage.

Question 7:
Describe what arrangements are in place within your agency to effectively manage any concerns raised and provide follow up.
What is the threshold in your agency regarding "low level" concerns?
Was there a system in place within your agency to identify multiple referrals and to trigger a safeguarding or ASC referral?

There were a significant number of reported incidents which gave rise to safeguarding concerns. This was particularly evident in relation to the number of occasions when Angela made statements suggesting abuse by the family friend.

Some of these concerns were formally recognised and dealt with within the multi-agency safeguarding arrangements, whilst others were either not dealt with at all, or were referred to individual Social Workers to follow up with informal enquiries, usually resulting a retraction from Angela and/or Claire insisting there was no foundation at all to Angela's statements.

However, the evidence seen by the SAR does not suggest that there was any consistently applied policy, procedure or guidance which influenced how individual reports / concerns / suspicions were responded to. Similarly there appears to have been no consistently applied thresholds for when a possible concern was referred into the safeguarding process. It is also clear that on occasions the person dealing with the latest reported incident had no knowledge of the history of similar reports. Consequently they were assessing potential risk without reference to important information. A key reason for this was an absence of professional challenge, either within the multi-agency arena or through management support, training and supervision processes.
(See key learning points 5 and 9)

Question 8:
Within your agency, what systems are in place to cross reference information held about family members of the same household, to give a broader picture of individual circumstances?

Some agencies did effectively cross reference information about Angela and Claire. This was evident in the ongoing discussions about Angela's mental capacity which were linked closely with discussions about Claire's capacity to look after Angela and her capacity to make decisions about housing. Similarly, the social housing provider cross referenced information across both households, in seeking to rehouse them in close proximity to each other.

In the case of ASC services, there was a period when Social Workers / Care Managers working with Angela and Claire respectively were apparently not aware of each other's involvement. This was possibly due to Angela coming under the domain of a mental health team, whilst Claire was dealt with as an older person with physical disabilities. However, with computer-based referral and case allocation systems it is difficult to understand how workers within the same organisation could be unaware of each other's involvement with another family member at the same address.

Questions 9 & 10:
Were multi-agency assessments robust enough to identify housing needs, capacity and vulnerability?
Was appropriate multi-agency support given to the family regarding housing needs?

In 2011 the family were living in very poor housing conditions, in an isolated location with no support from neighbours or other informal networks. This was acknowledged by the social housing provider, the police, health and ASC agencies as an unsafe and unsuitable environment for three vulnerable people. In addition to the unsuitable physical conditions, there were ongoing concerns

and police reports of anti-social behaviour and reports (unconfirmed but entirely credible) of targeted bullying by groups of local youths.

It is evident from records that the social housing provider staff were keen to rehouse Claire, Angela and Barry as soon as possible. This was a challenging task, not least because Claire would only consider properties in specific locations and there was a requirement to find two adjacent properties, due to Barry's dependence upon his mother and sister. On more than one occasion Claire accepted a new property and then changed her mind.

The social housing provider's Neighbourhood Housing Manager requested assistance of ASC, Mental Health Services, Tyne and Wear Fire and Rescue and Northumbria Police to try to persuade Claire, Angela and Barry to move from their current homes. Whilst every agency expressed concerns about the living situation, some agencies viewed the living situation as a housing issue for the social housing provider resolve on their own.
The main justification given for this lack of support from partner agencies was that the family had capacity and were making their own informed choices about how and where they lived. Based on all of the evidence available at that time, this was a fundamentally flawed judgement and an inappropriate justification for not working collaboratively to address this family's critical housing needs.

In summary, appropriate multi-agency support was not given to the family to address their housing needs. As a result of this, multi-agency assessments were clearly not robust enough to identify housing needs, capacity and vulnerability. That multi-agency approaches to assessment and support around housing needs did not happen was **a missed opportunity and a major multi-agency failure.**

Question 11:
What were the contributing factors which led to professional acceptance of the family's living conditions?
What contribution did your agency make to improve the home environment?

The primary contributing factors resulting acceptance of the family's living conditions include:

- A repeated assertion by some professionals that all family members were making informed and capacitated decisions to live in these conditions. This view appears to have been expressed particularly by ASC staff, but was then accepted without sufficiently robust professional challenge by the other agencies involved.
- There was a strong tendency for agencies to work in "silos", so that concerns about living conditions were identified as either "housing management" or "social care" problems.

There are many examples, where agencies worked to improve the home environment. These include:

- ASC arranged home care support to both households, during periods when support was accepted by Claire and by Barry.
- Professionals including District Nurses, CPNs, social housing provider staff and Social Workers going well outside their job roles and responsibilities to carry out tasks such as cooking and cleaning and removal of rubbish from the exterior of properties.
- The social housing provider working with the family to find them suitable housing away from the derelict estate in which they were living.
- The social housing provider working in conjunction with OT services to arrange adaptations needed for Claire and Barry's physical disabilities.

These efforts achieved short term improvements in the family's living conditions. However in the longer term, they did not result in sustainable improvements.

Question 12:
How did your agency act in supporting financial issues?

The financial issues which arose were primarily in relation to Barry. The issues were identified initially by the social housing provider, following which there was active involvement from ASC.

The social housing provider's support for Barry around financial issues included:

- Significant relocation compensation payments made to both Claire and Barry when they were rehoused.
- Practical support in purchasing / fitting items such as new carpets.
- Liaison with Department of Work and Pensions in connection with Barry's benefits claims.
- Making a safeguarding alert when there was concern about possible financial abuse.

The Adult Safeguarding response to the alert raised by the social housing provider and the Council Appointee arrangements have already been outlined. (See question 4).

In summary, both the social housing provider and the Council acted in a consistently professional way in supporting Barry with his finances. These are examples **of good practice.**

Question 13:
Were appropriate legal provisions (e.g. Mental Health Act, Mental Capacity Act, Power of Attorney) used in a suitable and timely manner for this family?

As outlined in response to question 1, there was widespread confusion and lack of understanding of the Mental Capacity Act. There was very clear evidence from 2011 onwards that Angela lacked capacity in relation to decisions about medical treatment and management of her diabetes. However, primary health care professionals and others allowed this situation to continue for nearly another

three years, apparently on the basis that Claire was capable of ensuring Angela would agree to her injections, blood tests and dietary controls. There was unequivocal evidence that Claire did not have this capability.

Even when an MCA assessment in 2012 confirmed Angela's lack of capacity in relation to her medical condition, this was not followed by best interests decisions which could have been taken at that stage. On other occasions it was agreed that ASC would carry out MCA assessments, but for reasons which remain unclear, the assessments did not take place.

The same issues arose in relation to Barry and his capacity to make decisions about his accommodation and care arrangements.

A running theme was that the issue mental capacity was used as reason *not* to take any action. The focus of the agencies involved was neither empowering, nor protecting. The authority to act was not used where it quite clearly should have been.

In summary, there were much earlier opportunities when both Barry and Angela should have had MCA assessments, followed where appropriate by best interests decisions in relation to their medical, accommodation and care needs. That these assessments either did not take place - or took place but were not followed up with any best interests decisions - were **missed opportunities and serious multi-agency failures.**

Question 14:
What assessment does your agency undertake to ensure the suitability of aids/adaptations for the recipient and the environment in which it will be used?

As Sunderland Council's OT service was not asked to provide a separate IMR or chronology, there is limited scope for the SAR to comment on this question. However, there is evidence that the OT service worked in partnership with the social housing provider, as an OT was involved in ensuring that the property

Barry was allocated in March 2013 would be suitable to his needs as a disabled person.

The property did in fact need to have a walk in shower installed. Although Barry moved into the property in March 2013, the shower was not installed until December 2013, which seems to be unacceptable delay.

OT services also arranged aids and adaptations for Claire, including equipment for transfers and a hospital bed. It subsequently became clear that she and Angela were unable to effectively use this equipment, partly because Angela (in her role as Claire's main carer) lacked the ability to operate the equipment and cluttered physical conditions in the home meant that there was not sufficient space for the equipment to be used effectively. This raises questions about the quality of the OT assessment leading to the provision of this equipment.

Question 15:
Does your agency record Angela and Barry as having a learning difficulty or disability? How and when were they assessed?

Both Angela and Barry have been assessed by the SALT team as having significant problems with communication. The SAR has not seen any record of either of them having had an assessment for possible learning difficulties. However, some records refer to Barry having a learning disability, believed to result from brain damage caused by an epileptic seizure.

Question 16:
From your review were there any points where information should have been shared or received by your agency?

There are individual examples where better quality information would have been helpful, such as the initial referral information provided to the District Nursing Service, gave no sense of the level of risks (both to Angela and to lone workers) which were likely to be present. The level of information sharing was sporadic

and quality was variable. On several occasions information was shared at meetings, but key agencies were not present, either because they were not invited, or they simply failed to attend.

However, the SAR has not identified *failure* to share information as having been the fundamental concern. Copious volumes of information were exchanged between all of the key agencies. This included inter-agency referrals, police alerts, a number of safeguarding alerts generated by North East Ambulance Service, MDT meetings, case conferences, planning meetings, e mails, letters, phone calls, etc. The primary concern was not that the **sharing of information was too often seen as a way of shifting responsibility from one agency to another, rather than as a means of developing effective multi-agency collaborations.**

5) Key Learning Points[5]:

- ***Key learning point 1: Mental Capacity Act / missed opportunity***

  The failure to consider use of the MCA (three years before Angela was in fact admitted following an MCA best interests decision, in similar circumstances) was a missed opportunity for much earlier interventions to ensure that Angela would receive treatment for an urgent and potentially life threatening condition. This would then have similarly highlighted the need to consider hospital discharge planning and Angela's mental capacity to make daily decisions (e.g. regarding insulin injections and dietary needs) which could ultimately prove to be "life or death" decisions.

- ***Key Learning Point 2: Inter-agency referral systems***

  It is essential that inter-agency referral systems for vulnerable adults include sufficient checks and balances, to ensure that there is timely follow up. This is a shared responsibility between the referrer and the receiving agency.

[5] The Key Learning Points arise from different events and agency responses, throughout the period covered by the SAR. Some events and responses have resulted in the same (or similar) learning points. A consequence is that some similar learning points are repeated in this summary.

- ***Key learning point 3: Attendance at safeguarding strategy meetings***
  Safeguarding strategy meetings about adults at risk, where physical or mental health problems are highly significant risk factors (as was the clearly the case in this instance) should have professional representation from the relevant healthcare services.

- ***Key learning point 4: Use of 'mental capacity' terminology***
  Professionals should avoid expressing opinions or making generalised statements to the effect that an individual has / lacks "mental capacity". Such statements are (at best) without any useful meaning and (at worst) can lead to inaccurate assumptions about whether or not a person is able to make and implement informed decisions about critical issues such as medical and social care, housing and management of finances.

- ***Key learning point 5: MCA assessments, recording and evidence base***
  Where there is evidence that a person might lack capacity to make an important or potentially critical decision (e.g. consent to medical interventions; where they live; how their care needs are to be met) then an MCA assessment should be conducted. The outcome should be clearly recorded, including a summary of the evidence to support the finding of capacity / lack of capacity, in relation to that decision.

- ***Key learning point 6: Attendance at strategy meetings / safeguarding plans***
  It is of critical importance that Safeguarding strategy meetings should be attended by all of the agencies which have significant roles to play in establishing an effective multi-agency plan, in line with Sunderland's Safeguarding Adults Policy and procedures. Where ongoing risks to vulnerable adults are clearly evident (as was the case with Angela, Claire and Barry) strategy meetings should result in a clear plan of specific actions required from each of the agencies represented. There should also be a scheduled review to ensure actions agreed have been implemented, to monitor safeguarding outcomes and make adjustments to the plan, if needed. None of this happened in this case.

- ***Key learning point 7: Hard to reach people and 'informed dissent'***
  Services working with people with 'hard to reach' people must consider the individual communication needs of the person. This may require special efforts, such as setting out information in an understandable format, or ensuring that the individual has adequate support from somebody who can assist them in reading and understanding the contents. If a person with known problems of mental impairment and mobility problems (which were both known factors for Barry) repeatedly fails to respond to appointment letters for monitoring of a serious medical condition, it is not acceptable to make an assumption of *"informed dissent".*

- ***Key learning point 8: Recording strategy meetings and action plans***
  Multi-agency meetings about adults at risk must have clear minutes including key actions allocated to named workers, for completion within a specified time limit.

- ***Key learning point 9: Best Interests decisions***
  If a patient has been assessed as lacking capacity to make a decision to accept or refuse medical treatment, clinicians then have a responsibility to make a 'best interests decision', which might include actions to ensure that treatment is administered, even though this appears to be against the patient's stated wishes at the time. In this case it had been established that Angela did lack capacity in this respect, but there is no record to show that the responsible clinicians even considered the need for a best interests decision to be made. This was a highly significant missed opportunity.

- ***Key learning point 10: Mental capacity, best interests decisions and the right to self-determination***
  Although the MCA assessment (in Feb 2012) found that Angela lacked capacity to make decisions about treatment and management of her diabetes, it is not clear from the records that the "best interest principle" as laid out in the Act was then followed. The Care Manager's recorded opinion about "not being able to state how people should lead their lives" was a reasonable general statement about the right to self-determination, but should have been robustly challenged, on the basis that Angela had been assessed as lacking mental capacity to make

decisions about treatment for a life threatening illness and her only carer was herself in very poor physical health.

Additionally, serious questions had been raised about Claire's capacity to make decisions on behalf of Angela. In this context, the view that the principle of self-determination should take precedence over all other considerations was seriously flawed. The outcome was that Angela moved back into a situation where her life would be placed at risk.

- ***Key learning point 11: Responding to abuse allegations***
  When Angela made the allegation of sexual abuse, this should have been taken seriously. There should have been a joint ASC /Police investigation and a safeguarding plan put in place, in a timely manner. That this did not happen was a major multi-agency failure.

- ***Key learning point 12: Repeated 'low level' allegations of abuse***
  This issue of repeated reports of "low level" incidents of alleged anti-social behaviour receiving no effective response is an unacceptably common finding of Serous Case Reviews. It is essential that systems are in place to ensure that each incident is not considered in isolation. Where there is evidence of repeated incidents (even where the individual incidents might seem very minor) this should result in a full investigation and appropriate safeguarding strategies where these are found to be needed. If there is evidence of criminal acts of victimisation a joint police / ASC response is essential.

Key learning point 13: Multi-agency support for professionals working with high risk service users

Services working with high risk, vulnerable and uncooperative people in the community are likely to face professional dilemmas on a daily basis. It is essential that they should have multi-agency support and be closely involved and engaged in safeguarding strategies. In the absence of any clear multi-agency safeguarding plans and joint working arrangements, there is an increased risk of professional misjudgements and mistakes happening.

- ***Key learning point 14: 'Think Family/ Whole Family'***

  When agencies are working with two or more vulnerable and high risk individuals from the same family, "*Think Family / Whole Family*" principles should be applied. This will help ensure that the needs of the family as a whole unit are considered carefully, alongside those of individual family members.

  This was especially important for this family, where critical inter-dependencies between individuals were very evident. This does not mean that wider family needs should have taken precedence over the needs of any of the three individuals. However, when assessing need (including single or multi-agency assessments) the family context and the wider impacts of any interventions on all family members should have been considered. This did not happen in this case, due primarily to a lack of communication and joint planning, both within and between agencies.

- ***Key learning point 15; responding to allegations of abuse and to retracted allegations***

  When a vulnerable adult makes a serious allegation of abuse, this should be followed up, in line with multi-agency safeguarding adults policies and procedures. At the time in question, it was a matter recognised good practice, but is now a legal duty under the 2014 Care Act.

  If the allegation is retracted, enquiries should very carefully consider all available evidence about the validity of both the initial allegation and the retraction. In the context of this case, available evidence would have included the previous allegation which Angela had made against Sam. Whatever the outcome, the allegation and the investigation should be clearly recorded, including rationales for decisions taken.

- ***Key learning point 16: Responsibility for carrying out MCA assessments and making best interests decisions***

  The MCA Code of Practice states:

  "The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made."

  The Code of Practice goes on to specify:

  If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent. In settings such as a hospital, this can involve the multi-disciplinary team (a team of people from different professional backgrounds who share responsibility for a patient). But ultimately, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed.

  There was a collective failure on the part of health and social care professionals to understand their respective roles and responsibilities in carrying out MCA assessments and making best interests decisions. This was a major factor leading to increasingly high risk affecting all three family members. For Angela in particular, it was clearly evident that her non-compliance with treatment was resulting in an ongoing risk of death. But still no effective action was taken.

- ***Key learning point 17: Responsibility for assessing and recording evidence base to support judgements about mental capacity***

  There is little room for doubt that the meeting on 12th March reached the correct conclusion about Angela's mental capacity. It is also clear that the decision for hospital admission and treatment of her diabetes was necessary and possibly saved Angela's life. However, this should have been based on a clearly evidenced and recorded MCA assessment.

  It is good practice for MCA assessments in such complex cases to draw on multi-professional expertise and knowledge of the person being assessed. However it is not acceptable (from a legal or human rights perspective) for a multi-agency case conference to assume authority to make a decision on mental capacity. Responsibility for this should have been taken by a suitably qualified medical practitioner involved in Angela's treatment plan.

6) Multi-agency recommendations:

The following multi-agency recommendations are for oversight by SSAB. There are also a number of single agency recommendations, which were identified within agency IMRS. See appendix 1 for a full list of single agency recommendations.

Multi-agency recommendations

1) Integrated services and the role of Voluntary & Community Sectors (VCS) and advocacy services:

SSAB should lead on training, awareness raising and any multi-agency policy procedure and guidance changes required, to improve multi-agency working with adults at risk, who also have complex needs. Priority areas include:

- Raising awareness of the importance of finding out what other services are involved with adults at risk, when making initial assessments.
- Always considering the option of referral to a VCS service for additional advice, support or advocacy services.
- Ensuring that the planned implementation of integrated health and social care services encourages active engagement with local VCS services, in working with adults with complex needs who are at risk.

2) Mental Capacity Act training:

SSAB should arrange a multi-agency audit of MCA training needs, in the light of learning from this case. If unmet needs for single agency training are identified, SSAB should require agencies to arrange relevant training and report back on implementation, within a specified time frame. If multi-agency training is needed, this should be commissioned and coordinated through the relevant sub-group of SSAB. All training arising from this recommendation should specifically consider the role of the MCA in responding to safeguarding concerns about self-neglect.

3) Defining safeguarding thresholds for self-neglect:

There should be a review of SSAB's Multi-agency Adult Safeguarding thresholds guidance, in relation to adults at risk from self-neglect. The aim

should be to ensure consistent approaches to defining thresholds at which self-neglect of personal care, health care and housing needs should be recognised as requiring a strategic safeguarding response.

4) Safeguarding strategy meetings:

SSAB should arrange a review of the effectiveness of the management of safeguarding strategy meetings. Taking account of learning from this case, the review should evaluate (and where found necessary revise) policies, procedures and systems for:

- Invitations: Ensuring all of the relevant agencies (where relevant to the case to include housing providers) are invited to / represented at meetings.
- Ensuring that the views of housing provider representatives at safeguarding strategy meetings are given due consideration, especially where housing needs are a fundamental area of concern.
- Recording: Ensuring meeting contents are accurately recorded, with an emphasis on clear and SMART[6] multi-agency action plans, circulated to all relevant agencies in a timely manner, following meetings.
- Monitoring: Ensuring that agreed actions are followed through, within an effective system to ensure accountability for actions agreed.

5) Challenging assumptions about "informed dissent":

All local GP practices to be advised of key learning from this SAR about the term "informed dissent". GPs should be reminded that informed dissent should not be assumed, especially when the patient is known to have communication problems, learning disabilities or other cognitive impairments. In these circumstances, repeated failures to attend for medical checks or treatments should be considered as possible evidence of a self-neglect adult safeguarding concern

[6] SMART: Specific Measurable Attainable Relevant (& Resourced) Time-bound.

6) Repeated 'low level' incidents:

SSAB should undertake an audit, to establish how effectively cumulative evidence of increased risk, based on repeated 'low level' safeguarding concerns, is identified and then acted upon. If necessary, there should be revisions of policy, procedure and guidance, to address any concerns arising from the audit.

7) Whole Family principles:

SSAB should review multi-agency policy, procedure and practice for working with families looking after one or more vulnerable adults, revising them (if necessary) to ensure that these are informed by Whole Family principles.

8) Carer Support Systems:

SSAB, working with Sunderland Carers' Centre should ensure that all agencies working with adults at risk from abuse, neglect or self-neglect have up-to-date information about Carer Support Systems available in Sunderland. SSAB should also prioritise multi-agency training on working with carers, to include the new statutory duties relating to assessments of carers needs and how those needs can be met.

9) Professional Challenge:

SSAB should ask all agencies to review and report back on how front line staff and managers are supported to professionally challenge decisions (i.e. within their own agency, or decisions taken by partner agencies) where it is believed such decisions are leaving adults at risk, through self-neglect or neglect / abuse by others.

Appendix 1: Single agency recommendations

Northumberland Tyne & Wear NHS Foundation Trust:

1) In line with this case and the Care Act 2014, all professionals in this case will be trained in the use of safeguarding procedures.

2) The training of MCA champions for each ward and department to further strengthen knowledge of MCA and DOLs

3) The use of professional challenge and refresher for staff in the LA dispute resolution process

4) Professionals involved in this case have a responsibility to ensure any safeguarding concerns have been reported when disclosed via the trust IR3 system, monitored by the SAPP team.

5) To share this report with the newly established Principal Care Pathways specifically in respect of family members cancelling appointments, other than the person themselves. The safeguarding team require assurance that the new pathways in place prevents discharge without consent or direct contact with the person.

The social housing provider:

1) Review storage of safeguarding records

2) Staff Training

3) Attendance at Strategy meetings

Sunderland City Council Adult Social Care:

1) Supervision process across ASC to be revisited and revised to ensure there is a standardised and universal approach across the service area. This will included training for managers and senior practitioners.

2) All ASC staff to undertake training and refresher training relating to the operational safeguarding procedures with an emphasis on the area of neglect and self-neglect.

3) All ASC Staff to undertake training and refresher training relating to the application of the Mental Capacity Act, the completion of Mental Capacity Assessments and Best Interest Assessments.

4) ASC Staff to undertake training and refresher training in the application of risk and completion of risk assessments as part of their work.
5) ASC staff to undertake AIS training and refresher training specifically relating to the checking of involvements and the requirement to review historical information at the point of allocation of new work and then on an ongoing basis.

City Hospitals Sunderland NHS Foundation Trust

1) CHSFT staff to undertake more in-depth professional enquiry regarding vulnerable / at risk adults' home, social circumstances and caring arrangements and any subsequent actions taken to be clearly documented in patient records
2) CHSFT staff must undertake formal Mental Capacity Assessments for patients who may lack capacity and document this in the medical records.
3) CHSFT staff must ensure appropriate use of the Independent Mental Capacity Advocate (IMCA) Service for patients who lack capacity and require an advocate
4) Comprehensive education & training to raise staff awareness of safeguarding vulnerable adults, learning disability, MCA & DoLS and role of the IMCA
5) All health care records to clearly identify designated advocates for vulnerable / at risk adults
6) All nursing documentation and assessments to be completed accurately

7) All patients' notes to clearly and accurately record the outcome of case conferences / MDT meetings
8) Staff to clearly distinguish between "Learning Disability" and "Learning Difficulty" in patients' health care records and ensure these patients' needs are assessed and reasonable adjustments made where required.

Sunderland Clinical Commissioning Group

1) The CCG should provide training in relation to the Mental Capacity Act for GPs in Sunderland.

2) Staff at GP Practice 1 should undertake further safeguarding adult training which is specific to their role.

3) Lessons learned from this review should be shared with GP Practice 1 and also disseminated to GP Practices across Sunderland.

4) GP templates for Long Term Conditions, Mental Health, and annual Learning Disability Reviews should be revised to include routine consideration of any issues in relation to Mental Capacity.

5) Sunderland CCG should advise all GP practices that where a GP or practice staff are advised or become aware that a Power of Attorney is in place for a registered patient they should request to see a copy of the original documentation to establish:

- Whether the POA relates to health and wellbeing.
- That the POA applies to the named patient
- Who is authorised to act on the patients behalf
- Whether the documentation is complete and has been registered with the Court of Protection.

The practice should then either record that the documentation has been verified and or scan a copy of the documentation to the patient's medical record.

6) GP Practice 1 to be advised that patients with a Learning Disability or known mental impairment should not be exempted from Quality Indicators unless they have been seen in person by a member of staff from the practice and a valid reason for the exemption has been provided.

7) GP Practice 1 to be advised that they should use the learning from this case to review their Learning Disability register to ensure it is a comprehensive record of all patients with a Learning Disability who are registered at the practice.

8) GP Practice 1 to be advised that they should use the learning from this case to inform a review of their procedures for identification and recording of carers

within the practice.

Northumbria Police

1) Consideration to develop an escalation process after 3 ACNs within a 3 month period to enable referral to Adult Safeguarding.

2) Ensure that practitioners are aware of LMAPS as an option to be considered around safeguarding or managing risks.

South Tyneside NHS Foundation Trust

1) Mental Capacity Act and Mental Capacity Act DoLS – all Lakeside Nursing staff must complete the relevant level of training within 3 months.

2) Safeguarding Policy to be updated and to include practice guidance.

3) Guidance to be developed on use of the Significant Event form which must be contained in the District Nurse Office record (or on an electronic patient record)

4) Specific safeguarding role of the Safeguarding Champion, Safe Care Lead and Caseload Holder to be identified.

5) Multi-agency meeting forms to be completed following attendance at any multi-agency / disciplinary meetings.

6) All team discussions relating to safeguarding adult issues must be recorded to reflect issue, appropriate action to be taken and outcome.