East Sussex Safeguarding Adults Board

Report of the discretionary Safeguarding Adults Review regarding Adult B

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1. Introduction

1.1 Background to the SAR

1.1.1 This Safeguarding Adults Review (SAR) concerns the death of a 94-year-old woman who died in hospital from natural causes but who had experienced a range of unexplained injuries in the period before her death. A SAR should always be considered if:

- an adult has died (including death by suicide), and abuse or neglect is known or suspected to be a factor in their death; or
- an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity or quality of life (whether because of physical or psychological effects), or the individual would have been likely to have died but for an intervention; and
- there is concern that partner agencies could have worked more effectively to protect the adult.

Safeguarding Adults Boards (SABs) may also arrange for a SAR in any other situation which involves an adult, in its area, with needs for care and support[1].

1.1.2 A SAR referral was made on 19th January 2018 by a practitioner in Adult Social Care & Health (ASCH), following a safeguarding enquiry that had been undertaken (referred to in episode 5). The East Sussex SAR Subgroup considered this referral on 26th January 2018 and 23rd February 2018 and found that the statutory requirement to undertake a SAR was not met as Adult B had died from natural causes. However, the subgroup recommended that a SAR should be carried out on a discretionary basis as is included in the provisions outlined above, to enable learning to be taken forward as there were concerns regarding the nature and extent of injuries sustained by Adult B prior to her death. The Independent Chair of the East Sussex SAB endorsed this decision on 27th February 2018, and a SAR panel was appointed.

1.2 The terms of reference

1.2.1 The specific terms of reference are attached as Appendix 2 but all agencies were asked to report on their work under the following headings:

- How effectively issues of Adult B's mental capacity and consent were addressed, including the extent to which factors such as coercion and control were considered.

[1] Sections 44(1) – (3), Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

- Whether the historical concerns were sufficiently considered when agencies responded to individual incidents – particularly in 2017.

- Whether practitioners involved initially at the time of the 2017 injuries were sufficiently curious in their investigations of the injuries.

- Whether assessments undertaken understood family dynamics and whether there was consideration of disguised compliance by the wider family in these assessments.

1.2.2 The time frame of the SAR was from November 2012 to 27th September 2017, the date of Adult B's death. Agencies were also asked to report on any significant information prior to 2012.

1.2.3 The subjects of the SAR were Adult B (date of death: 27/09/2017) and immediate family members, particularly the son and his wife, and grand-daughters (GD1 and GD2).

1.3 SAR process

1.3.1 The SAR was conducted using a systems methodology that:

- recognises the complex circumstances in which practitioners work together to safeguard adults;

- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

- is transparent about the way data is collected and analysed; and

- makes use of relevant research and case evidence to inform the findings.

The report has three main sections:

a) 'Summary of facts' is a description of the services provided to Adult B that explains how agencies worked together to support her.

b) 'Analysis' is an appraisal of the practice with, where possible, an explanation of factors that helped or hindered effective service delivery.

c) 'Lessons learned' are the ways in which this specific case highlights findings about the safeguarding system as a whole.

This is then followed by conclusions and recommendations that are linked to the terms of reference.

1.3.2 Individual agency reports were received from the following sources:

- East Sussex Adult Social Care & Health (ASCH)
- Home care agency 1 (HC1)
- Home care agency 2 (HC2)
- Sussex Police
- Clinical Commissioning Group East Sussex: primary care practice within Eastbourne Hailsham Seaford CCG
- East Sussex Healthcare NHS Trust (ESHT)
- South East Coast Ambulance Service NHS Foundation Trust was identified as having been involved during the SAR and provided information albeit not a full report

1.3.3 A key part of the methodology is the contact with frontline practitioners who have been involved with the family. There was a learning event where frontline practitioners and their managers examined inter-agency working and identified strengths and weaknesses in the safeguarding system.

1.3.4 The Lead Reviewer was Fiona Johnson, an independent social work consultant who was Head of Children's Safeguards & Quality Assurance in East Sussex County Council between 2004 and 2010. Fiona qualified as a social worker in 1982 and has been a senior manager in Children's and Adults services since 1997, contributing to the development of strategy and operational services with a focus on safeguarding. She is independent of the East Sussex SAB and its partner agencies, although she does work for the East Sussex Local Safeguarding Children Board as the Independent Chair of their Child Death Overview Panel.

1.4 Parallel processes

1.4.1 There were no parallel processes as the police criminal investigation and the coronial process were completed prior to the start of the discretionary SAR. The Lead Reviewer was given a copy of the post mortem report provided to the coroner.

1.5 Family input to the SAR

1.5.1 Adult B's son was advised about the discretionary SAR and was offered the opportunity of contributing to the review. He declined to participate in the SAR or to meet with the Lead Reviewer.

2. Summary of facts – description of the support provided to Adult B

2.1 Family structure

Adult B	Subject of the SAR
Son	Adult B's son who cared for her in his home from 2014
Daughter-in-law	Adult B's son's wife
GD1	Adult B's grand-daughter who cared for her in Adult B's home in 2012
GD2	Adult B's grand-daughter who lives independently

2.2 Timeline

Date	Event
KPE 1 13/11/2012 – 29/01/2013	
02/10/2012	Home care agency 1 (HC1) carer noticed bruising on Adult B's left shoulder and a small cut surrounded by bruising on her forehead.
13/11/2012	A safeguarding alert (terminology of the time) was raised by HC1 agency.
14/11/2012	Initial strategy discussion, no input by police or GP.
20/11/2012	A visit was made by an Adult Social Care & Health (ASCH) worker to Adult B and her son was present.
10/12/2012	A financial assessment was completed by a Finance Visiting Officer.
11/12/2012	HC1 carer notes blood on hair – Adult B alleges GD1 hits her with hair brush – information passed to ASCH.
13/12/2012	Son says they did not require ASCH support.
17/12/2012	Following supervision, ASCH contacts GP, district nurse and mental health services; no response from GP, no concerns from other agencies.

07/01/2013	Further allegation by Adult B to HC1 carer – information passed to ASCH.
15/01/2013	Joint visit by ASCH worker with HC1 carer.
29/01/2013	Case closed by ASCH – no information passed to HC1.
KPE 2 11/03/2014 – 07/07/2014	
11/03/2014	Following annual review, HC1 refers again to ASCH with concerns about neglect.
19/03/2014	Police are involved with ASCH and do joint visit at the home of GD2 – Adult B states no current concerns, so police decide no action.
26/03/2014	Safeguarding strategy meeting, ASCH and HC1 involved – police sent apologies, unsuccessful attempt to contact community nursing, GP not invited, minutes only sent to police and HC1.
16/04/2014	ASCH visit again, and Adult B reports she is moving in with her son.
29/04/2014	District nursing start monthly visits to check blood pressure and change catheter (8 weekly).
23/05/2014	Safeguarding conference held, ASCH and HC1 attend, apologies received from police, CQC and community nursing – GP not invited, no minutes circulated.
07/07/2014	Case closed to ASCH following visit on 02/07/2014 to Adult B and son.
KPE 3 28/07/2015 – 05/04/2016	
28/07/2015	HC1 refers Adult B to community nurse / GP because of concerns about soreness under her breasts, discussion about possible neglect.
29/07/2015	GP visits Adult B – no concerns.
25/08/2015	Son cancels care service from HC1. HC1 informs ASCH and advises them that the family were running a food service to other elderly people.
22/09/2015	Home Care Agency 2 (HC2) starts to work with Adult B, visiting weekly to provide a full strip wash and dress.
05/04/2016	HC2 contacts ASCH because Adult B has had a fall and requests an assessment – OT contacts son and advice is given.
KPE 4 12/09/2016 – 01/09/2017	
12/09/2016	Telephone message from son saying Adult B had pulled out her catheter. Nurse visited, catheter changed, old catheter seen with balloon still intact.
15/09/2016	Catheter dislodged again, reinserted next day.
17/09/2016	Catheter dislodged again, reinserted same day.
19/10/2016	Sacrum pressure ulcer treated, catheter noted to have become

	dislodged.
31/10/2016	Further pressure ulcers on buttock and heel, family advised about the need to turn Adult B but say this is not possible because of the catheter becoming dislodged. Adult B seen to have lost weight, discussed with family.
02/12/2016	District nurses visiting to provide skin care because of ulcers – bruising and skin tears noted on numerous occasions.
01/09/2017	Concerns regarding numbers of skin tears and bruises leads to discussion with the family of the need for a safeguarding referral.
01/09/2017	District nurse refers Adult B to Falls Clinic.
KPE 5 19/09/2017 – 27/09/2017	
19/09/2017	Adult B found with bruising and is admitted to hospital.
27/09/2017	Adult B dies from pneumonia and sepsis.

2.3 Background history

2.3.1 There was little information held by agencies about Adult B prior to 2008. She was living alone in the ground floor of a house that she owned. She was suffering from osteoporosis, had poor mobility, a history of strokes and a hearing impediment. Adult B appeared to have mental capacity to make decisions. She was sociable and liked company. She was very family oriented.

2.3.2 HC1 started caring for Adult B in January 2008 initially providing one hour a week for personal care. Following a spell in hospital, the calls recommenced on 7th May 2008 and increased to six 30-minute calls a week. Adult B went back into hospital on 20th March 2009, returning home on 24th April 2009 and was readmitted on 24th May 2009. Adult B returned home on 3rd August 2009, but the calls were reduced to one one-hour call a week, as the family took over her care. Adult B was assessed financially, and she chose to be self-funding.

2.3.3 The only other agency in regular contact with Adult B was her GP; she was registered with the same practice from 1964 and had the same named GP from 2014.

2.4 Key Practice Episode 1: 13/11/2012 – 29/01/2013 First safeguarding concerns noted

2.4.1 At this time Adult B was living in her own home but was being supported by her grand-daughter (GD1) who was being paid by Adult B to live in and

provide overnight care, her son was also visiting daily for two hours every morning. HC1 were still visiting weekly and provided a full strip wash and helped Adult B to dress. On 13th November 2012, the HC1 carer noticed that Adult B had a bruise on her forehead and that there were blood spots on her head. Adult B disclosed to the carer that this had been caused by GD1 hitting her head with the hair brush, she also said that she was only washed when the HC1 carer called as GD1 did not help her to do this although it was part of her responsibilities. Adult B did not want to discuss this with her son as she did not want to cause him further stress. This information was passed as a safeguarding referral to Adult Social Care & Health (ASCH).

2.4.2 An initial strategy discussion took place on 14th November 2012, neither the police nor the GP were invited. The safeguarding alert was not taken into an investigation as the manager decided to address Adult B's needs with social work intervention as she had mental capacity and did not want a safeguarding investigation. It was thought that she was likely to end the small self-funded care package if her grand-daughter was the subject of a safeguarding investigation and this would have increased her risk significantly. The plan was for the worker to engage and assess the situation and work in partnership with Adult B to alleviate the safeguarding risks. If the worker identified further risk, she would raise another safeguarding alert as the outcome of her intervention.

2.4.3 The worker visited within the week and met with Adult B and her son, and they discussed her care arrangements. Adult B was clear that she was happy with the HC1 carer visiting weekly and agreed when her son stated that they could not afford any additional support. Her son explained that Adult B was paying GD1 to stay and was happy to do this using her own money. It was recorded that Adult B demonstrated capacity throughout the visit and that she had "a strong grasp on her finances". Following this, it was arranged for a finance officer to visit and complete a financial assessment. This identified that Adult B was eligible for services and could have received a bigger package of care for less than she was paying under the self-funding arrangements. At this time, it was also noted that her son had lasting power of attorney for property and financial affairs[2]. As a result, it was agreed that the worker would contact Adult B's GP for any information to establish any history of concerns, and to search for any records on GD1 including checking with the mental health team for any involvement. No information was found on GD1 and whilst the GP was contacted there was no record of a response.

2.4.4 Following this visit, ASCH contacted the son who advised that Adult B wished to continue as self-funding and did not want any additional support. Soon after this, HC1 carers reported further concerns about GD1 hurting Adult B but

[2] A lasting power of attorney (LPA) is a legal document that lets you (the 'donor') appoint one or more people (known as 'attorneys') to help you make decisions or to make decisions on your behalf. ... There are 2 types of LPA: health and welfare. property and financial affairs. https://www.gov.uk/power-of-attorney

also advised that she still did not want these incidents to be formally investigated as safeguarding concerns. At this point, there was discussion of raising a further safeguarding alert and the worker involved recalls completing the initial paperwork, however, a safeguarding concern form, either partially or fully completed, has not been located in the ASCH database.

2.4.5 The ASCH worker then visited Adult B at a time when the son was not present and interviewed her whilst the HC1 agency carer was present to discuss her current concerns, to explain the support that could be available to her and to establish her wishes. The options discussed included increased paid carer involvement with reduced or ending personal care input from family members, Adult B moving out, respite care or GD1 moving out. Adult B described GD1's behaviour as "heavy handed" and said that "now that carers have recorded evidence of bruising in the daily log that her granddaughter would stop". It is noted that Adult B again declined to give consent for a safeguarding investigation or any action to be taken.

2.4.6 On 29th January 2013, it was recorded in ASCH records that the case had been discussed in supervision and it was agreed that "there is no ongoing need for ASCH involvement at the current time due to Adult B's wishes". An action was identified to inform HC1 agency to continue to monitor and report any concerns as appropriate and the case was closed to ASCH. A telephone call to HC1 is recorded as having been made by the ASCH worker on 29th January 2013. HC1 have no record of any contact with ASCH informing them that they had closed the case.

2.5 Key Practice Episode 2: 11/03/2014 – 07/07/2014 HC1 raise further concerns

2.5.1 A safeguarding concern was raised with ASCH by HC1 agency on 19th March 2014 based on statements given by Adult B in an annual review by the agency on 11th March 2014. Adult B alleged that GD1 was being physically abusive and controlling. Adult B alleged that she was being hit by GD1 and the agency had documented bruises on her head and arms. Also, that GD1 denied her food and drink and only allowed her to use the toilet at certain times. Carers had reported a marked change in Adult B's presentation when GD1 was present and said that Adult B disclosed that GD1 had told her to stare straight ahead or keep her eyes closed and that GD1 would hit her if she was not compliant. Adult B told the carer that she wanted the situation to change but did not want to move to residential care as this would deprive her son of his inheritance. Adult B's son ordinarily visited regularly and helped with her care, however, he had not visited over the previous eight weeks due to broken ribs.

2.5.2 Police and ASCH saw Adult B on 19th March 2014. She was visiting another grand-daughter (GD2) and two social workers talked with Adult B whilst the

police officer talked to the family members in another room. Adult B stated that there were no current concerns and that the bruising she had mentioned was from over a year ago. Adult B was recorded as saying that everything was fine with GD1 and she was happy with the care she was receiving. Adult B also stated that she bruised easily because her skin was fragile. After the visit, the police stated that they had observed nothing of concern and would not be taking further action. A safeguarding strategy meeting took place on 26th March 2014 with ASCH and HC1 agency in attendance. The police were invited but gave apologies. Following this, a plan was agreed to contact the district nursing service for their input and views; for a joint visit to be made with an Occupational Therapist (OT); for the ASCH social worker to observe the support provided by GD1; and the GP to be contacted regarding medication and the history of any call-outs or concerns. The district nursing service reported that they had no concerns. The social worker and OT visited Adult B together on 16th April 2014. Adult B was reported to be looking well and GD1 and the son were also present towards the end of the visit. Adult B was noted to have talked about a plan to move in with her son. It was recorded that neither the social worker nor OT had concerns about Adult B's presentation and interaction with her family. There was no evidence of contact with the GP.

2.5.3 A safeguarding case conference was held on 23rd May 2014 with ASCH and HC1 agency in attendance. Apologies were received from the Care Quality Commission, ASCH Quality Monitoring Team, the police and the community nursing service but the GP was not invited. It appears that neither Adult B nor the family were invited. The outcome was recorded as 'inconclusive' and the notes stated that there was no "substantiated evidence" of abuse taking place. It was also noted that Adult B had denied abuse and had not consented to the investigation. Minutes from this meeting were not circulated to other agencies. It was recorded that Adult B had now moved in with her son and that private home care was to continue weekly. It was considered that GD1 would no longer be providing care for Adult B. Adult B and her son were visited on 2nd July 2014 by the social worker and given feedback on the outcome of the investigation.

2.6 Key Practice Episode 3: 28/07/2015 – 25/08/2015 HC1 refers Adult B to community nurse

2.6.1 Following Adult B moving to live with her son, HC1 workers noted an improvement in her well-being; she presented as being happier and there were fewer reports of bruises and injuries. In July 2015, however, there were concerns about soreness under her breasts including broken skin, so they contacted the district nursing service and asked for a visit. After some discussion, it was agreed that a GP referral should be made. The GP saw Adult B and no safeguarding concerns were identified, however, it was agreed that there should be ongoing district nursing input because of concerns about pressure sores and easily damaged skin.

2.6.2 In August 2015, the son contacted the HC1 agency and cancelled the care package saying that the family were intending to provide all care. HC1 telephoned ASCH and left a message on the answerphone advising them that their involvement had ceased; they also told ASCH that the family were thought to be providing an informal meals service to other older people in the area. ASCH has no record of this contact and was unaware that HC1 agency had ceased to be involved. Within a month, HC 2 started visiting Adult B on a weekly basis to provide a full strip wash and dress. They were unaware of HC1 agency's previous involvement or of the earlier safeguarding concerns.

2.6.3 On 5th April 2016, HC2 contacted ASCH saying that Adult B had had a fall and that an assessment was required. ASCH contacted the son who said that Adult B's mobility had been in slow decline for between five to eight years and that, as a family, they did not feel that any form of falls rehabilitation intervention would be of any use. He wanted a handling belt so that family members could retain a grip on his mother and prevent her from falling as she mobilised. The son was informed that an assessment would be required for a handling belt to be prescribed and that an assessment could not occur before June 2016. The worker suggested to the son that if he was sure that a handling belt would be suitable he could purchase one privately. The case was closed.

2.7 Key Practice Episode 4: 12/09/2016 – 01/09/2017 District nurses visiting note tears and bruises

2.7.1 District nurses visited Adult B frequently over a twelve-month period. During this time, they recorded twenty incidents of skin tears and nine incidents of bruising. There were limited explanations given by the family for the injuries which were mainly said to be the result of Adult B being clumsy or falling and knocking herself. There were also four occasions when Adult B's catheter was dislodged and had to be reinserted. On one occasion, it was noted that the old catheter was seen with the balloon still intact which meant that it would have caused Adult B significant pain when it was dislodged. There were also several pressure sores noted on her heels and knees. The family were provided with repose boots[3] but reported that Adult B found them uncomfortable and kicked them off. The family were also offered a repose mattress[4] but this was refused. Adult B was seen to have long toe nails and there were concerns that she was losing weight. There is no evidence that Adult B was weighed although her possible weight loss was discussed with the son. There was also a record that a referral to the podiatrist was considered but no evidence that it occurred. A referral was made to the Falls Clinic on the 1st September 2017 which was the same day that the district

[3] Repose boots and mattresses are footwear and mattresses designed to reduce the development of pressure sores in people with limited mobility

[4] ibid

nurse advised the son that a safeguarding referral would be made if the level of injuries and tears continued. There is no evidence that this was discussed in supervision and no safeguarding referral was made.

2.7.2 During this period Adult B was visited by nine staff nurses, four healthcare assistants and one district nurse. Visiting was usually every week to ten days and there was no obvious pattern as to why and when nurses visited although sometimes welfare assistants requested a nurse to follow-up if they had concerns about specific injuries or pressure sores. The visits often had to be re-scheduled as the family would refuse entry if Adult B was eating and sometimes repeat visits were difficult to achieve as the son would not be available. There is no evidence that Adult B was ever seen alone and there was no recorded discussion of any explanation for the tears and bruises having been provided by her.

2.8 Key Practice Episode 5: 19/09/2017 – 27/09/2017 Safeguarding investigation

2.8.1 On 19th September 2017, a district nurse visited Adult B and found that she had very thick make-up applied to her face. When the nurse removed the make-up, she found that Adult B had significant cuts and bruises to her face and appeared to have an injured jaw and had cuts to her arms and legs. The nurse asked the son about the injuries and he could not provide an explanation for them. She then advised the son that she would ring for an ambulance to take Adult B to Accident and Emergency as she was concerned that she might have a fractured jaw. The son responded saying that he would do this, so the nurse did not arrange transport to the hospital. After she left, the district nurse rang the GP and asked for an immediate visit and referred the case as a safeguarding concern to ASCH. The request for a GP visit was made after 12.00pm and there was no GP immediately available as all GPs in Eastbourne were attending training[5]. The receptionist record of the referral request suggested that the visit could be postponed until the next day, so no immediate action was taken.

2.8.2 On receipt of the safeguarding concern, ASCH checked whether Adult B had been seen by a doctor or taken to hospital. When it became clear that this had not happened, the ASCH Emergency Duty service became involved and contact was made with the police and they undertook a joint visit to the family that evening. An ambulance was called within five minutes of their arrival as Adult B was very unwell; the ambulance took over two and a half hours to arrive. During this period, the social worker attempted to talk with Adult B and asked her several questions including “Are you safe?” to which she replied,

[5] When GPs are on training cover is maintained by IC24 a company that supply GP out of hours services and provide health care for urgent medical problems outside normal surgery hours. During annual primary care up-dates hosted by the CCG IC24 provide urgent medical cover to the GP practices

"Don't know", and "How did you get your bruises?" where the response was "Don't know". The son was questioned by a police officer and said that he had not taken his mother for medical attention as advised by the nurse as she disliked hospitals. He also reported that his mother had fallen the previous day and that her cognition had reduced significantly over recent days.

2.8.3 On admission to hospital, Adult B was noted to be hypotensive (low blood pressure) and hypothermic (low body temperature) at 33°C and in a very poor state. Doctors in the Emergency Department found that Adult B was cachectic (low body weight) and with so little strength that they felt that she would not be able to mobilise independently, doctors described her as bedbound. She had bruising and lacerations across the body including inside the mouth and inside the left ear. Over 26 injuries were recorded including a fractured nose and fractured jaw, old and new bruising to the face, arms and legs, bruising to the inside and roof of the mouth, and bruising to the leg where there was an over-tight catheter bag, it was also noted that she had overgrown toe nails. Shortly after her arrival at hospital, Adult B was diagnosed with sepsis and pneumonia.

2.8.4 On 20th September 2017, a section 42 safeguarding enquiry[6] began. A joint visit was made to Adult B by the police and ASCH, but she was very ill and was unresponsive. The police liaised with the hospital and family. A safeguarding planning meeting took place on 25th September 2017 with a range of agencies invited although not all could attend. Actions for the enquiry were identified, which included: photographs of visible injuries to be obtained and forwarded to the police; family to be informed of the safeguarding enquiry; previous safeguarding concerns to be forwarded to the police. On 27th September 2017, the police and ASCH were informed that Adult B had died.

2.8.5 Coroner's officers were made aware of Adult B's death on the 28th September 2017. The hospital safeguarding concerns were noted in the Coroner's officer report which was seen by both the Coroner and pathologist. Images of Adult B were shared with the pathologist. A Coroner's post mortem was undertaken on 6th October 2017 by the hospital pathologist. The conclusions were that Adult B died of natural causes resulting from:

- patchy pneumonia with pulmonary oedema;
- acute left heart failure;
- aortic stenosis.

[6] An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs. https://www.scie.org.uk/safeguarding/adults/practice/question

The pathologist's 'short cause'[7] report comprised one page giving the facts detailed above. There was no information or comment in relation to the injuries / wounds and sores to Adult B's body.

2.8.6 Following the completion of the post mortem, the police decided that, as Adult B remained unconscious following her admission to hospital and the police could not obtain an account from her of how she received her injuries, they were unable to prove beyond reasonable doubt an offence of assault or of wilful neglect, and therefore there would be no criminal investigation. The incident was subsequently filed as an adult safeguarding referral.

3. Analysis – Appraisal of practice against pre-set questions (terms of reference) with factors that helped or hindered effective service delivery

3.1 How effectively were issues of Adult B's mental capacity and consent addressed, including the extent to which factors such as coercion and control were considered?

3.1.1 It is clear from this SAR that, when practitioners were working with Adult B, capacity was always assumed and was never addressed formally in terms of a stand-alone assessment. In the main, this would seem to have been a valid approach as, until the very end of her life, she was described by all practitioners to be capable of communicating and expressing her views when they were requested. The Mental Capacity Act[8] states that a person lacks capacity if they are unable to make a specific decision at a specific time, because of an impairment of, or disturbance in, the functioning of the mind or brain. This could be a partial or temporary loss and it is possible for a person to lack capacity to make one specific decision but to be considered able to make other decisions. The assessment of a person's capacity to make decisions should never be based simply on the person's age, appearance or assumptions about their condition, including physical disabilities, learning difficulties and temporary conditions (eg. being drunk or unconscious), or any other aspect of their behaviour. A person's capacity changes and there will need to be regular assessment with regards to each decision made about their capacity.

[7] A 'short cause' post mortem is a quick autopsy undertaken primarily to determine the clinical cause of death; a Home Office 'forensic' post mortem is commissioned (usually by the police) if the death is thought to have occurred as a result of criminal activity

[8] The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity.
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

3.1.2 ASCH was involved with Adult B on three occasions and during the first two interventions the issue of her capacity to make decisions about her life was fundamental in determining the nature of their input and involvement. It was clear that the practitioners involved were concerned about the possibility of whether there was pressure from family members influencing Adult B's decision making and this informed their decision-making about whether to take the referral into safeguarding. These professionals appeared to have a flawed understanding of safeguarding options as they considered that without consent from Adult B they could not progress their concerns under safeguarding. The factors that influence practitioners when deciding how to address safeguarding concerns are considered further in section 4.1 which examines the effectiveness of 'Making Safeguarding Personal' in East Sussex. Similarly, staff from HC1 agency were aware of Adult B's capability to make decisions and recorded clearly her wishes and views about making a safeguarding referral.

3.1.3 This approach is less evident in the interventions of the district nurses who were clearly concerned about safeguarding issues and discussed them with the son. There is no evidence, however, that they discussed these issues with Adult B or that they ever saw her alone. The reasons for this are discussed further in section 4.1 but a significant influence appears to be that when providing a service in a family's own home they are deterred from asking family members' permission to see the patient alone. Other agencies involved with Adult B, the GP and HC2 agency also had little or no contact with Adult B alone, but as they had no safeguarding concerns this may be understandable. It is, however, good practice to provide all people with the opportunity for private communication. One factor that may have been relevant is Adult B's hearing impairment, however, there is little evidence that this was formally assessed or that there was any judgement about on how this may have impacted on her ability to make decisions.

3.2 Were historical concerns sufficiently considered when agencies responded to individual incidents – particularly in 2017?

3.2.1 For a variety of reasons which are considered further in Section 4.2 'Factors that limit knowledge and understanding of historic concerns', few agencies had a knowledge of, or understanding of, the historical concerns. So, whilst ASCH was aware of the history which was considered when responding to the referrals made in 2012 and 2014, this knowledge did not appear to inform decision making in 2015 and 2016 when the son ends the HC1 agency input, and later requests an assessment following a fall and is told there will be a three month wait for an assessment. Similarly, when the police are involved in 2017 they were unaware of the investigations in 2015 and 2016 and in fact when producing information for the SAR were not immediately aware of their input in 2016. HC2 agency became involved in 2015 and was unaware of the previous concerns. The district nursing service was visiting very regularly from

2014 but there is no evidence that they were aware of, or considered, the previous safeguarding enquiries when they became concerned about the level of injuries being experienced by Adult B. Most significantly, the GP had no knowledge of any safeguarding concerns prior to Adult B's death.

3.3 Were practitioners involved initially at the time of the 2017 injuries sufficiently curious in their investigations of the injuries?

3.3.1 The key practitioners involved in the investigation of the injuries in 2017 were district nursing, ASCH, the police and hospital. District nursing was proactive in identifying the injuries to Adult B and made a timely safeguarding referral. The initial response to the referral by ASCH was impressive as they quickly identified the risks and were proactive in contacting Adult B. Once the joint investigation started with the police, ASCH became less actively involved despite having significant past safeguarding history, this was because the police indicated that they were leading on the investigation. The hospital staff clearly identified from the outset their concerns about Adult B's presentation which was evident in their immediate safeguarding referral. They provided a detailed breakdown of the injuries she had experienced which should have raised concerns as they were clearly raising questions about the likelihood of Adult B receiving them through a fall as explained by the family. The response by the police lacked curiosity and the investigation seemed to be demanding evidence that was '*beyond reasonable doubt*' (the threshold for conviction) rather than a more open approach. The Crown Prosecution Service threshold to authorise charges is if there is a realistic prospect of conviction and it's in the public interest. To launch a police criminal investigation requires only that they have reasonable grounds to suspect an offence has been committed and that one of the THRIVE (Threat, Harm, Risk, Investigation opportunities, Vulnerability of the victim and Engagement) applies. A much lower threshold than beyond reasonable doubt. The reasons for this are explored further in Section 4.4 'Are current systems for investigating unexpected deaths of adults adequate?'. A key factor, however, would seem to be a lack of clarity as to whether a crime had in fact been committed, and the determination by the Coroner that the death was a result of 'natural causes' appears to have been a driving factor in ending the investigation. This was unfortunate as it meant that the family members were not interviewed beyond the initial contact on the 19th September 2017 and there was no discussion with the family members about Accident & Emergency staff's perception that Adult B's lack of mobility meant that their explanation of her injuries was questionable. Nor was there any other evidence gathering such as information at the scene or from medical professionals involved with Adult B before her death.

3.4 Did assessments undertaken understand family dynamics and was there consideration of disguised compliance in these assessments?

3.4.1 The assessments undertaken by ASCH in 2012 and 2014 showed some understanding of the family dynamics and there was consideration of whether the family were fully working in partnership with practitioners. This work was informed by the very good relationship that HC1 agency staff had developed with Adult B. The staff involved, however, were very conscious of needing to consider Adult B's wishes and feelings about interventions with her family. Adult B was also clear that her problems were with GD1 and indicated that the care she received from her son was acceptable. Her anxiety about involving the son stemmed from concerns for his health rather than any suggestion that he was providing less than adequate care.

3.4.2 Later, when the district nursing service identified concerns, there was very little exploration about family dynamics despite some evidence that the family were less than co-operative in their working with health practitioners. Some of the reasons for this are outlined in section 4.3 which examines the 'Reasons practitioners struggle with challenging family members caring for vulnerable older people'. A lack of continuity in the nursing service also may have meant that individual staff were unaware of the pattern of poor partnership working between the family member and the nursing service. Another relevant factor, however, would seem to be a lack of confidence to be assertive when working with family members in their own home. This was most apparent on the 19th September when the nurse was clear that Adult B needed urgent medical attention and made an urgent referral to the GP and a safeguarding referral but did not insist that the family immediately call an ambulance to transport Adult B to hospital or call the ambulance herself.

3.5 Identified good practice

3.5.1 There was evidence of very good practice by HC1 agency who engaged well with Adult B, gaining her trust to share concerns about GD1, and who then recorded those concerns and shared them with ASCH via safeguarding referrals.

3.5.2 The response by ASCH to the initial referral was also positive. There was a clear understanding by the practitioners of the complexities associated with progressing a safeguarding referral when the victim was ambivalent about their involvement, and it is noteworthy that the social care worker involved made efforts to see Adult B alone. It was also positive that a financial assessment referral was made. Ultimately, Adult B made the decision that she did not wish for further intervention, however, ASCH was aware of the ongoing risks and provided a mechanism for HC1 agency to monitor Adult B

after ASCH ceased to be involved. This monitoring resulted in a further safeguarding investigation in 2014 and that safeguarding enquiry led to a change in Adult B's living and care arrangements which resulted in an immediate improvement in her presentation.

3.5.3 The level of documentation provided by the district nursing service was good, and the curiosity exhibited by the nurse who removed the make-up concealing Adult B's injuries in September 2017 was impressive as this was the trigger to raise a safeguarding concern.

3.5.4 The immediate ASCH response in 2017 to the safeguarding referral was very proactive, the urgency of the response was immediately identified which led to staff phoning hospitals to check if Adult B had been seen. When it was apparent that this had not happened, there was an immediate joint out-of-hours visit with the police, which was good practice.

3.5.5 Similarly, the actions of the practitioners in Accident & Emergency who provided a very detailed review of Adult B's injuries and a list of their concerns at admission to hospital triggering a further safeguarding response was impressive.

4. Lessons learned from the SAR – how this specific case highlights findings about the safeguarding system as a whole

4.1 Making Safeguarding Personal – is it working in East Sussex? What does this case show us about how issues of mental capacity and consent are addressed, including whether coercion and control is considered?

4.1.1 Making Safeguarding Personal (MSP) is a national approach to promote responses to safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety[9]. Six key principles underpin all adult safeguarding work. They apply to all sectors and settings:

Principle	Description
Empowerment	Presumption of person-led decisions and informed consent.

[9] http://sussexsafeguardingadults.procedures.org.uk/ykoss/sussex-safeguarding-adults-policy/sussex-safeguarding-adults-policy

Prevention	It is better to take action before harm occurs.
Proportionality	The least intrusive response appropriate to the risk presented.
Protection	Support and representation for those in greatest need.
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability	Accountability and transparency in delivering safeguarding.

The joint work between ASCH and HC1 agency in 2012 and 2014 appeared to be informed by MSP, with a focus on empowerment. The interventions were clearly driven by the wishes and feelings of Adult B, with a focus on preventing harm but aimed at achieving this with the least detrimental intervention that Adult B would accept. It was clear that practitioners were not confident to act without Adult B's consent and, while this may have been appropriate in this case, it needs to be understood that on occasion the individual's wishes can and should be over-ruled. There were also some weaknesses in communication between ASCH and HC1 agency, particularly when ASCH ceased to be involved. The overall focus of the joint work, however, was positive and the outcome in 2014 when Adult B moved to live with her son appeared, at that time, to enable her to be safe whilst meeting her other desire which was to pass on an inheritance to her son.

4.1.2 This was a challenging issue as Adult B at this time would appear to have capacity to make decisions, and there was no evidence that the son presented any risk to Adult B's well-being. She was clear that it was GD1 who had harmed her and said that her only hesitancy about involving her son in resolving the problems with GD1 were concerns about his health. It is ethically difficult to overrule an individual with capacity unless it is evident that there is a significant risk. People have the right to make unwise decisions, and their needs for safety, life and freedom from inhumane or degrading treatment may be over-ridden by emotional or physical dependency. The Mental Capacity Act 2005, implemented in 2007, has five key principles, one of which is that 'A person is not to be treated as unable to make a decision merely because they make an unwise decision'[10]. One of the most challenging issues for practitioners is to decide, with the person, whether they are making decisions free from undue influence. Adult B had the capability to make decisions but evidence from the SAR indicates that coercion and control may have been causing her to adapt her decisions to minimise risk to herself. As such, the core issue was that on occasions Adult B was disempowered from making decisions freely. When considering capacity, it is important to consider whether coercion could be affecting an individual's ability to make

[10] https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

decisions. In this case, there was clear evidence that GD1 was coercive and controlling of Adult B, however, this was less clear when considering her relationship with her son.

4.1.3 Coercive control is an act, or a pattern of acts, of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim[11]. The impact on the victim is to inhibit them from acting freely and making decisions about their life. Empowerment, therefore, becomes an important aspect for practitioners to consider when working with a vulnerable person who may be the victim of coercion and control. Practitioners need to consider whether the vulnerable person is free to talk openly or whether they need to be given opportunities to share information away from the person who is being controlling. In this case, in the early days, Adult B trusted her home care worker and had time alone with her. This enabled Adult B, on occasion, to share with the home care worker her concerns about GD1. Once Adult B moved in with her son, and the home care arrangements changed, she had less opportunity to meet with practitioners away from family members and it would appear that she did not develop such close relationships, either with the home care staff, or the district nursing staff.

4.1.4 As stated previously, the response by the district nursing service when identifying concerns regarding repeated injuries experienced by Adult B seemed to evidence less understanding of MSP. The absence of direct communication with Adult B about the bruises and tears, and the lack of evidence that she was seen alone, would suggest a lack of understanding of a '*Presumption of person-led decisions and informed consent'* and *'It is better to take action before harm occurs'.* Some of this is explained by practitioners lacking confidence because they were working within the family's home (this is explored further in para 4.4), however, it is important that services maintain the same standards for intervention regardless of location, and agencies need to empower staff to have the same approach wherever services are delivered. The Care Act 2014 has set out clearly the roles and responsibilities across all agencies to keep the most vulnerable in our communities safe. There is an assumption that 'professional curiosity' will be applied about care arrangements and it would generally be expected by all practitioners. The absence of individual personal contact one-to-one with Adult B also appears evident in the interventions by the GP and HC2 agency in that there are no records of discussions with her separate from her family. It is unclear whether this is normal practice in these services and likely to be replicated by practitioners with other service users, but it is in marked contrast with the more personal care and interventions apparent in the engagement with Adult B by ASCH and HC1 agency between 2012 and 2014.

[11] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

4.2 What did this case tell us about factors that limit knowledge and understanding of historic concerns?

4.2.1 The agencies with the most consistent and regular involvement with Adult B were HC1 agency and HC2 agency. They were visiting weekly for the last five years of Adult B's life and, as they were providing her with intimate care, they had the greatest opportunity for building with her a relationship of trust. This was evident in her involvement with the HC1 agency and ceased when the son ended that arrangement and transferred her care to the HC2 agency. It is not clear why he did this, however, one significant effect was that the new carer had no knowledge of the history of previous safeguarding concerns. In this instance, there were no systems in place for such information to be handed on where care packages were self-funded as in these circumstances ASCH had no ongoing involvement. The HC1 agency did advise ASCH that their involvement had ended but this does not appear to have been recorded and practitioners reviewing the case record were unaware that a new agency had become involved.

4.2.2 The district nursing service, in theory, should have understood the history of previous safeguarding concerns which could therefore have informed their interventions when Adult B was found with a series of tears and bruises. In practice, the service was delivered by a high number of nursing staff and, whilst their recording of individual interventions was good, there is little evidence that they were able to have an overview of the chronological history or to relate that to past records. One reason for this is that the service had moved to a new IT system and it was reported at the workshop that accessing past paper records was difficult (it is noteworthy that the report initially provided for the SAR did not include information prior to 2016 which was discovered later) and it was confirmed that reviewing records electronically was not easy using the electronic system. There is no use of chronologies within this service and as none of the injuries were recorded on Datix as a safeguarding concern[12] that also did not trigger an overview. Review of the Risk Register during 2017 showed that the Out of Hospital Division (this includes the community nurses) had four risks relating to unreliable IT system, mobile phone access and demand exceeding capacity of the community nursing service.

4.2.3 The other agency that was involved throughout with Adult B was the GP. In England, the GP record is seen as a key point for collating information from other health services and for vulnerable adults acts as a safety net for key social and health information. The GP is the main access point for health services for vulnerable adults and acts as a hub for health records or concerns as well as triggering some routine health interventions such as immunisations.

[12] Specialist patient safety software system used for recording reports of clinical incidents, patient morbidity and mortality etc. *East Sussex Healthcare NHS Trust (ESHT) – Quality Improvement in Response to the 2015 Care Quality Commission (CQC) Inspections* East Sussex Health Overview and Scrutiny Committee (HOSC)

It is, therefore, surprising that the GP had no record of any safeguarding concerns regarding Adult B and was unaware of the multi-agency assessments that took place in 2012 and 2014 or the district nurse concerns regarding the tears and bruises in 2016 and 2017. This SAR identified that there was no direct communication between ASCH and the GP, and furthermore that there is no evidence that the GP was invited to attend or contribute to the safeguarding process (strategy meeting and safeguarding conference). Similarly, there was no discussion between the district nursing service and GP about their possible safeguarding concerns for Adult B and she was never raised for discussion at a multi-disciplinary meeting (MDT). Discussion at the workshop indicated that whilst procedures were clear that GPs were a key part of the safeguarding system there was also a perspective that the service was under pressure so would not be able to attend meetings which was why they were not invited. This therefore became a self-fulfilling prophecy. The GP attending the workshop confirmed that attending meetings was difficult but was clear that if he were requested to attend, a report would be provided and that minutes of safeguarding meetings would be read and would then inform their work with vulnerable adults.

4.2.4 The role of ASCH in this case was mainly to respond to referrals from agencies who had longer-term involvement and to assess whether the risks met a threshold for longer-term involvement by ASCH, which they did not. It is imperative in such a model of involvement that agencies with long-term input are kept involved with the outcomes of the assessments and risks are shared. The GP needed to know about the concerns about GD1 and possible risks from the son, and the withdrawal of the home care agency should have triggered a consideration of whether this changed the risk factors for Adult B. This case has highlighted the risk that increased reliance on short-term working practices, in both health and social care, can create an environment where practitioners may take a short-term view on the circumstances of the people they are working with and decision making may be compromised by these models. This has an inhibiting effect on professional curiosity, preventing compounding risk factors in case work to be identified and acted on. Practitioners do all they can to maintain the status quo to meet timeframes and complete the work and so are less able to envisage and act upon the wider risk factors. This SAR identified a weakness around continuity of information sharing between agencies and between practitioners within agencies. One explanation for this weakness is that agencies and practitioners become focussed on achieving their immediate goals and are not able to think about the wider issues.

4.3 What did this case tell us about why practitioners lack curiosity and struggle with challenging family members caring for vulnerable older people?

4.3.1 Throughout the SAR, one explanation provided by practitioners for the lack of individual one-to-one contact with Adult B was that staff found it difficult to ask family members to leave the room and give them privacy because it was their home. This lack of confidence may reflect an underlying assumption that is being made which is that as family members they have a privileged relationship with the older person and are the best people to determine the nature of the practitioner's intervention. Where practitioners are involved with a family, they assume the family / carer dynamic presented is a true reflection and most of the time this is the case. Practitioners have a default view that families and carers are caring, they will not question this unless there are specific concerns.

4.3.2 This is supported by research which has identified that it is generally assumed that family members can be trusted more than others, and the presumption of an expectation of trust in family relationships is well established. Giddens asserted that 'kins-people can usually be relied upon to meet a range of obligations more or less regardless of whether they feel personally sympathetic towards the specific individuals involved'. This has been challenged and, in the specific context of elder mistreatment, Chappell et al and Biggs and Powell have pointed out that trusting in families conflicts with the descriptions of 'the family' as a site of inter-generational stress, conflict and violence that are common in accounts of elder mistreatment[13].

4.4 Are current systems for investigating unexpected deaths of adults adequate – what did this case tell us about assessments understanding of family dynamics and consideration of disguised compliance?

4.4.1 A key issue that was discussed at length in the workshop with key practitioners was the nature of the multi-agency investigation of Adult B's injuries in 2017, and whether it was sufficiently robust. There were concerns that if Adult B had died on admission to hospital the investigation would have been different. There was also a view, expressed in the police report, and echoed at the workshop by all practitioners that if she had been a child there would have been a different response regardless of the outcome. It was felt that there should have been further contact with the family members to investigate the contradictions between Adult B's presentation at the hospital and their explanation of the cause of the injuries. The workshop members

[13] Defining elder mistreatment: reflections on the United Kingdom Study of Abuse and Neglect of Older People JOSIE DIXON (a1), JILL MANTHORPE (a2), SIMON BIGGS (a2), ALICE MOWLAM (a1) https://doi.org/10.1017/S0144686X0999047X Published online: 14 December 2009

considered that there was insufficient consideration of previous history at the time of the investigation, and that the post mortem findings of death by natural causes unduly affected the conclusion by the police, supported by other agencies, that there should be no further criminal investigation[14].

4.4.2 Following from this, the workshop discussion further expanded to consider whether unexpected deaths of adults, where abuse is suspected to be a contributory factor in the death, should be investigated in a similar way to children's deaths which was suggested by the police in their report. In Children's Services there is an expectation that *'Following the unexpected death of a young child, all families should be visited at home within 24-48 hours by a police officer responsible for investigating the child's death and a consultant paediatrician or other health professional experienced in responding to unexpected child deaths …'.* The aim of this intervention is *'To complete and jointly review the medical history at an early stage so as to identify any possible medical or child protection factors contributing to the death and inform the coroner and pathologist; [and] To provide the family with immediate and later information and advice about medical questions and bereavement support'*[15].

4.4.3 Currently when a person dies and there is concern that abuse could be a contributory factor, the agencies with immediate primary responsibility are the police and the coronial service. The police response will depend upon which criminal offences are suspected, whether the crime is still taking place, and on other factors such as whether anyone is at immediate risk of harm. Coroners investigate deaths that have been reported to them if it appears that: the death was violent or unnatural, the cause of death is unknown, or the person died in prison, police custody, or another type of state detention. In these cases, coroners must investigate to find out, for the benefit of bereaved people and for official records, who has died and how, when, and where they died[16]. There may also be a Serious Incident Investigation[17] or a Safeguarding Adults Review (SAR). From discussions at the workshop, it was clear that currently there is little input from other services into the coronial investigation and police response, despite those practitioners possibly having the greatest knowledge of the individual who has died. The current safeguarding policy and procedures do not include guidance for agencies as to how they could contribute to the current investigative processes, and they are not clear as to how they overlap with other processes, such as the local authority undertaking a safeguarding enquiry. In this case, there were aspects of the police investigation that could have been challenged, in particular, their decision to

[14] This decision is being reviewed by a senior police officer

[15] Pan Sussex Child Protection and Safeguarding Procedures Manual https://sussexchildprotection.procedures.org.uk/search?kw=child+death

[16] http://sussexsafeguardingadults.procedures.org.uk/pkotz/sussex-safeguarding-adults-procedures/receiving-concerns-and-undertaking-enquiries/#s2798

[17] **Serious incidents** in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure these **incidents** are identified correctly, **investigated** thoroughly a and, most importantly, learned from to prevent the likelihood of similar *incidents* happening again. https://improvement.nhs.uk/resources/serious-incident-framework/

cease the investigation. There is nothing in the current procedures to assist practitioners from other agencies in considering their role whether to challenge the police about such matters.

4.4.4 It was felt at the workshop that if there had been a process, like that for children, whereby all agencies met to discuss the death this would have led to a more robust challenge of the family's explanations and may have resulted in a fuller and more detailed post mortem report. Such a process would also have allowed for discussion of the impact on Adult B of the delayed response by the ambulance service in transporting her to hospital. The ambulance request was categorised as a 'Cat C 30' meaning that a resource should have been on scene within 30 minutes. Unfortunately, the ambulance service was extremely busy, and the response time was 2 hours and 34 minutes[18]. Adult B was very unwell when she arrived at the hospital and while the main reason for the delay in her receiving treatment was the family failing to take her there, a factor that must also be considered is the slow ambulance service. The delayed response by the ambulance would not have impacted on her injuries but may have impacted on the speed of Adult B's physical deterioration. Practitioners at the workshop reported that, in their experience, such response times were not unusual. This clearly places vulnerable adults at risk but also is a misuse of practitioner time given that the police officer and social worker were waiting with Adult B until the ambulance arrived.

5. Conclusions

5.1 Mental capacity and empowerment

After Adult B moved in to live with her son, she became inadequately supported with very little recorded evidence of her wishes and feelings and, although there was an understanding that she had capacity, this was not formally assessed. During that time, she was seen regularly by nursing staff, the GP and HC2 care staff, however, she was never seen alone from her family and concerns about her care were addressed to them without obtaining information from Adult B about how injuries had occurred. There were various reasons for practitioners' actions, but chief explanations were a concern about asking family members in their own home for space to have private communication with Adult B. There was also a lack of continuity of nursing staff, and difficulties in accessing electronic records that prevented the pattern of injuries being easily identified.

[18] Consideration is being given as to whether SECAmb should consider a Serious Incident investigation into the delay

5.2 Lack of understanding of history

There was poor communication and liaison between key agencies working with vulnerable older people particularly around attendance at safeguarding case conferences and strategy discussions. This was partly because an expectation has developed that some key professionals may struggle to engage, such as GPs, due to competing pressures hence they are not always invited; and partly reflected resource pressures within the safeguarding system exacerbated by poor IT systems that did not facilitate the use of chronologies. There were also no systems for transferring safeguarding information when the agency providing care in the home changed.

5.3 Reasons practitioners do not show curiosity

Across agencies there was a lack of confidence by practitioners in challenging family members when they were providing care for a relative. In part, this was about practitioners feeling inhibited because they were working in the family members' home. It is probable, however, that it also related to assumptions that were made about relationships within families and a difficulty for practitioners in 'thinking the unthinkable', and may also indicate different reactions by practitioners to the death of an older person as opposed to a child or young person.

5.4 Areas for improvement in investigating the deaths of vulnerable adults

The final investigation into the reasons for Adult B's death particularly evidenced differences between the ways in which child deaths and adult deaths are investigated. The SAR identified clear shortcomings in the last safeguarding investigation (particularly aspects of the police investigation) and it appeared that a major reason for this was concern not to cause the family distress in the context of the death of a very elderly lady.

6. SAB recommendations

6.1 Mental capacity and empowerment

All agencies to reassure the SAB that their practice, when working directly with service users, enables their practitioners with the opportunity for direct personal contact, separate from family members, regardless of where they are providing the service.

6.2 Lack of understanding of history

The SAB to undertake a sample audit of general agency involvement in the safeguarding process including invitation and attendance at safeguarding meetings and receipt of minutes of such meetings. This is to inform the development of robust mechanisms that ensure appropriate representation at safeguarding meetings, information sharing if attendance is not confirmed, and secure electronic communication.

6.3 Reasons practitioners do not show curiosity

The SAB to develop multi-agency workforce development opportunities for practitioners working with complex cases, for example where there is coercion and control, to enable improved confidence in engaging directly with service users and developing greater professional curiosity and more effective safeguarding of vulnerable adults.

6.4 Areas for improvement in investigating the deaths of vulnerable adults

The SAB should consider developing alternative arrangements for investigating unexpected adult deaths where abuse is suspected or known to be a factor in the death. These arrangements should be based on existing adult legal mandates and established agency roles, drawing on the learning in Children's Services about the strengths and weaknesses of the current Child Death Review processes.

Fiona Johnson
13/05/2019

Appendix 1 – Individual agency recommendations

1. Adult Social Care and Health

1.1 Improve frontline staff and managers' understanding and consistency of safeguarding threshold decision making, domestic abuse and safe enquiries.

1.2 Review the risk assessment tools in LAS (the ASCH information database).

1.3 Greater uptake of reflective practice offer for practitioners to include complex case scenarios with key themes such as: intergenerational abuse, professional curiosity, safeguarding thresholds and safe enquiries.

1.4 Putting systems in place to ensure consideration is always given if a GP needs to be informed of a safeguarding concern and invited to attend any safeguarding meetings, or send a representative, or send information to safeguarding meetings.

1.5 Develop and implement standardised invite / response letters for safeguarding meetings and recording of invites / responses.

1.6 Provide training and development for practitioners on effective and confident challenging. Training to be tiered and mandatory according to practitioner grade.

2. Home care agency 1

2.1 Once a safeguarding concern has been raised, diarise dates to chase for updates on the situation.

3. Sussex Police

3.1 To consider the protocols applicable in an unexpected child death specifically in relation to a joint police / consultant paediatrician or other health professional visit to a family within 24/48 hours in cases such as Adult B where there are unexplained injuries / marks on the victim's body that are unaccounted for.

4. East Sussex Healthcare NHS Trust (ESHT)

4.1 Signs of control, coercion and disguised compliance must be included in ESHT Level 3 SAAR (Safeguarding Adults at Risk) training package.

4.2 Greater consistency in the allocation of community nurses complex cases.

4.3 The implementation of Safeguarding Supervision Policy within the Out of Hospital Division.

4.4 To review the introductory pack given to service users at the start of the service to include a reference to providing privacy.

4.5 To improve the use of alert systems on electronic records to enable better access to a chronological history of problems.

5. Clinical Commissioning Groups, East Sussex

5.1 Improved record keeping in general, and, in particular, with respect to requests from outside agencies.

5.2 Increase learning for GPs around professional curiosity with particular regard to adults at risk.

5.3 Consider all unexpected deaths as ‘significant events’ to be formally reviewed with input from all members of the wider practice team.

Appendix 2 – Glossary of terms and abbreviations

ASCH	**Adult Social Care & Health** – services provided by East Sussex County Council Adult Social Care & Health.
CQC	**Care Quality Commission** – the independent regulator of health and social care in England.
ESHT	**East Sussex Healthcare NHS Trust** – provides NHS hospital and community services throughout East Sussex.
GP	**General practitioner** – a doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.
HC1	**Home care agency 1** – a provider of in-home care services, registered with the Care Quality Commission.
HC2	**Home care agency 2** – a provider of in-home care services, registered with the Care Quality Commission.
MSP	**Making Safeguarding Personal** – is a national approach to promote responses to safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.
SAB	**Safeguarding Adults Board** – The Care Act 2014 places adult safeguarding on a legal footing. From April 2015, each local authority must set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the police and the NHS (specifically the local Clinical Commissioning Groups), and the power to include other relevant bodies.
SAR	**Safeguarding Adult Review** – Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of, or has experienced, serious abuse or neglect (known or suspected), and there is concern that partner agencies could have worked more effectively together. The aim of the SAR is to identify and implement learning from this.
SECAmb	**The South East Coast Ambulance Service NHS Foundation Trust** – is the NHS Ambulance Services Trust for south-eastern England, covering Kent (including Medway), Surrey, West Sussex and East Sussex (including Brighton and Hove).

Appendix 3 –

Terms of reference: Discretionary Safeguarding Adults Review (SAR)

1.1 The purpose of this SAR is to identify what lessons are to be learnt about the way in which local agencies worked together to ensure they are responding appropriately when concerns are raised about people who may be experiencing abuse and neglect, particularly when these concerns are within family contexts, and where there are complexities impacting on capacity decisions and refusal to engage in safeguarding interventions.

1.2 The statutory requirement of a SAR within section 44 of the Care Act was not met; however, the East Sussex Safeguarding Adults Board (SAB) has made the decision to conduct a discretionary SAR, to enable learning to be taken forward where there were concerns regarding the extent of injuries sustained for Adult B, before her death.

1.3 Ethos of the SAR

This SAR will be considered in a fair and open manner. It will be objective in its approach and will be thorough, rigorous, and evidence based. All contact with individuals and stakeholders will be respectful, recognising any circumstances and religious diversity or other protected characteristics in accordance with the Equality Act 2010.

2. Scope of the SAR

2.1 The SAR will focus on the events leading up to the death of Adult B and will consider the service interventions for Adult B. Engagement with Adult B and her family by the professionals involved will also be considered. The SAR will have a particular focus on the following factors in this case:

1. Mental capacity and consent: The extent to which factors such as coercion and / or family influence was considered when accepting Adult B's refusal for safeguarding interventions.
2. Historical concerns: The extent to which these were considered with each safeguarding concern that was raised, to develop appropriate risk assessments.

3. Areas of good practice: drawing out where professionals appropriately raised concerns and evidenced professional curiosity.
4. Organisational and practitioner perspectives: drawing out how both of these influenced decision-making in this case.
5. Procedure and practice: Analysis of procedures and practice at the time and practice occurring now.

2.2 Agencies

Agencies that were in contact with Adult B will be asked to contribute to this SAR, as well as agencies that were not in contact which might have been expected to respond. Those are as follows:

- East Sussex Adult Social Care
- Home Care Agency 2
- Sussex Police
- Clinical Commissioning Group East Sussex
- East Sussex Healthcare NHS Trust
- Primary care practice within Eastbourne Hailsham Seaford CCG
- Home Care Agency 1
- The Chair of the Safeguarding Adults Review Panel is the Head of Adult Safeguarding, Adult Social Care & Health, supported by the Development Manager, Safeguarding Adults Board. Members of the SAR panel will also assist in the process.
- The lead reviewer / facilitator is Fiona Johnson, who will be responsible for the overview report and facilitation of a learning event.

2.3 Time period

Having considered the relevant events, the focus of the SAR will run from November 2012 to the death of Adult B on 27th September 2017. The subsequent enquiries made by agencies involved after Adult B's death will also form part of the SAR.

3. Methodology

3.1 The SAR will take a hybrid approach incorporating a learning event.

3.2 Frontline professionals and their managers will be invited to take part in the action learning event.

3.3 Agencies will be asked to complete a focussed report, including a timeline of key events. An overview report will then be produced for the Safeguarding Adults Board by the lead reviewer / facilitator, and the SAR panel will translate any recommendations into an action plan.

3.3 The action learning event will attempt to understand what practitioners were making sense of the case at the time. A key principle of this approach is to avoid the bias of hindsight; to be able to consider what would be done the same, and what would be done differently.

3.4 The SAR will consider other reviews or enquiries that have been undertaken, including:

- individual section 42 safeguarding enquiry
- coroner's investigation
- any other out of area review identified

Appendix 4 – Bibliography

The Mental Capacity Act (MCA) 2005
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

The Care Act 2014 Sections 44(1) – (3)
http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

Making Safeguarding Personal
http://sussexsafeguardingadults.procedures.org.uk/ykoss/sussex-safeguarding-adults-policy/sussex-safeguarding-adults-policy

The Mental Capacity Act 2005 https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

East Sussex Healthcare NHS Trust (ESHT) – Quality Improvement in Response to the 2015 Care Quality Commission (CQC) Inspections East Sussex Health Overview and Scrutiny Committee (HOSC)

Defining elder mistreatment: reflections on the United Kingdom Study of Abuse and Neglect of Older People, Josie Dixon (a1), Jill Manthorpe (a2), Simon Biggs (a2), Alice Mowlam (a1) https://doi.org/10.1017/S0144686X0999047X Published online: 14 December 2009

Pan Sussex Child Protection and Safeguarding Procedures Manual
https://sussexchildprotection.procedures.org.uk/search?kw=child+death