NOTTINGHAMSHIRE ADULT SAFEGUARDING BOARD

SAFEGUARDING ADULTS REVIEW USING THE

SIGNIFICANT INCIDENT LEARNING PROCESS

OF THE CIRCUMSTANCES CONCERNING THE DEATHS OF

MR AND MRS G

Confidentiality statement

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the NSAB/SAR chair.

The disclosure of information (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved

INDEPENDENT REVIEWER:
Mark Dalton **December 2015**

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INTRODUCTION

Introduction to the Safeguarding Adults Review.

1.1 Mr and Mrs G were an older married couple who died within a relatively short period of time of each other. They had an array of complex needs and received a significant amount of support from Health and Social Care agencies to enable them to continue to remain living together at home. Mrs G was diabetic and her death was the result of an overdose of insulin. The final overdose was the third she had taken within the previous 12 months and she had informed District Nursing staff of her intention to take an overdose of insulin that she had stockpiled in the house. She was aged 61 at the time of her death. Her husband Mr G had a diagnosis of Alzheimer Dementia and also suffered from other health problems. He died five weeks later as the result of an aortic aneurysm. He was a few months away from his 80th birthday when he died.

1.2 The decision to make both Mr and Mrs G the subject of this review is because there were a number of inter-dependencies between them that affected the services they received. Mr G had also been seen as a carer for his wife, although it would seem that he was increasingly unable to fulfil this role in the year preceding her death. The period under review covers the final year of Mr and Mrs G's life.

The Decision Making Process.

1.3 Initially Nottinghamshire Healthcare NHS Foundation Trust made a referral for a Serious Case Review concerning Mrs G in January 2015 (prior to the death of Mr G) due to concerns about how underlying mental health problems had been managed alongside her diabetes. The initial trawl for information revealed that Mr G was also in receipt of services and had also recently died. A request was made to commission a joint review in March 2015 and subsequently agreed by the Independent Chair of the Nottinghamshire Safeguarding Adults Board. Although the decision to commission a Serious Case Review predates the implementation of the Care Act 2014 by a few months, the Review is fully compliant with the provisions of the Act.

1.4 Key issues were identified which focussed on the individual and joint assessments of need for Mr and Mrs G. (See Appendix 1 for the full terms of reference).

1.5 The scope of the review was agreed as 22nd December 2013 until 26th January 2015; this period covers one year prior to the death of Mrs G and up to the death of Mr G.

1.6 On this occasion the Nottinghamshire Safeguarding Adults Board agreed to commission a review using the Significant Incident Learning Process (SILP) methodology.

The Key Principles of SILP.

1.7 The key principle of a SILP is the engagement of frontline staff and first line managers as active participants in the review process, alongside members of the Safeguarding Adults Board Serious Case Review subgroup, Designated and Specialist Safeguarding staff. The involvement of frontline staff and first line managers gives a high degree of

commitment to the review process and therefore a greater commitment to learning and dissemination of the lessons from the review.

1.8 The process focuses on understanding why someone acted in a certain way. It highlights what factors in the system contributed to their decision making at the time. This process is separate from any potential grievance process or disciplinary action. It is about open and transparent learning from practice, in order to improve inter-agency working. Importantly, it also highlights what is working well and patterns of good practice.

1.9 This engagement comprises:

- Management reviews being commissioned from all the agencies/providers engaged with the subject of the review during the scoping period,

- All agency reports being shared with Learning Event participants at two Learning Events,

- Learning Events involving a large number of Practitioners, Managers and Safeguarding Lead professionals coming together for a day,

- A draft Overview Report which critically reflects the management reviews that gives equal weight to the comments and perceptions of the participants in the learning event,

- A second Recall Learning Event at which the first draft of this Overview Report is debated.

THE PROCESS

Agency Involvement.

1.10 Management Reviews were provided by the following agencies:

- Bassetlaw Clinical Commissioning Group
- Comfort Call
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- East Midlands Ambulance Service
- First Care DCA Ltd
- New Directions Nottinghamshire CRI
- Nottinghamshire Adult Social Care Health and Public Protection
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottinghamshire Police

Although a key agency in this case, the GP practice did not fully engage with the review process either in terms of the information they provided from their records or by participating in the Learning Events.

Engagement with the family.

1.11 Mr and Mrs G had four children. One of their younger daughters and her partner were heavily involved with their care and have met with the Lead Reviewer and the Nottinghamshire Safeguarding Adults Board Manager to discuss the help and support offered to Mr and Mrs G.

1.12 Their views have been incorporated throughout the report and have influenced some of the discussion of the emerging themes from this case.

Key Practice Episodes.

1.13 A key practice episode (KPE) can be a single event or a particular time period where there were key changes in the circumstances of the case which require further analysis. A KPE can be good or problematic and the use of the word "key" emphasises that this is not a list of every event in a person's life; rather it is intended to shine a light on those events which seem significant in understanding the decisions made at the time.

1.14 Inevitably there is some overlap between key practice episodes due to the complex interface between different services.

BACKGROUND INFORMATION

2.1 Mr and Mrs G had both worked in the caring professions and had been heavily involved in community activities in the past. These gradually became curtailed as Mr G's level of confusion became more noticeable. They both suffered from several chronic conditions that were likely to deteriorate with age. Mr G, for example, had been diagnosed with dementia in 2004 and Mrs G had been an insulin-dependent diabetic for 30 years. She also had a history of problems with her memory and possible dementia.

2.2 Despite these medical conditions their health needs and social circumstances were relatively stable until April 2013 when Mrs G became seriously ill with an infection unrelated to her diabetes. The illness caused Mrs G to fall into a coma and suffer a stroke and numerous chest infections and she spent four months in hospital. Family members describe the illness as life changing; there was a marked personality and mood change and she was initially bed bound and unable to complete simple tasks and take care of herself. She retained the memory of being independent and it was a source of some frustration and resentment to her that she was no longer capable of tasks she knew that she had once done with ease. Her mental health was kept under close review and she was referred to the Working Age Dementia Team.

2.3 Mr and Mrs G's needs were managed in a way which allowed them to remain at home; Mrs G was allocated a Social Worker from the Physical Disability Team. Mr G was recognised as a carer for his wife; an arrangement that seems to have been set up following her discharge from a nursing home in September 2013 (although not all agencies were aware of this). The degree to which he was able to provide "care" was limited by his capability as a dementia sufferer, and her willingness to be cared for by him

2.4 The family question whether Mr G ever had the capacity to care for his wife; they maintain that he was able to disguise the level of his confusion and talk convincingly about what he was able to do. However he was not able to follow through his good intentions and because of his illness he was too unreliable to help in managing Mrs G's diabetes. These reservations were not expressed to the Social Worker or Health staff at the time, and the evidence from the Social Care assessment was that Mr G was capable of undertaking household tasks.

2.5 An important factor in understanding the delivery of services is a recognition that the relationship between Mr and Mrs G in their final year was often perceived as hostile and acrimonious. There was a mutual inter-dependence but this was often a source of resentment on the part of Mrs G. It is an aspect of professional record keeping that we tend to record the remarkable and the exception to the norm and incidents of concern. Therefore there are many examples in the records of the arguments and rows between them, however the family have also reminded us that at times the pre-existing positive, caring and good humoured relationship between the couple was also in evidence.

2.6 In September 2013 a care package had been arranged following Mrs G's discharge from a Residential Home where she had received some respite care. A pattern of care had been established whereby Mrs G was receiving regular daily visits from District Nurses (who would visit in pairs because of the threat of aggression from Mrs G) to test blood sugar and ensure that she took her insulin. In addition, the Diabetic Nurse would also regularly review her diabetes and support the District Nurses. A Social Worker from the Physical Disabilities Team visited regularly and arranged for a Support Worker to offer help with personal care.

2.7 By October 2013 Mrs G asked for the care package to be cancelled as the couple felt they were receiving sufficient support from family and friends. The Social Worker agreed to cancel the care and to review the situation in three months' time in January 2014. This proved to be an astute decision; as the situation at home soon broke down. The family have informed the review that in reality the family support was limited and was never going to be sufficient to meet their parents' needs; it was an example of how convincing Mr and Mrs G could be in their dealings with professionals. It also demonstrates that, despite family and professional misgivings, their right to choose and make decisions was being respected.

2.8 In December 2013 two significant events occurred which suggested that there were additional stresses in the relationship; on 26th December Mrs G walked to her local Police Station to complain that Mr G would not leave her alone or let her do anything for herself. Mr G had followed his wife to the Police Station and the Police were able to resolve the issue and take them both home.[1] The second incident two days later on 28th December involved a 999 call to the Ambulance Service by Mrs G. She reported feeling generally unwell and in the light of her medical history she was taken to the Emergency Department of the local hospital.

[1] The police completed a DASH (Domestic Abuse, Stalking and Honour Based Violence) and assessed the risk as standard; they also raised a safeguarding concern which was submitted to the MASH. (Multi Agency Safeguarding Hub).

2.9 These two incidents are significant because they provide some evidence that the informal care regime was not meeting their needs, and the state of their relationship meant that they were no longer able and willing to work together.

2.10 On 8th January 2014 Mr and Mrs G were visited by Social Care and Mr G was assessed in his own right, but not deemed to be eligible for support from the Older Adults Team at this time. The informal support from family and friends was not sufficient to meet their needs. However the only care package they would accept at this time was relatively modest, comprising of six hours of support primarily with the aim of giving Mr and Mrs G a break from each other.

Summary – background information.

2.11 In summary, there is a contrast between support required for the complex health needs of both Mr and Mrs G and their social needs. This was a matter of choice for Mr and Mrs G; they had declined help from Adult Social Care, and were possibly reluctant to admit that due to social isolation, their deteriorating relationship and the impact that health problems were having on their ability to cope, they needed help.

2.12 However it should also be remembered that the backdrop to these events had been the life-changing and debilitating illness Mrs G had suffered in 2013, and while she may have seemed mentally more confused, physically she was actually improving. Family members consider it remarkable that she had the strength to walk from home to the Police Station in December for example.

2.13 As always, the key determinant of a package of support is what is acceptable to the service user; Mr and Mrs G were both presumed to have mental capacity[2] to make decisions about their own care and clearly exercised choice over the amount of support they wanted at this time.

Key Practice Episode 1- safeguarding referral made to MASH (Multi-Agency Safeguarding Hub) by District Nurse April 2014.

3.1 In early April 2014 concerns were raised about the level of support Mrs G was receiving; on 2nd April her GP checked with her Social Worker over the minimal help being provided to the couple. The Social Worker was able to confirm that help with direct payments to assist in accessing the community was all they would accept.

3.2 Two days later, Mrs G was referred to the District Nursing team by the hospital for an assessment for support for her diabetes and other long-term conditions. The District Nurse visited the home to complete the assessment on 23rd April, when she was informed by Mrs G there were a number of issues they had been "hiding" from professionals. These included the extent to which Mr G was drinking and the fact that she was very unhappy and had wanted to commit suicide earlier that day, although these feelings had now passed. She also told the District Nurse that she would discuss this with her Social Worker who was due to visit later that day.

[2] It should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. Mental Capacity Act 2005. Code of Practice. p15.

3.3 However it was clear that Mrs G did not share these issues when the Social Worker visited; in fact the Social Worker was asked to leave by Mrs G before the assessment could be completed. The Social Worker had witnessed Mrs G threaten physical harm on Mr G and was worried to the extent of making a referral to the Police requesting a safe and well check later that day. The Police liaised with Mrs G's daughter and the GP and it was agreed the best course of action would be for the GP to visit and request Police assistance if he was concerned. As would often prove to be the case, the situation had lost some of its aggression and tension without being resolved. However the GP was concerned about Mr G's ability to check his wife's blood sugar levels in view of his dementia and suspected drinking.

3.4 The Social Worker visited again the following day to check on the situation. Once again a level of hostility from Mrs G meant that these issues could not be constructively explored. However it was clear that Mrs G would need help managing her diabetes and that the relationship between her and Mr G was a cause for concern in itself. However, Mrs G had rejected help from the Community Nurse and the case had been closed to the Community Nursing Team.

3.5 The Community Nurse subsequently made a safeguarding referral to the MASH (Multi-Agency Safeguarding Hub) because "she was unhappy with the lack of input for diabetes management and the welfare of the patient". In reality there were additional concerns that could also have been raised; Mrs G refusing to take her insulin, the level of emotional abuse and threat of violence, Mr G's drinking and Mrs G's suicidal thoughts were all known about – to varying degrees – to different professionals.

3.6 Discussion between the advanced social work practitioner (ASWP) for the MASH and social worker acknowledged the existing close involvement with the family and it was decided that it would not be appropriate to undertake a safeguarding assessment given the level of work already being undertaken.

Summary - KPE 1.

3.7 This was the second incident notified to MASH within four months. Unfortunately the focus on the management of the diabetes as the safeguarding concern – when it could also legitimately include reference to Mrs G's suicidal thoughts, on-going emotional abuse and the threat of violence within the couples' relationship – did not prompt a coordinated response.

Practice Messages – KPE 1.

3.8 The detrimental effect Mr and Mrs G's behaviour was having on each other's health suggests that their relationship problems needed to be managed differently and a coordinated approach adopted. At a minimum a multi-disciplinary meeting between the agencies involved would have been helpful.

3.9 The issue of mental capacity[3] had been raised by some professionals, prompted in the main by Mrs G's rejection of additional help. However it was the professional

[3] Mental Capacity Act 2005 – the Act has 5 statutory principles which are of relevance here:
1. A person must be assumed to have capacity unless it is established that they lack capacity.

opinion of all the practitioners who worked face to face with Mr and Mrs G that, in spite of their mental health problems, they clearly retained the capacity to understand the choices they made and had an awareness of the potential consequences.

3.10 The assessment of mental capacity is a professional responsibility for all agencies. Where there is a disagreement between professionals over an individual's mental capacity, the formal assessment should be undertaken by the person with the relevant professional background and training.

3.11 Professionals should be aware of the potential pitfalls in relying on service users giving information to other agencies. Throughout the period under review, there is evidence of good communication between professionals. This was confirmed by the individuals involved and their managers at the Learning Events. This is one of the few examples where, possibly as a consequence of reassurance from Mrs G that she would discuss the matter with her social worker, professionals did not directly pass on their concerns to each other. In this case the information Mrs G had discussed with the District Nurse was not passed on to the Social Worker. Inevitably service users can be quite selective in the information they share. It would have been prudent for the professionals to communicate directly with each other.

3.12 Mr G's drinking could also have prompted a referral to specialist alcohol services. Given his previous history, an early referral would have been appropriate.

3.13 The referral to the MASH appears to have contained limited information and focused on a specific area, Mrs G's care, i.e. concerns about the management of her diabetes with a non-specific reference to the "welfare of the patient". Referrals about Safeguarding matters should be as explicit and detailed as possible.

Key Practice Episode 2 - June 2014 - admission to Mental Health Ward. Subsequent events include overdose on home leave, concerns about home situation and domestic abuse.

4.1 During May and June 2014 a number of possible solutions had been tried to improve the lives of Mr and Mrs G. These included a period of respite in response to Mrs G stating that she did not want to live at home or with her husband. However, this arrangement broke down within 24 hours; Mrs G returned home and agreed to additional support with personal care to allow her to remain there. At this time she was also receiving twice daily visits from the District Nurse to support her insulin use, however, this arrangement broke down on 30th April; Mrs G stated that she had been diabetic for 30 years and was able to manage her symptoms and did not want further support from the District Nursing team. As a result of this she was discharged from their caseload. This decision was again revisited on 21st May following concerns from the

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Diabetic Clinic and Mrs G's GP, after six failed attempts to visit her; she was finally seen at home on 4th June. She again reiterated her decision that she did not wish for contact from the District Nursing Team.

4.2 The constant themes in the dialogue between Mrs G and those working with her were Mrs G's ambivalent attitude towards remaining in her marriage and the degree to which she would accept help in managing her diabetes and personal care. Numerous attempts were made to provide support on both these issues but, without exception, they were short lived and usually reversed within a couple of days of being put in place.

4.3 The GP made a referral to the Crisis Resolution and Home Treatment Team (CRHT) on 19th June, where Mrs G was assessed and accepted the service due to her suicidal thoughts. A multi-disciplinary meeting was held on 20th June and it was agreed to admit Mrs G as a voluntary in-patient due to the concerns about her safety in the community. However Mrs G subsequently refused to be admitted as a voluntary patient and was detained under Section 2 of the Mental Health Act 1983 & 2007[4].

4.4 One of the first actions Mrs G took whilst in hospital was to raise concerns about how her husband would cope without her. A visit from the Older Adults Team was arranged and took place on 8th July, but again the offer of care services was declined.

4.5 A date for discharge from hospital was arranged for 14th July[5]. During her time in hospital, Mrs G had reiterated her unhappiness at home and suggested there may have been more incidents of domestic abuse. Her attitude towards Mr G oscillated between feeling that she wanted to leave him and feeling that she should stay in the relationship because he could not cope without her. She also accepted that she now needed help with her medication and agreed to accept support from the Diabetic Service.

4.6 Given previous experience it was perhaps unsurprising that on 15th July – her first day back at home – Mrs G had refused to see the Diabetic Nurse and told her not to come back, however she was still under the care of the Crisis Team at this point.

4.7 An intentional overdose occurred on 16th July, leading to a further admission to the Mental Health Ward. Two days after Mrs G returned home, Mr G unfortunately fell whilst intoxicated and was admitted briefly to hospital. An offer of help from the Intensive Rehabilitation Intervention Service (IRIS) team had been made that was rejected by Mr G. Subsequently Mr G accepted the meals at home service, but did not require any further help at that stage and his case was closed on 5th August.

4.8 Mrs G was next hospitalised on the 6th August due to gastric problems and diarrhoea. This resulted in a two-day stay after which she was discharged home. This was the first of a series of short admissions which seem to be the result of digestive and gastric problems.

[4] This section of the Act allows for detention for assessment up to 28 days

[5] A full package of care for Mr and Mrs G was not yet in place; so Mrs G was given extended "home leave" and referred to the Crisis Resolution and Home Treatment Team (CRHT) for support.

4.9 The mental health admission brought into focus the extent of the difficulties being faced by Mr and Mrs G. Of particular significance was the open acknowledgement of the deterioration in the relationship between the couple, including the possibility of separation. The possibility that Mr G's drinking might be a problem had also been raised by Mrs G in her discussions in hospital and through his recent falls being associated with alcohol consumption.

4.10 Finally, the issue of whether either party could be considered the carer for the other was raised by thinking through the options should the couple separate. It would seem that Mrs G would sometimes recognise that her husband would not cope without her, also the concentration on planning support at the point of discharge called into question the apparently long-standing arrangement that Mr G was, in some way, the carer for his wife. It would seem that Mr G had been designated as a carer at some point in the past[6], although he was not capable of caring for her at this time. In the context of Mrs G's needs, caring for her would entail being able to check her blood sugar levels and having a basic grasp of what to do if this was too high or too low, preparing meals, personal care and household chores. Unfortunately many of these tasks were beyond Mr G by this time.

Summary - KPE 2.

4.11 Both Mr and Mrs G had a habit of rejecting offers of help; whether this was due to personal pride or resenting professionals being involved with their family is not known. The case records from all agencies demonstrate that they rejected help more often than they accepted it. This was the full range of services from carer support through to the District Nurse and other forms of medical help.

4.12 Concerns were no longer mainly focused on Mrs G's management of her diabetes and her suicidal ideation. Additional concerns about the deteriorating relationship between Mr and Mrs G had become apparent and concerns about Mr G's drinking also needed to be addressed.

4.13 Mr G had a history of alcohol dependency, although he had successfully managed this for a number of years. His recent drinking would be a further source of conflict and an obvious cycle of cause and effect became evident: Mr G allegedly drank because of the hostility and aggression directed towards him and this in turn proved to be another reason for further hostility and aggression. Patterns of behaviour can be relatively easy to recognise from the outside but much more difficult to break for the protagonists. It would also suggest that despite protestations to the contrary, paradoxically Mr and Mrs G did not really want the situation at home to change.

Practice Messages – KPE 2.

4.14 A case conference would have been extremely helpful at this point given the challenges in meeting the needs of Mr and Mrs G. Professionals would also have had the opportunity of considering a joint approach to the relationship difficulties, and

[6] Agencies had conflicting information about whether Mr G should be considered as a carer for his wife; some of the carer agencies involved have clear referral information that this was the case, however other agencies such as the District Nurses were not told this. In practical terms, Mr G. Probably did not have the capacity to manage his wives diabetes, and even if he had this would not have been acceptable to her in July 2014.

acknowledging the cycle of Mr and Mrs G agreeing to plans in the short term and changing them with no notice.

4.15 The interface between hospital and community services is a crucial point in planning services and the discharge planning process did not fully take into account the difficulty in supporting Mrs G on her return home. A pattern of discharges being followed by re-admission in a short period of time became the norm.

4.16 It is difficult to establish if a "lead" agency was taking overall responsibility for coordinating the package of care. Focussing on one aspect of Mr or Mrs G's care lead to a somewhat piecemeal approach; an identifiable lead agency could have helped counteract this tendency.

4.17 The quality of discharge planning may have been improved if the Mental Health Ward had closer contact with other family members and involved them to a greater extent in discharge planning.

4.18 The concern about Mr G's drinking in July would have been an appropriate time to consider a referral to specialist alcohol services.

4.19 The abusive nature of the relationship could also have been considered more proactively. Examples of emotional abuse and threats of physical abuse between Mr and Mrs G were known to different professionals working with the couple. The existence of domestic abuse in older relationships often goes unrecognised.[7] and the risk of further abuse should have been properly assessed using the specialist risk assessment tool.[8]

Key Practice Episode 3 - December 2014 – Discharge from hospital. Hiding insulin and deteriorating relationships all round.

5.1 During the three months prior to December there had been a succession of minor crises involving the deteriorating physical and mental health of Mr and Mrs G. These had included ambivalence about whether the couple should remain together, whether they should move into some kind of supported accommodation and Mr G's increased alcohol consumption.

5.2 There had also been six hospital admissions for Mrs G, including two following an overdose and Mr G attending A & E twice following a fall when drunk. Mrs G's second overdose prompted a month long admission and she remained an in-patient from 28th October through to 2nd December.

5.3 Mr G was now in receipt of a care package in his own right from the Older Persons Team (although in practice he had been supported by Social Care who had arranged several short term packages of support in response to crises for several months). A range of services were involved – mainly on a short-term basis – to address presenting problems as they occurred. These included the Mental Health Services for

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[7] How professionals' false assumptions allow domestic abuse between older couples to go unnoticed. Community Care. http://www.communitycare.co.uk/2015/03/26/domestic-abuse-doesnt-stop-at-60/

[8] See footnote 1 (page 6)

Older People's team who assessed Mr G. This assessment had been requested by the Crisis Resolution and Home Treatment (CRHT) team. The Falls Team had also visited Mr G following a fall in September.

5.4 During October there was the first attempt to engage Mr G with New Directions Nottinghamshire[9]. He attended an initial assessment on 20th October and was assessed as minimising the extent of his drinking, but agreed to further appointments. However he subsequently refused offers of face to face meetings and would use the need to visit his wife in hospital as the reason for this. Mr G would have no further contact with New Directions until he was re-referred by the Rapid Response Team in January 2015.

5.5 A package of care for Mr G had been agreed – this comprised two visits per day to assist in meal preparation and general household chores. On the significant proportion of scheduled visits Mr G was not at home, and therefore did not benefit from the support. Mrs G received twice daily visits from the District Nurse to help with her insulin injections and received support from a Care Agency in her own right. However, again, a significant number of these visits were unsuccessful because Mrs G would not allow workers in.

5.6 Mrs G was discharged from hospital on 2nd December; the discharge diagnosis given was that of Adjustment Disorder[10]. The decision to move into some form of residential care had been reversed and she was discharged home with a package of support. The referral was made to the Crisis Resolution and Home Support (CRHT) team for a seven-day follow-up visit. The visit on 7th December coincided with a visit from the District Nursing team. Mrs G was agitated and very angry; this was directed at both her husband and the professionals visiting. In the course of the visit, she disclosed that she had some insulin around the house, but refused to disclose its whereabouts. The District Nurse then left the property and Mrs G appeared to calm down, stating "don't worry, I'm not going to overdose". However a decision had been made to change the type of insulin prescribed to Mrs G in between October and November 2014. Previously she had taken what is described as a rapid/intermediate acting form of insulin. She was subsequently prescribed a long-acting form of insulin used to treat adults with type 2 diabetes and is taken only once per day. It is a possibility that Mrs G did not understand, or had forgotten that her medication had significantly changed.

5.7 The CRHT worker also left the property at Mrs G's request. The District Nurse was uneasy leaving the situation and concerned about the suicidal thoughts and alleged stockpiling of insulin. After consultation with her senior she alerted the out of hours GP and the NHS non-emergency service and an ambulance was called.

5.8 Mrs G refused to cooperate with the ambulance crew and did not allow them to complete observations and refused to go to hospital. The ambulance crew assessed her as having the mental capacity to refuse treatment or transport and she remained at home. The ambulance crew referred back to Social Care and the GP because of their concerns about her mental health and the social conditions.

[9] New Directions Nottinghamshire is the local provider of drug and alcohol recovery services

[10] An Adjustment Disorder occurs when an individual is unable to cope or adjust to a particular stress or major life event and their reaction is more severe than we normally expected. Adjustment disorders are also associated with a higher risk of suicide and suicidal behaviour.

5.9 The following day, the 8th December, Mr G called 999 having found his wife slumped in a chair and stated that she had taken an overdose of insulin. An ambulance attended and provided some treatment to stabilise her condition before transporting her to hospital.

5.10 Unfortunately on this occasion there was no recovery and Mrs G died 14 days later on 22nd December.

Summary – KPE 3.

5.11 The CRHT and District Nurse had different perceptions of Mrs G's problems; primarily the crisis team considered that this was a social problem (the stressor being the relationship between Mr and Mrs G), whereas for the District Nurse the primary concerns were the management of diabetes and the mental health problems.

5.12 It is likely that all of these issues could have been managed if there had been a strong relationship between Mr and Mrs G and they were willing to work together. Unfortunately this was not the case and a series of incidents, probably fuelled equally by Mr G's use of alcohol and Mrs G's mood swings as a result of her misuse (sometimes deliberate and at times accidental) of her insulin, led to allegations of violence between them. No acts of physical violence were ever witnessed by professionals, although they heard several arguments and had incidents reported to them. The most serious of these occurred on 4th December. Mrs G contacted the Police and reported that her husband had attacked her and pushed her to the floor. The Police attended and established that no assault had occurred but there had been an argument over a set of keys, which they had both been trying to grab. To avoid further problems that day, Mr G agreed to stay at a friend's house overnight and was taken there by the Police. The Police undertook a further safe and well check the following day, and both Mr and Mrs G confirmed that everything was fine.

5.13 Family members have shared their view that Mrs G's final overdose was the result of an accident. They believe that she had been discharged from hospital with a different dosage of insulin; a slow release version which came in larger doses. The advantage would be that it reduced the number of injections to be given in a day. Due to her unfamiliarity with the size of the dose in each syringe, the family believes that Mrs G had taken more than she had intended with fatal consequences.

5.14 It remains a possibility that Mrs G, who had been diabetic for 30 years, overdosed on insulin which she had stockpiled over a period of time and the overdose was completely unrelated to the recent change of medication. However it has been established that the type of insulin prescribed to Mrs G had been changed from a rapid/intermediate acting form of insulin to a long-lasting one. The Diabetic Nurse recorded on the medical notes that Mrs G "…has previously taken overdoses mixed insulin recently when she was at home, and said she wanted to take her own life. So for safety continue on L (the long form of insulin)". This was a logical and considered action to take, given the history of overdoses. It is not possible to ascertain whether Mrs G understood the significance of the change of insulin and whether she deliberately ignored the information she had been given about the risks of overdosing.

Practice messages – KPE 3.

5.15 At the time of Mrs G's discharge from hospital on 2nd December it would have been helpful to convene a multi-disciplinary case conference to look at the safeguarding issues for both Mr and Mrs G. Previous history would strongly suggest that the frustrations Mrs G felt living with Mr G would affect her mood and exacerbate her unhappiness.

5.16 The number of hospital admissions and rapid breakdown of arrangements to support Mrs G at home lends weight to the theory offered by the family that admission to hospital may have represented a respite from the difficult home situation for Mrs G. It is possible that she would create a situation where she was admitted to hospital where she felt safe. Discharge plans may therefore have been better informed if they had consulted the family.

5.17 It has not been possible to verify the truth of the family's belief; however it must be considered as a possibility given Mrs G's insulin dosage had changed. This is potentially a key piece of learning for agencies; to ensure that patients are fully aware and conversant with any changes to their medication. Equally importantly, the professional network must also be kept fully informed of these changes and that vulnerable people are monitored for a time after changes to medication are introduced.

Key Practice Episode 4 – January 2015 – care for Mr G.

6.1 Mr G's needs were centred on two issues; his consumption of alcohol and the relationship with his wife. From the evidence it would seem that he had a long standing problem with alcohol although in the years leading up to the period under review this was controlled. In the year under review his drinking again became an issue. It appears that he regularly drank more than he would admit to and that it was a source of conflict between Mr and Mrs G.

6.2 The two weeks Mrs G remained in hospital in December were a period of limbo for Mr G; he wanted to remain at home, but also wanted to see what Mrs G's needs would be before making plans. A further MASH referral was made by the District Nurse on 16th December. At this time Mr G was receiving regular Home Care visits twice daily. A proportion of these were not successful, with the added concern that Mr G may have been at the pub in the early morning.

6.3 Of course it must be remembered that Mr G had been recently bereaved and at a time of year when it is particularly difficult. Carers became increasingly concerned about his level of confusion. His drinking may have increased – or he may have been more open about the amount he consumed. On 8th January he attended A & E because of a fall when intoxicated and was kept in overnight. He was discharged with the support of his family the following day. On 12th January the District Nurse made a referral to the Alcohol Team due to his reported consumption of a bottle of vodka per day.

6.4 Professionals were concerned about Mr G both in terms of his alcohol consumption and his low mood following his wife's funeral. The care package was reviewed and increased and a number of group activities identified, and Mr G attended his first session of the Age Well group on 20th January. On the same day his GP made a further referral to New Directions in recognition of the long-standing problem with alcohol and the recent additional stress brought on by bereavement. He suffered a further two falls due to intoxication on 15th and 22nd January and attended the GP surgery on both dates to have a wound to his ankle dressed. Mr G was unable to attend his second Age Well session on 23rd January due to the fall he had suffered the previous day.

6.5 On 26th January Mr G attended his first appointment with New Directions. Mr G recognised that he needed to reduce his consumption and agreed to a recovery plan.

6.6 Mr G collapsed at home later the same day and was discovered by his daughter who called the ambulance. He was very unwell and transported to hospital. He had suffered a ruptured aortic aneurysm[11]. Unfortunately he did not recover and died in hospital later that day.

Summary – KPE 4.

6.7 The eventual cause of Mr G's death was not predictable although his lifestyle was unhealthy and he was at greater risk of illness and accident due to his use of alcohol and issues resulting from his dementia. However at the time of his death services were still aimed at improving the quality of his life, curbing his alcohol consumption and planning to meet his care needs.

6.8 The focus was on managing and reducing Mr G's alcohol consumption. Given that all of his falls had occurred whilst he was intoxicated this was the right priority. However it should be remembered that he was still grieving and adjusting to the death of his wife and these factors would also have a major impact on his ability to cope.

Practice message - KPE 4.

6.9 Working with someone in the early stages of grief is clearly difficult and sensitive work. However because of the on-going physical and mental health concerns, professionals attempted to engage him in services that would address some of his health needs and also provide some emotional support. There can be a tendency to "back off" in times of grief, and it is to the credit of the workers involved that they had services arranged that would have addressed some of Mr G's needs.

[11] An abdominal aortic aneurysm (AAA) is a swelling (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body. A ruptured aneurysm can cause massive internal bleeding, which is usually fatal. Around 8 out of 10 people with a rupture either die before they reach hospital or don't survive surgery. NHS Choices. (http://www.nhs.uk/Conditions/repairofabdominalaneurysm/Pages/Introduction.aspx)

KEY FINDINGS AND EMERGING THEMES

Emerging Themes:

Assessing capacity and capability.

7.1 Throughout the period under review there are several occasions where the assessment of capacity became an issue, with professionals disagreeing about whether Mr or Mrs G had mental capacity. In addition, the family have also questioned whether Mr G should have been assessed as having mental capacity to care for Mrs G in 2013 because of his dementia. The capacity of a person with dementia will fluctuate and at various times over a number of months Mr G was seen undertaking tasks around the house suggesting that he could provide a level of day to day care.

7.2 Members of the family accept that Mr G could be plausible and convincing and superficially present a picture of competence which belied his actual ability. For a number of years, with the gradual onset of dementia, Mr G had become increasingly dependent on his wife. There is no doubt that he sincerely believed he had the capacity to look after her, and would tell people that this was what he wanted to do. However, the reality was that he had become very forgetful and existing within his own world and unsure of the distinction between what he had done and what he thought he had done.

7.3 It should also be remembered that if a person is assessed as lacking capacity decisions should still be made in their best interests and their wishes and feelings cannot be ignored. It is apparent that at times Mr and Mrs G would present as fully competent in making decisions about their own well-being and care, but it was also known that Mrs G's capacity would be affected by changes to her medication and her mental health, while in the case of her husband, the assessment of capacity for a person with dementia needed to be based on longer periods of observation and taking into account the views of family and other carers.

7.4 The Mental Capacity Act is a public safeguard, not a practice tool; its purpose is to afford vulnerable people protection. There are challenges for professionals and family members in acting within the letter and spirit of the Act. The question posed by an assessment of capacity is decision specific; and relates to the ability to make a particular decision at a particular time. It is an important principle that a decision about overall capacity is not extrapolated from a specific example.

7.5 This review has also raised an important distinction between "capacity" and "capability" and the tendency to confuse the two. Mental capacity is clearly defined in the Mental Capacity Act and refers to the cognitive ability to understand and make decisions. "Capability" has no legal definition and the word is not used in the Mental Capacity Act in any context, however on a day to day level the capability of a person to undertake tasks is taken as an indicator of the truthfulness or accuracy of the assessment of their "capacity".

7.6 It is usual in the context of an assessment under the Care Act to consider the abilities of the individual being assessed and "ability" and "capability" are synonyms used

inter-changeably. The fact that an individual no longer has the capability to do something should not, in itself, be taken as evidence that they lack the capacity to do it. Under the Mental Capacity Act and the Care Act individuals retain the right to make "unwise decisions"[12] and this would include undertaking tasks that they had variable capability of completing.

Assessment of needs.

7.7 There was a great deal of good practice in evidence in this case. The respective Social Workers for Mr and Mrs G were tenacious and creative in responding to their needs. The Social Worker for Mrs G had the most involvement and played a key role in coordinating packages of care.

7.8 However, it became apparent that a repetitive sequence of admissions to hospital, followed by discharge back home had developed in the months before Mrs G's death. The Social Worker was busy with the day-to-day case management tasks alongside the rest of her workload. There is no evidence in the Adult Social Care Management Review of management oversight or supervision discussions which focussed on this repetitive pattern of admissions and sought to respond in a different way.

7.9 Initially, Mr G had been assessed as a carer, and although he was known to be a dementia sufferer this was not thought to be too severe to prevent him from playing an active part in his wife's care. In retrospect family members had a different view; they accept that he had good intentions, and probably believed that he was capable of offering care. However, they believe that although he could talk convincingly about his ability, the reality was different and he was more limited because of his illness. Therefore the initial assessment may have been over-optimistic in terms of his ability.

7.10 In the case of Mr and Mrs G the notion of "carer" was not a helpful concept. To a certain extent they both regarded themselves as the carer of the other. Mr G would routinely describe himself as Mrs G's carer, and in turn she would cite his inability to cope without her as the reason for not leaving him. This mutual dependence for familiarity and companionship ultimately was more important than the aggression and hostility that professionals sometimes observed.

7.11 From the perspective of Social Care it would seem that although Mr and Mrs G were allocated to separate Social Workers from different teams, in reality it was impossible not to see them as a couple as their needs were inextricably bound together. On a day-to-day level communication between the respective Social Workers was good; there was mutual support and effective information sharing.

7.12 It is not clear whether the inter-dependence of the couple was acknowledged in the management and supervision offered to all of the workers. The demands of this case meant that joint supervision would have been particularly helpful in devising a strategy to respond to the expected crises. At this particular time, case supervision was provided regularly in the Physical Disability Team (Mrs G's case was discussed five

[12] The fourth principle of the Act: "A person is not to be treated as unable to make a decision merely because he makes an unwise decision" Mental Capacity Act.
(http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf)

times in supervision during 2014). However there were difficulties experienced in providing consistent supervision to the Team. While issues of accountability and statutory responsibility were covered, there was no capacity for focussed and challenging supervision to support the worker with a difficult case.

7.13 In complex cases such as this there are a number of factors which exacerbate risk and also make it difficult to assess. Supervisors of front line practitioners in all disciplines should provide within their supervision regimes time for reflection, help in identifying patterns of behaviour, signposting to specialist advice and help in identifying strengths within the professional network and the family.

Working with Mr and Mrs G as a couple.

7.14 The information provided as part of this review from the various agencies suggests that, for the most part, agencies responded to the needs of Mr and Mrs G as individuals and had a primary service user/patient. The impact Mr and Mrs G had on each other impinged on these plans to such a degree that a formal acknowledgement that there was an important relationship to deal with may have been useful and prompted more effective joint planning.

7.15 In the face of Mrs G's dominance it is apparent that on occasion Mr G's needs were in danger of being overlooked. A consideration of the dynamics of the relationship may have been helpful in two specific areas: firstly with regard to discharge planning, any plans made on the basis that Mr G could provide safe care for his wife, quite apart from any involvement in the administration of her medication were unrealistic. Secondly, it may have helped manage the concern about domestic abuse more productively.

7.16 The family's view is that Mr and Mrs G were quite taciturn about sharing information about their personal and family history; it became apparent through the course of this review that little information about their lives before they became service users was known to professionals. Information about the dynamics of the relationship and differing allegiances within the wider family may have helped plan more realistic family support.

Management of medication.

7.17 Diabetes is associated with an increased likelihood of anxiety disorders and poor diabetes control has been known to lead to depressive illnesses. Mrs G's health needs were complex, and to some extent contradictory. On the one hand she was seen by her family as making a slow recovery from the serious illness she suffered in April 2013 - evidence for the recovery was improving strength and mobility. On the other hand the number of hospital admissions in a short space of time suggests a much more fragile state of health.

7.18 It seems likely that her condition was exacerbated by two factors, firstly the memory of what she had once been capable of doing and secondly the burden of living with a demanding chronic disease. Mrs G would also probably have added concern about her husband to that list. [13]

[13] Based on her views expressed to nursing staff and her social worker

7.19 It is notable that when Mrs G was admitted to hospital and her medication and diet stabilised she usually responded well to treatment and could be discharged fairly quickly.

Domestic abuse.

7.20 Domestic abuse may not be the most helpful construct to apply to this relationship; family members have stated that it had been a stressful relationship for a number of years and deteriorated as Mr G's dementia worsened.[14] However, before Mrs G's illness in 2013 they were able to live independent lives and had enough social outlets and independence to deal with any stress. The deterioration in the relationship seems to be borne of the frustration regarding health problems which forced them together and made them dependent on each other and outside care.

7.21 Mrs G made two separate complaints of domestic violence against Mr G; on 26th December 2013, when she walked the half mile to the Police Station, and subsequently almost 12 months later, on 4th December 2014 when she called the Police out following an argument. Neither of these incidents were in themselves serious, but in the context of the verbal aggression that Mrs G would often display towards her husband, it could be argued there was a pattern of ongoing emotional abuse which could have been another reason for engaging in some work with Mr and Mrs G as a couple.

7.22 The majority of professionals have commented on Mrs G's verbal aggression towards Mr G. He found these attacks deeply upsetting; and in all likelihood was unaware of what he had done to provoke this response.

7.23 The needs of Mr and Mrs G would not have fitted the referral criteria for any of the existing organisations offering domestic abuse services in the area. However it would have been good practice to complete a risk assessment. The only available response would be from the Police and their role was limited to safe and well checks. The limited amount of domestic abuse research in the older population is focussed on women being the usual victim and men the perpetrator. Where men are seen as the victim the age range is usually below that of Mr G.[15]

MASH/Safeguarding referrals.

7.24 There were three separate safeguarding referrals made in respect of Mr and Mrs G. The first referral came from the Police on 26th December 2013 following Mrs G walking to the Police station to complain about Mr G. The second was from the Community Nurse on 28th April 2014 and was prompted by Mrs G's reluctance to discuss her care needs or meet with her Social Worker. She had also noticed the aggression towards Mr G. In the light of the existing Social Care involvement this referral did not result in any additional safeguarding action. The focus of this referral was on concern about diabetes management and the welfare of Mrs G; as such the safeguarding issues were implied rather than made explicit.

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[14] However professionals need to remain aware of the possibility of domestic abuse in older services users. See footnote 7 page 12.

[15] The British Crime survey collects data on males subject to abuse aged between 16-59 years.

7.25 The third referral on 4th December was a more obvious safeguarding concern when one of the Home Care staff reported that Mr G had complained that he had been assaulted by Mrs G. The same incident had been reported to the Police by Mrs G, who claimed that her husband had pushed her to the floor. The respective social workers for Mr and Mrs G undertook a joint visit. However, neither Mr nor Mrs G wanted to pursue the matter and declined help from Social Care.

7.26 This would have been an opportunity to convene a safeguarding strategy meeting in the light of the background to this incident and the concern about the potential for verbal aggression to become physical. With the exception of the DASH assessment tool it is not clear how risk is assessed amongst older people in Nottinghamshire. There is a generic risk assessment tool embedded in the Frameworki[16] recording system which is only available to Social Care. Consideration could be given to the development of standardised risk assessment tools (i.e. ones that were available to all agencies) and guidance for sharing information that would be helpful for workers facing similar situations.

CONCLUSION

8.1 Mr and Mrs G had a complex range of needs requiring medical and social support to enable them to live within the community. Providing this support became more difficult when the help which would make their lives easier was rejected by them, often very forcibly and with a degree of aggression. The workers involved correctly recognised this as a manifestation of their illnesses, rather than a personal attack and continued to endeavour to meet their needs and enable them to exercise choice over their lives.

8.2 It was accepted that Mrs G retained her mental capacity throughout the period under review and even when she was sectioned under the Mental Health Act her cognitive ability was believed to meet the threshold test for mental capacity. However a number of professionals believed that her capacity had deteriorated (following her illness in 2013) and she suffered a degree of “cognitive impairment” including memory problems and confusion.

8.3 Mr G’s capacity was less contentious; as a dementia sufferer by definition at some point he would lose his mental capacity and decisions would need to be made in his best interest. However in the period under review his mental capacity was not formally assessed. Although there were questions regarding his capability, it is apparent that he knew what he wanted and was aware of the decisions he made.

8.4 The sad death of Mrs G cannot be considered unexpected given the history of previous overdoses and her stated desire to end her life. However, questions remain about her true intention; she may have been trying to engineer a return to hospital and misjudged the dose and her family believe that the lack of familiarity with a new insulin injection may have led to taking an amount which was ultimately fatal. The Coroner’s verdict was one of accidental death.

[16] Frameworki is the electronic case recording system used by Nottinghamshire Adult Social Care Department

8.5 The impact of the loss of his wife on Mr G was profound and predictable, his alcohol consumption increased as he endeavoured to cope with grief and loss. While the cause of his death could not be predicted it would not be considered unusual given his history.

SUMMARY

9.1 The care provided to Mr and Mrs G was appropriate to their needs, given that it was constrained by what they found acceptable. There is ample evidence that workers from Adult Social Care and Health endeavoured to provide services sometimes in the face of hostility and aggression. When measured against the requirements of the Care Act 2014 and the Care and Support Statutory Guidance (both of which came into force after the period of this review), the standard of care provided was compliant with that expected under the legislation.

9.2 This review has not identified any significant problems with the delivery of services, but has noted that improvements in some key areas would strengthen services and support workers who work with families that have complex needs.

9.3 These improvements include:

- Improving discharge planning – discharge meetings need to be timed to allow relevant agencies to participate and also give time to allow support services to be put in place prior to discharge.
- Multi-disciplinary meetings/case conferences – it is evident that different agencies held different information about the family, working with hostility and managing risks. Identifying lead responsibility and remaining up-to-date with a rapidly changing case may all have been addressed through the simple process of bringing front-line professionals together.
- Case supervision for complex cases – busy practitioners need support in "stepping back" and considering the strategic direction of the case.
- Contingency plans – effective arrangements to provide case supervision in the long term absence of a manager should be regularly reviewed.

RECOMMENDATIONS

Overarching Recommendations for the Nottinghamshire Safeguarding Adults Board (NSAB).

1. Nottinghamshire Safeguarding Adults Board should review guidance for adult safeguarding referrals to consider whether the number of referrals received within a set period of time as well as the seriousness of an incident should be sufficient to trigger a Section 42 enquiry[17].

2. Nottinghamshire Safeguarding Adults Board should ensure that there is a consistent system in place for recording safeguarding referrals to enable the MASH to identify patterns of concern and multiple referrals for the same address and/or person.

3. Nottinghamshire Safeguarding Adults Board should consider whether multi-agency risk assessment meetings are fully effective across Nottinghamshire and consider adopting a model such as the PRISM (Profiling Risk Integrated care and Self-Management) model from mid-Nottinghamshire to ensure that there is consistent case coordination.

4. Nottinghamshire Safeguarding Adults Board should seek assurance that partner agencies are aware of their duties under the Mental Capacity Act and that they undertake assessments in accordance with the Code of Practice. [18]

5. Nottinghamshire Safeguarding Adults Board should seek assurance that all agencies and practices understand their role and the expectations of participation in Safeguarding Adults Reviews under the Care Act[19] and support the involvement of their staff at all levels in the Adult Case Review process.

6. Nottinghamshire Safeguarding Adults Board should ensure guidance for families and carers regarding Mental Capacity Assessments are readily available. This guidance could helpfully include:
   - The limitations of professional power and authority.
   - Information regarding deprivation of liberty safeguards.
   - The two stage assessment process.
   - Decision making

Single Agency Recommendations

The following recommendations were included in the management Reviews provided by the agencies involved. Not all agencies made recommendations following this review.

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[17] Section 42 of the Care Act 2014 stipulates that local authorities **must** make enquiries, or cause others to do so, if they reasonably suspect an adult who meets the criteria is, or is at risk of, being abused or neglected.

[18] Mental Capacity Act 2005 Code of Practice. In particular, 'who can be a decision maker' p69 is relevant. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf)

[19] The care Act 2014 ss44/45. http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

East Midlands Ambulance Service (EMAS).

1. For EMAS to recognise why there were three missed opportunities to raise care concerns for Mr and Mrs G. This will form the basis of a Reflective exercise with EMAS staff to be carried out by the end of January 2016.

First Care DCA Ltd.

1. At onset of service, it would be helpful to receive full details of the client. The company state this isn't always the case with referrals. It will be made a good practice measure now to ensure all assessments and details are given prior to any commencement of services. The client's full history will be known. Staff can be informed of any potential occurrences. In this case it would have explained why Mr G was very often not home when staff arrived.

2. On speaking with staff as well as management, it was very apparent that clear, open lines of communication were open at all times. The company as a whole were very clear on the procedure for reporting alleged abuse. Throughout this package this point was crucial. Management state they were very well supported by the SW team. Lines of communication are kept open, meaning the client has the best support system possible.

New Directions Nottinghamshire CRI.

1. Engagement of service users – Utilising many different methods of engagement of service users by telephone, text, letter and consideration of home visits. To effectively promote engagement of hard to reach service users.

2. History of referrals and engagement – When service user's re-renter into service, a discussion with team leader/senior practitioner regarding their previous engagement should be had, a plan agreed and documented of how this may be more effective in promoting service user engagement and retention.

3. Change referral and assessment documentation – Question within referral and assessment that asks if a service user has any caring responsibilities for another adult. To effectively identify if a service user has any caring responsibilities.

4. Consideration of complex case discussion – If a 'carer' is identified at referral/assessment these needs should be documented and discussed with appropriate multi-agency professionals and designated safeguarding lead/team leader. To effectively address any concerns regarding an adult with increased vulnerabilities.

5. 'Carer's' information documented – This information should be documented on CRIis (CRI information system) safeguarding module to identify the most appropriate safeguarding risk management plan. To ensure that information that increases risk and vulnerability is effectively assessed and managed.

6. Minimum standards of recording – Continue to quality assure staff case notes, using CRI Quality Improvement Programme. Dip sample case notes are audited against CRI's quality standards regularly and action plans completed in each locality to

evidence continuous quality improvement. To ensure staff use CRI's 'minimum standard' of recording within case notes. These standards prompt workers to ask relevant questions that could have addressed some of the identified complexities in this case

Nottinghamshire Adult Social Care Health and Public Protection.

1. ASCH staff should ensure multi-disciplinary meetings are convened in community settings in cases such as this where there are issues about capacity, risks and unwise decisions. There needs to be genuine multi-disciplinary engagement. It could be argued that using a Safeguarding Adults Strategy meeting could have addressed this. Clearly a shared risk management process is needed to manage risks in relation to adults with capacity; where there is a risk of serious harm or death and a high level of concerns from partner agencies.

2. Mental Capacity Act assessments need to be undertaken where there is disagreement about the capacity of a service user and / or concern about the risks associated with that decision. These assessments need to be decision specific and can be reviewed and renewed when circumstances change.

3. ASCH staff need to undertake and record risk assessments in situations such as these in order to articulate risk, propose appropriate management and ensure a framework for escalation. Risk assessments need sharing and at times creating, with multi-disciplinary partners.

Nottinghamshire Healthcare NHS Foundation Trust.

1. That all teams, regardless of whether a referral to adult social care is in place, should appropriately escalate their concerns, if these are not specifically addressed.

2. That all teams must adhere to best practice on discharge planning involving all appropriate agencies. To enable safe discharge packages to be put in place.

3. Within complex cases such as these a lead team should be identified to coordinate care and safe discharge. On admission a discussion should take place with all professionals involved to agree who should be the lead professional to enable best practice around coordination of care and safe discharge.

4. For both the Local Services and Health Partnership Divisions to scope as soon as practicable, ease of referral into each service. A task and finish group to be set up to look at appropriate referral pathways to enable ease of access and smooth pathways for patients regardless of Health condition.

APPENDIX 1

Safeguarding Adults Review
Mrs G and Mr G

Terms of Reference and Scope

Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

Condition 1 is met if—
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and NSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

Case Summary

Nottinghamshire Foundation Healthcare NHS Trust made a referral to the NSAB SCR panel for Mrs G.

An exercise was undertaken to trawl for information in the form of requests for summary of agency information.

Mrs G was a patient of both mental health and district nursing services. Mrs G was also in receipt of Social Care and had been in contact with police and EMAS prior to her death. A number of issues were identified in the agency information which appeared pertinent to the time prior to Mrs G's death. These included an apparent change in discharge planning from residential to home at Mrs G's request, concerns regarding medicines management, over capacity and domestic violence between Mrs G and her husband with Mrs G being a victim on some occasions and the perpetrator on others.

A summary of the most recent events as documented from agency information is as follows.

After alleged insulin overdoses in October 2014 Mrs G was admitted to hospital and remained there until her discharge on 1st December 2014. 7th December 2014 Mrs G disclosed to the police an altercation with her husband. On the same day Mrs G disclosed that she had secreted insulin at home. She was insulin dependent. The District Nurse and Crisis Resolution Home Treatment (CRHT) Team visited her home

address but she refused to disclose where the insulin was hidden. About one hour after the CRHT left the address they were informed by EMAS that they were in attendance at her home address. They were informed that Mrs G had disclosed that she had taken an insulin overdose but that she had refused medical treatment. 8th December EMAS attended the home of Mrs G who was pale clammy and unresponsive. Hypoglycaemic and hypothermic treatment provided on route to hospital. Mrs G remained in hospital until her death on 22nd December 2014.

During the analysis of agency summaries provided to the SCR group it was identified that Mrs G's husband Mr G had died in January 2015.

As such a subsequent request trawl for agency summaries was undertaken, this time in relation to Mr G and an interim SCR meeting convened. Agency summaries and a combined timeline based on information available that spanned agency interaction with Mrs G and Mr G were analysed.

To summarise Mr G information appears to show as with Mrs G, that there were a number of different agencies involved with Mr G, he too was in receipt of health and social care. Mr G was identified as a carer for Mrs G and had been assessed for capacity and showed possible contradictory information regarding Mr G's alcohol intake.

The SCR sub group (now known as Safeguarding Adults Review (SAR) Sub Group) agreed that it would be more sensible to progress a joint safeguarding adults review as there appeared to be a significant number of interdependencies between them that should be taken into consideration. A request was made to the NSAB chair and a subsequent request for more information was acted on. The March 2015 SCR group meeting agreed and confirmed the request for a joint safeguarding adults review for Mrs G and Mr G.

Decision to hold a Safeguarding Adults Review

The request for a safeguarding adults review was agreed by the Independent Chair of NSAB as "incidents of poor information sharing and gathering from multi-agency partners which, had they been different, may have aided more effective assessment and analysis of risk. Detailed exploration of this may help the multi-agency networks better understand and learning".

Key Issues

- Were Mrs G and Mr G's needs identified, assessed and met individually?
- Were Mrs G and Mr G's needs identified, assessed and met collectively?
- Did agencies make appropriate linkages between the couple when considering their respective vulnerabilities and needs?
- Were the dynamics of Mrs G and Mr G's relationship and the consequent impact on each individual adequately assessed?

- Were the dynamics of Mrs G and Mr G's relationship and the consequent impact on each individual built into care planning and subsequent interventions?

- Were Mrs G and Mr G's roles as carers for each other recognised and assessed?

- Were appropriate multi-agency and interagency tools (e.g. processes, mechanisms and systems) in place to effectively identify and manage risk?

- Where tools were in place, were they used appropriately?

- Were individual professionals applying appropriate analysis of information and using escalation channels effectively?

Scope

The scope of the review should be from between 22nd December 2013 and 26th January 2015. This period covers one year prior to the death of Mrs G to the death of Mr G.

Method of Review

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

In June 2015, the SAR Sub Group agreed to use the 'Significant Incident Learning Process' or 'SILP' via the independent review organisation ***Review Consulting.*** This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.

Independent Reviewer and Chair

The named independent reviewer commissioned via Review Consulting is **Mark Dalton.**