Nottinghamshire Safeguarding Adults Board

Stop abuse and neglect

Safeguarding Adults Review (SAR) – Executive Summary

Subject: Claire

Date of Birth: 21.05.1968

SAR Independent Author: Pete Morgan

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Overview

This Safeguarding Adults Review relates to a 53-year-old woman who for the purposes of this summary will be referred to as Claire*. Claire was known to Police and Children's Social Care from 2007 when she made allegations of domestic abuse and her daughter made allegations of sexual assault against her partner Derek*.

Claire and Derek were both known to have alcohol misuse issues and in 2011, at the age of 43, Claire suffered an acquired hypoxic brain injury that led to her requiring 24-hour care. Following an extensive stay in hospital, the decision was made for Claire to be discharged home into the care of her partner (later to become husband), Derek, with a supporting care package.

Over several years Claire's husband refused access to carers and professionals. He stated he was caring for his wife, and he also made complaints about the care being delivered. Relationships became so strained that providers refused to continue with Claire's care package, due to verbal abuse and inappropriate language staff received from Derek.

Practitioners voiced their concerns and made Safeguarding referrals. The concerns became so great that on 1st March 2018, the GP and Police were called out to make an assessment. They found that Claire had not been assisted to get out of bed, or to leave the property for many months. She appeared emaciated and withdrawn, and it was unclear if she had been fed and if she was getting enough fluids. The local authority made an urgent application under s16 of the Mental Capacity Act (2005) for the Court to make orders to place Claire under their care.

Upon admission to a care home Claire was found to have blanching sores, matted hair with severe dandruff, the soles of both her feet were black, her finger nails had dirt underneath them, as well as other health issues, symptomatic of not being cared for properly.

Throughout the two years that Claire has been in her current setting she has begun to thrive through the care and extensive therapies that she has received.

Themes

Meeting the requirements of the Care Act 2014

There is evidence that practice did not reflect the change of culture to the more person-centred approach required by the Care Act 2014. Although the pre-review period is prior to the implementation of the Care Act 2014 and therefore s9 or s10 Assessments, under the NHS and Community Care Act 1990, there was a requirement for care assessments and their resulting care plans and packages to be reviewed at least annually. There is no evidence of either Social Care or the Nottinghamshire Clinical Commissioning Group undertaking any such reviews.

Acting in accordance with the Mental Capacity Act (MCA) 2005

Numerous concerns over whether agencies acted in accordance of the MCA for example, Claire was found not to have been consulted when Derek's name was added to Claire's tenancy. In addition, there were delays to an Independent Mental Capacity Advocate being requested to support Claire or legal advice sought in relation to Claire's discharge home and subsequent support in the community.

Providing care and support to individuals and families who are resistant or refusing to engage and co-operate with services

Throughout the review period, there are examples of Derek's behaviour towards staff being aggressive and manipulative and there was a lack of any coordinated response to this behaviour between the agencies. This can be seen as being in part due to the lack of formal multi-agency reviews of Claire's needs assessment or her care package. In addition, there was an acknowledgement of reticence to address the issues with Derek's behaviour for fear of jeopardising the relationship with him and of his likely response. Had staff been supported and able to challenge Derek at an earlier stage, it may have been possible to safeguard Claire more effectively and instigate the application to the Court of Protection earlier.

Recommendations

Recommendation 1:

That the SAB seek assurance that local housing providers work in partnership with health and social care commissioners to review tenancy agreements where tenants are identified as possibly losing capacity.

Recommendation 2:

That the SAB seek assurance from the CCG that primary care carries out medication reviews for adults lacking capacity in accordance with the Mental Capacity Act 2005 to maximise their input into the review and safeguards their best interests.

Recommendation 3:

That the SAB seek assurance that partner agencies and the services they commission are acting in accordance with the Mental Capacity Act 2005 and its supporting Code of Practice to ensure that;

- **capacity assessments are completed and recorded in accordance with local procedures**
- **there is proper legal scrutiny of long-term decisions re adults who lack capacity in accordance with the judgement of the Court of Protection re Steven Neary (2011)**
- **appropriate referrals are made to the Court of Protection for the appointment of a Deputy or any relevant Order**

- **their staff are conversant with its implementation re marriage and sexual relationships and how to refer to the local Forced Marriage protocols and procedures.**

Recommendation 4:
That the SAB seek assurance that the national guidelines for the Registrar's Offices are compliant with the Mental Capacity Act 2005 and national guidelines and legislation re Forced Marriages

Recommendation 5:
That the SAB seek assurance that partner agencies are ensuring their staff and those in agencies they commission services from are following the local multi-agency safeguarding adult procedures when making referrals, using the language of the Care Act 2014 and its supporting Statutory Guidance

Recommendation 6:
That the SAB seek assurance from the MASH that it has in place robust processes and systems for recording and monitoring the receipt of and response to safeguarding concerns it receives to ensure the timely and effective completion of s42 Enquiries under the Care Act 2014

Recommendation 7:
That the SAB seek assurance from the MASH that it has in place a robust and effective screening process to ensure all safeguarding concerns in which domestic abuse is identified are responded to appropriately, including the investigation of possible crimes under s76 of the Serious Crimes Act 2015

Recommendation 8:
That the SAB seek assurance that ASCH has developed, implemented and promoted an escalation process to support the local multi-agency safeguarding adult procedures, supported by internal escalation processes within partner agencies and services they commission

Recommendation 9:
That the SAB seek assurance that partner agencies, in particular ASCH have effective and robust triage and monitoring processes in place to ensure all appropriate cases are referred to the MASH and their outcomes monitored

Recommendation 10:
That the SAB seek assurance that ASCH is ensuring all relevant agencies and individuals are invited to attend meetings under the local safeguarding adult procedures and that minutes detailing the content and outcomes of all such meetings are distributed appropriately.

Recommendation 11:

That the SAB seek assurance from ASCH that they offering, completing and reviewing assessments of an adult's care and support needs and a carer's support needs in accordance with s9 and s10 respectively and, where appropriate s68, of the Care Act 2014

Recommendation 12:

That the SAB seek assurance from ASCH and the CCG that complex care packages are reviewed regularly and when circumstances change and are managed on a multi-agency basis

Recommendation 13:
That the SAB seek assurance that partner agencies and the services they commission have appropriate supervision arrangements in place to ensure staff are able to reflect on their practice and be supported to appropriately exercise "professional curiosity" and challenge service users, carers and fellow practitioners

Recommendation 14:
That the SAB seek assurance that partner agencies have developed, implemented and are monitoring a multi-agency protocol for responding to aggressive and potentially abusive carers/family members and looks to develop a similar joint protocol with the Safeguarding Children Partnership on the basis of the concerns re Derek's behaviour

Recommendation 15:

That the SAB seek assurance from partner agencies that they are ensuring that their staff, and staff in services they commission, are appropriately "legally literate", including knowing when and being able to access to specialist legal advice in complex cases

Recommendation 16:

That the SAB bring the concerns about CSC's response to their duties re private fostering placements to the attention of the Safeguarding Children Partnership for their consideration

*please note that names and details have been changed to protect the identity of the individuals involved

Appendix A: Terms of Reference

Introduction

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

Legal Framework

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

In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance:

- Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults

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

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

Scope

The scoping period for this review is 1st April 2015 to 30th April 2019 however, agencies will be asked to provide information about any significant events back to 1st January 2011 just prior to when Claire sustained her brain injury.

'The review will consider how agencies responded both individually and together to the following specific issues:

- meeting the requirements of sections 2, 9,10, 42, 67 and 68 of the Care Act 2014
- acting in accordance with the Mental Capacity Act 2005
- providing care and support to individuals and families who are resistant or refusing to engage and co-operate with services
- domestic abuse in the context of a carer being the alleged perpetrator of abuse and
- the neglect that led to a deterioration in Claire's health

Methodology

The reviews primary focus will be on agency reports but with some input from frontline practitioners to describe their experience of the events. This approach does not seek to apportion blame but identify both areas of good practice and those for improvement.

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

The principles and benefits of using this model are:

- Conclusions can be realised quicker and embedded in learning
- Enhances partnership working and collaborative problem solving
- Recommendations are made in a robust manner which help shape learning and practice

The overview report will focus on an analysis, leading to findings and recommendations rather than a detailed chronology of events.

Details of the Independent Reviewer / Chair

Pete Morgan - P. Morgan Consultancy Services Limited

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

An Executive Summary will be produced and published on Nottinghamshire Safeguarding Adults Board's website.

Organisational Contributions

- Nottinghamshire County Council Legal and Democratic Services
- Nottinghamshire County Council Adult Social Care and Health
- Greater Nottingham Clinical Commissioning Partnerships
- Nottinghamshire Constabulary
- Nottingham City Care
- Nottinghamshire Healthcare Trust
- Nottinghamshire County Council Children's Services
- GP Practice
- Nottingham University Hospital NHS Trust – Adult Services
- Jigsaw Homes Group

Board Over-sight

The SAR sub-group will report to the Board and has established a Panel which will have oversight of this Review. The Board will have final sign-off of this Review and the completed Overview Report.

Review Panel

The SAR Sub-group will act as the Review Panel.

Agreed format of report for agency information

Individual Management Reports including a Chronology, Timeline (for prior to the scoping period) and Action Plans.

Timescales for completion

It is anticipated that a finished version will be submitted by April 2020.

Ownership of agency information submitted as part of the review

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

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

Level of involvement of practitioners

There will be a Practitioner Event with front-line staff who had or have direct contact with Claire and her family.

The involvement of family members in the SAR

Consideration will be given to the best way of engaging with Claire as part of this process through the use of the Mental Capacity Act 2005.

A decision has been made at the SAR Sub Group not to engage with the partner of Claire due to ongoing criminal investigations, Court of Protection case and the potential risk to Claire.

A timetable for completion of the review

Scoping Meeting	20th August
Initial Information shared	20th August
Letter to agencies to nominate author and invite to briefing	23rd August
First Panel Meeting (SAR sub-group)	6th September
Letters to Agencies	w/c 9th September
Agency author briefing session	16th September
Engagement family	Flexible after 6th Sept, before 9th October
Agency Reports submitted to reviewer	29th November 2019
Relevant info distributed to Practitioner/Learning event attendees	6th December 2019
Practitioner/ Learning Event	16th December 2019
Meet with Claire	After practitioner event

First draft of Overview Report to Panel (SAR sub-group)	29th January 2020
Second draft agreed via virtual panel (SAR Sub Group)	11th March 2020
Final draft sent to NSAB	2nd April 2020
Presentation to NSAB for final sign-off	9th April 2020

How legal advice will be provided to the SARSG or SAR panel, (in addition to agencies own internal legal advice)

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