East Sussex Safeguarding Adults Board

Report of the Safeguarding Adult Review (SAR) regarding 'Anna'

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1. INTRODUCTION

1.1. Background to the Safeguarding Adult Review (SAR)

1.1.1. The subject of this SAR is being referred to using the anonymised name of Anna. Anna died in hospital on 27/02/2020 at the age of 85. Her cause of death was due to natural causes but there were concerns about her presentation on admission to hospital on 24/02/2020 when she was noted to have multiple bruising and skin tears over several parts of her body. There were historical concerns regarding abuse of Anna by her daughter and she had been placed in residential care where she lived for over a year. Anna had moved back to live with her daughter five months prior to her death.

1.1.2. A Safeguarding Adults Board (SAB) has a statutory duty under Section 44 of the Care Act 2014 to arrange a SAR where:

a) an adult with care and support needs has died and abuse or neglect is known to be a factor in their death, or an adult is still alive but has experienced serious abuse or neglect, and
b) there is concern that partner agencies could have worked together more effectively to protect the adult.

1.1.3. SAB members must cooperate in and contribute to the review with a view to identifying lessons to be learnt. The purpose is not to allocate blame, but to determine what the relevant agencies involved in the case might have done differently and to identify ways of how agencies work, singly and together, to help protect adults at risk of abuse and neglect.

1.1.4. The SAR referral was made on 02/02/2021 by Adult Social Care and Health (ASCH). The case met the mandatory requirement for a SAR under Section 44 of the Care Act and a decision to undertake a SAR was endorsed by the Independent Chair of the East Sussex Safeguarding Adults Board (SAB) on 28/03/2021. It was felt that the circumstances of Anna's death had some similarities with a previous SAR (Adult B) published by the East Sussex SAB on 28/02/2020 and that SAR Anna should explore the extent to which the learning from that review had been embedded in practice as well as to explore additional areas of learning specific to the circumstances.

1.2. The Terms of Reference

1.2.1. The specific terms of reference are attached as appendix 1. It was agreed that the review would take a hybrid approach with two parallel pieces of work: an audit of how the relevant actions of Adult B had been embedded and what impact they were having on practice; and a learning event involving frontline practitioners and their managers, with specific focus on two safeguarding enquiries undertaken between 2017 and 2020.

1.2.2. The review had a focus on the following research questions:

a) How well was the learning from Adult B embedded in general safeguarding practice?
b) How effective are practitioners at intervening when faced with hostility and aggression from carers?
c) How do practitioners in East Sussex identify and address cultural needs?
d) How do practitioners share information about risk and co-ordinate safeguarding work between different agencies in East Sussex?

1.3. SAR process

1.3.1. The report has four main sections: 2) 'Summary of facts', a description of the services provided to Anna explaining how agencies worked together to support her; 3) 'Analysis', an appraisal of the practice with, where possible, an explanation of factors that helped or hindered effective service delivery; and 4) a summary of the review undertaken about how the recommendations from the Adult B SAR have been implemented; and finally 5) 'Lessons learned', the ways in which this specific case highlights findings about the safeguarding system as a whole and reflections on what this may indicate about the implementation of the Adult B recommendations. This is followed by Section 6 conclusions and recommendations.

1.3.2. The following agencies made up the Review Team: -

- ASCH, East Sussex County Council (ESCC)
- Sussex Police
- NHS East Sussex Clinical Commissioning Group (CCG)
- Sussex Partnership NHS Foundation Trust (SPFT)
- East Sussex Healthcare NHS Trust (ESHT)
- Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit Brighton & Hove and East Sussex

1.3.3. Summary of information reports were received from the following agencies:

- ASCH
- Financial Services, ESCC
- Sussex Police
- Sussex Partnership Foundation Trust (SPFT)
- East Sussex Healthcare NHS Trust (ESHT)

1.3.4. In addition, the Lead Reviewer had access to the relevant records from the following agencies:

- GP records
- Minutes of the MARAC meeting on 25/7/2017
- Coroners Officer report
- A chronology from EESHT regarding the involvement of the District Nursing service and Anna's attendances at hospital
- ASCH records regarding the final safeguarding investigation initiated 24/2/2021.

1.3.5. 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 1994, contributing to the development of strategy and operational services with a focus on safeguarding. She is independent of East Sussex SAB and its partner agencies.

1.4. Parallel Processes

1.4.1. There were no parallel processes as the criminal investigation and coronial process were completed prior to the SAR being undertaken. The Lead Reviewer had access to documents prepared for the coroner.

1.5. Family Input to the SAR

1.5.1. All three of Anna's daughters were contacted and offered the opportunity to meet with the Lead Reviewer on several occasions by email and phone, however none of them responded and therefore they have not participated in the review.

2. SUMMARY OF FACTS – description of the support provided to Anna

2.1.1. In this report, the following terms have been used to refer to people involved in this case and their relationship to Anna:

- Anna – Subject of SAR
- Husband – Anna's husband
- Daughter 1 – Daughter (father unknown, said to be adopted by Husband)
- Daughter 2 – Daughter (father Husband)
- Daughter 3 – Daughter (father Husband)
- Son-in-law – Partner of Daughter 1
- Grandson – Daughter 1's son

2.2. Background history

2.2.1. Anna was born in Europe and moved to the UK for work reasons when she was 22. Daughter 1 was born two years later it is not known who her father was. Four years later Anna married, and it is reported that her husband adopted Daughter 1. Anna then had two further children and remained living with her husband until 2012 when she moved to live with Daughter 1. Anna did not divorce her husband and when he died in 2014, he left money to Anna and her two younger daughters, with nothing being given to Daughter 1.

2.2.2. In 2013 Daughter 2 contacted ASCH and alleged that an adult that she was caring for was at risk of financial abuse from Daughter 1, and that Daughter 1 had

attempted to defraud their father out of his home. The investigation of this allegation did not prove anything untoward, and no action taken. A record of the concerns was noted on Daughter 1's social care records but nothing was recorded on Anna's social care notes.

2.2.3. Prior to 2015 Anna's main professional contact was with her GP. She was being treated for Chronic Obstructive Pulmonary Disease (COPD) and for depression. In 2011, as part of a review of her medication for depression, Anna reported to her GP that her husband was frightening and controlling; soon after this, she moved to live with Daughter 1 and after the move, told the GP that she was less depressed. It is not clear how often Anna saw her younger daughters before she moved in with Daughter 1, however while she was living with her there was no contact.

2.2.4. In 2015 Anna had a fall and was admitted to hospital; later she had a hip replacement operation. Following these admissions, she and Daughter 1 were offered support, but this was rejected by Daughter 1. In February 2016 Anna had a further fall and in July 2016 she had a knee replacement operation. Following this operation Daughter 1 agreed to an assessment for support by ASCH, but then cancelled their visit. However, district nursing services started at this time. Anna continued to be treated for depression by the GP during this period.

2.2.5. In December 2016 Anna was admitted to hospital following a fall and on discharge a referral was made to the Joint Community Rehabilitation (JCR) Service. After visiting in January 2017, JCR workers raised concerns regarding the home environment and interfamilial relationships. The home was described as cold and damp, and Daughter 1 was seen to be threatening to Anna, withholding the TV remote control and her walking sticks, as an inducement / threat to take more exercise. These concerns resulted in a joint visit in February 2017 between JCR and ASCH who were undertaking a carer's assessment because of concerns about the placement breaking down. No further safeguarding action was taken. It was noted that Daughter 1 was providing all care and that she could be 'blunt and unsympathetic towards her mother'. Daughter 1 again refused any support in caring for her mother.

2.2.6. Later in January 2017 Daughter 1 made a request to the GP for a dementia assessment of her mother. The GP asked the district nursing service to undertake a urine sample and a blood test to rule out a urinary tract infection (UTI) and investigate for dementia. Following this returning negative, a referral was made to the Memory Assessment Service (MAS).

2.3. First safeguarding concerns February 2017 – July 2017

2.3.1. In February 2017 Daughter 1 brought Anna to the surgery and was observed being openly aggressive to her mother. Following this the GP made a safeguarding referral to ASCH. As a result, ASCH visited Anna at home; she reported she was happy and did not want the situation to change. The worker noted bruising to Anna's arms, and she explained this happened when she bumped into things going to the toilet. The route however was uncluttered with no obvious obstacles. No further action was taken.

2.3.2. In June 2017 Nutrition and Dietetics contacted the GP with concerns about Anna's weight loss. The GP spoke to ASCH to check what response had taken place to the referral in February and was told that the case had been closed as the patient did not feel at risk and did not want anything to be done. Following this the GP referred Anna to the Specialist Older Adults Mental Health Service (SOAMHS), because of concerns about possible depression and dementia.

2.3.3. On 06/07/2017 Daughter 1 was observed by staff at the GP practice being abusive to her mother, they also noticed injuries including a black eye, skin tears to her forearm and older wounds on her elbow said to be due to a fall ten days earlier. Anna was examined by the GP who arranged admission to hospital and a safeguarding referral was made to ASCH. While in hospital the Resource Officer from the hospital social work team made several visits to Anna to discuss the safeguarding concerns. Initially Anna denied that Daughter 1 had been abusive but subsequently she disclosed that Daughter 1 had hit her and said she did not want to return to her care.

2.3.4. Following this disclosure an initial safeguarding planning meeting was held where it was decided that Anna would be moved to residential care where contact with her daughter would be managed and supervised. At this point it was decided not to involve the police as Anna was clear she would not talk to them. It was felt at the time that Anna had capacity to make this decision. The matter was deemed domestic abuse and a DASH[1] form was completed, and a referral made to the Independent Domestic Violence Advisor (IDVA) Service. On 25/07/20 the matter was discussed at a MARAC meeting and Anna was named as the victim of domestic abuse with Daughter 1 as perpetrator. Risks identified included physical abuse, economic abuse, and isolation but it was noted that Anna was not returning to the care of Daughter 1. Abbreviated notes of the MARAC discussion were circulated to all agencies.

2.3.5. On 31/07/2017 Anna moved into a care home. After some time, Daughter 1 visited her there and advice was given to care home staff that all visits should be supervised. Anna was also seen at this time by an Associate Specialist in Psychiatry who diagnosed mild depression and mild deficits regarding memory impairment.

[1] Domestic Abuse, Stalking and Honour Based Violence – DASH checklist is a tool used by workrs to assess risk of somestic abuse -

2.4. Concerns regarding financial abuse August 2017 – May 2018

2.4.1. Following Anna's move to the care home concerns were raised regarding possible financial abuse by Daughter 1 who had lasting power of attorney (LPA). A safeguarding planning meeting was held on 18/09/2017 where it was noted that information gathered indicated over £100,000.00 had been used to pay off credit card debts and fund a garage conversion and roof repairs. The next day a mental capacity assessment was completed that concluded on balance of probability Anna lacked the capacity to manage her finances without support, because of inexperience, rather than a mental health condition. The case notes at this time recorded that Anna had consented to the registration of the power of attorney naming Daughter 1 as LPA and that Anna was not aware of how her money had been spent but did not want any action to be taken. It was determined that Anna had not been a victim of coercion and control regarding her finances but that she was a victim of financial abuse by Daughter 1, who had withheld information and misappropriated funds. It also determined that Anna had not intentionally depleted her capital to avoid paying for care services. It was recommended that Daughter 1's LPA should be revoked as soon as possible and that, in the interim, Anna's bank accounts should be frozen.

2.4.2. Following this the Office of the Public Guardian (OPG) were contacted who asked for clarification as to whether Anna had capacity to request an investigation into alleged financial abuse. On 21/09/2017 it was noted that Anna's finances were so low that the risk of further financial abuse was low. A mental capacity act assessment was undertaken by ASCH on 09/10/2017 which deemed that Anna lacked capacity to manage her finances. On 09/11/2017, an OPG investigator visited Anna and separately assessed that 'she had capacity to manage her finances but chose not to'. The OPG advised on 28/11/2017 that they did not support court or police action but recommended that Anna had made the decision to revoke Daughter 1's LPA and to nominate the Local Authority to manage her finances.

2.4.3. Following this an 'appointeeship' referral was completed by ASCH on 9/01/2018. In January 2018 Daughter 1 visited Anna at the care home and asked her for a cheque for £2,000.00. This was not provided as Anna did not have such money. On 26/01/2018, the care home contacted ASCH because Anna had visited Daughter1 in her home and on her return to the care home said that she wanted to go back to live with her daughter as she needed to support her financially. ASCH advised the care home not to allow further visits until they had been able to visit and discuss the matter with Anna. The same day a further capacity assessment is recorded where it was noted that Anna lacked capacity. On 30/01/2018, a safeguarding meeting was held attended by finance representatives that confirmed that OPG had registered a new LPA naming ESCC. Following this meeting ASCH visited Anna in the care home and completed a capacity assessment in relation to finances that concluded that she had capacity. There was discussion regarding where Anna wanted to live, and she agreed that she preferred to remain in the care home. On 16/02/2018 a

further meeting between finance and ASCH agreed that Daughter 1 should be invoiced for the full cost of the care home. The care home placement was confirmed at that meeting as permanent, however there was no changes made to the safeguarding plan, and nothing was recorded indicating there was consideration of whether the decision to invoice the daughter for the care home costs placed Anna at greater risk. There is also no record of what discussion there was with the Care Home about whether Daughter 1 should visit Anna or what safeguards about such visits should be put in place.

2.4.4. In January 2018 Daughter 2 contacted Sussex Police asking for help in contacting Anna as Daughter 1 was refusing to tell her where she was living. Sussex Police contacted ASCH who facilitated contact between Daughter 2 and her mother who was happy to see her. In the following months Daughter 3 who did not live locally also visited Anna in the care home. By April 2018 it is evident from records that Daughter 1 was also visiting as she had seen Anna at the home on Mother's Day in March 2018.

2.4.5. On 24/04/2018 ASCH telephoned the care home to confirm that the safeguarding enquiry would be closed. The care home staff expressed concern about this decision as Anna was still talking about wishing to return to live with Daughter 1. The enquiry was formally closed on 30/05/2018. The closure note concluded '*This has been a long and complex safeguarding enquiry. We have considered that [Anna] experienced physical, emotional, potentially domestic, and financial abuse and potentially neglect too. This is in the context of her advising professionals for many months that she was happy at home prior to her disclosure. She is now living out of the family home and is able to manage her day, interactions, choices herself with the help of the staff in the home. Alongside this, our Finance department has worked alongside us to ensure that she is safe from a financial perspective'.*

2.4.6. From April 2018 onwards Finance staff continued to manage the processes involved with recouping the costs of the care home from Daughter 1; she appealed against the decision to charge her for the costs but was unsuccessful. Daughter 1 did not however pay any money to ESCC and by May 2019 the Local Authority was attempting to recoup the debts using legal means. At the same time the Finance Department was progressing the application for the Local Authority to function as an appointee on behalf of Anna. This process was also opposed by Daughter 1 but eventually in August 2019 the Local Authority achieved 'interim deputyship' which enabled them to access a savings account on behalf of Anna and the money in this account was used to pay the care home fee debts incurred by Anna prior to the decision to invoice Daughter 1 for the care home fees. During this period there was no contact between the Finance staff progressing the recoupment of the fees and the ASCH staff responsible for safeguarding Anna, and the latter were unaware of the legal processes that ensued regarding the non-payment of the debt by Daughter 1.

2.5. Anna moves back to live with Daughter 1 September 2019 – October 2019

2.5.1. On 24/09/2019 ASCH visited Anna in the care home for a placement review meeting because she was saying to staff in the care home that she wished to return to live with Daughter 1. The social worker talked with Anna and reminded her of the previous disclosures of abuse. In response she said I '*probably deserved it'* and '*I have learnt my lesson.'* Anna presented as lacking insight into her care needs and seemed unaware that ESCC was managing her finances. The social worker arranged to revisit on the 17/10/2019, with a colleague, with the intention of completing a capacity assessment.

2.5.2. On 13/10/2019 the care home contacted the Emergency Duty Service (EDS) to say that, as usual Anna had visited Daughter 1 but that the daughter had phoned them to say that Anna would not be returning to the care home. The next day the care home and ASCH unsuccessfully tried to contact Daughter 1 and Anna. The care home also contacted the district nursing service as they were due to see Anna to dress her ulcerated legs. The district nursing service said they could not now visit as Anna was now living outside the geographical area they served and advised that Anna needed to register with a GP in the area, who could arrange nursing services. On 15/10/2019 ASCH sought legal advice about whether to involve the police if they were refused entry. The solicitor advised to try direct contact with the family prior to involving the police and said that if Anna was at serious risk of harm ESCC could apply to the courts but that there would need to be compelling evidence of risk of harm to back up the application.

2.5.3. On 15/10/2019 ASCH attempted to visit Anna at Daughter 1's house. They were not able to access the house but were escorted off the premises by a man who was aggressive and threatened to call the police. ASCH contacted Sussex Police that day requesting their support to undertake a joint visit to undertake a welfare check as Anna had not been seen. ASCH records indicated that the police confirmed they were aware of the historic abuse. On 16/10/2019 Sussex Police visited the property alone and saw Anna and her daughter. They noted that Anna seemed happy, they saw her legs and could see no dressings and no open wounds she appeared well cared for and the accommodation was satisfactory. This information was passed to ASCH on 17/10/2019.

2.5.4. On 18/10/2019 ASCH contacted the district nurses who advised that they would try and visit Anna on 21/10/2019 to undertake a check of her legs prior to her care transferring to a new surgery. On 21/10/2019 the District Nurses attempted unsuccessfully to contact Daughter 1. The same day Anna was discussed in supervision by ASCH practitioners, and it was agreed to give notice on the care placement and await the outcome of the district nurse visit before taking any action. It was also agreed to write to the previous GP advising that Anna had been moved to a place of safety following abuse by Daughter 1, but that she had returned to the daughter's care without agreement and had not been seen by ASCH since the move. On 22/10/2019 there is a record in ASCH notes of a further telephone call to the district nurses who said they had not been able to contact

Anna but would continue to try and do so. There is no record of this conversation in the district nursing records but, the next day, there is a note that the care plan was ending with the service formally ceasing on 21/11/2019. This information was not shared with ASCH.

2.5.5. On 28/10/2019 there is a record of a case discussion with a Senior Practitioner in ASCH where it was noted that Daughter 1 had arranged for Anna to receive her medication and ordered a lifeline and was arranging for her to be registered with their 'family doctor'. It was hoped this would enable the district nurses to monitor Anna.

2.5.6. On 24/10/2019 Daughter 2 contacted ASCH expressing concern that Anna had moved back to live with Daughter 1. She was told that Sussex Police had visited Anna and had observed her to be happy and well. Two days later Daughter 3 contacted ASCH and asked for advice as to what she could do if Daughter 1 refused to allow her access to Anna. ASCH informed her they could not provide advice on this matter. There was no further contact with either Daughter 2 or Daughter 3 and it is not known whether they were able to see their mother once she had moved back to live with Daughter 1.

2.6. Service involvement November 2019 – January 2020

2.6.1. On 05/11/2019 a safeguarding concern was raised by ASCH that Anna had been removed from the care home before a mental capacity assessment could be completed and that ASCH were being denied access to Anna with concerns that her health needs were not being met. It is unclear what triggered this record at this time.

2.6.2. On 07/11/2019 ASCH recorded a telephone call to Sussex Police advising them of the safeguarding concerns that had been raised and the potential need for a joint visit with the police. The police agreed to undertake a joint visit if necessary but also stated that they considered that it would not be safe or productive for ASCH to visit without the police. Sussex Police have no record of this conversation.

2.6.3. On 06/11/2019 Anna was registered with a new GP (not the GP who she had seen prior to moving to the care home) and on the 08/11/2019 Daughter 1 had a telephone consultation with the GP requesting a home visit prior to restarting district nursing service. On 11/11/2019 the GP undertook a home visit at the request of Daughter 1 and agreed that Anna's legs did not need to be dressed. This GP was unaware of the history of abuse and saw nothing untoward at the visit. It was agreed that Daughter 1 would take Anna to the medical centre for dressings on her legs if it were felt to be necessary.

2.6.4. During December 2019 Anna was seen by nursing staff on three occasions at GP medical centres for dressings on her legs which had cellulitis and were becoming ulcerated. On each occasion she was accompanied by Daughter 1, and they were told that if the legs deteriorated, they should contact the GP.

2.6.5. On 02/01/2020 ASCH recorded a case note confirming Anna had been registered with a new GP. ASCH then closed the safeguarding enquiry noting that Anna was registered with a new GP and receiving the support she required.

2.6.6. On 08/01/2020 the GP visited Anna at home following a request from Daughter 1. Anna was seen to have cellulitis in her left leg and was prescribed antibiotics. She was asked to book a follow up review if needed that is if the wound continued to break down. Anna was due to attend surgery on 21/01/2020 for a routine 'spirometry' (a breathing test relating to her COPD) appointment. Anna failed to attend this appointment.

2.7. Final safeguarding assessment February 2020 – March 2020

2.7.1. On 24/02/2020 Daughter 1 telephoned the GP saying her mother had been unwell since the previous day and had not had anything to eat or drink since then, had not taken her medication and was a bit confused, speaking in her native tongue and not communicating. The intended GP response was to undertake a home visit however this was cancelled when Daughter 1 told the surgery that Anna had been taken to hospital.

2.7.2. On 24/02/2020 Anna was taken to the hospital Accident & Emergency department by Daughter 1. On admission she presented as very unwell with delirium, sepsis, multiple bruising on her arms, ulcers on her legs, feet and hips, multiple skin tears on her legs and blisters on her feet. Accident & Emergency staff response was to admit Anna to hospital and to address her immediate health needs as she was seriously ill. The next day 25/02/2020, the Ward Sister noted '*Multiple unexplained bruises and lacerations?'* and made a referral to ASCH saying she felt that Anna showed signs of physical abuse as well as general neglect. ASCH advised the Ward Sister to contact Sussex Police, but it is recorded by ASCH that the Ward Sister said, *'she was too busy with other patients and requested that I contact the police.*' It was agreed that on this occasion only, ASCH would contact Sussex Police. There is no record of this in ESHT records although it is recorded that two telephone calls were made to ASCH. ASCH contacted the Police Multi-Agency Safeguarding Hub (MASH) who arranged a visit to the hospital. Sussex Police visited that day and spoke to a nurse (unclear whether it was the same nurse) who denied that the bruising seen was a sign of physical abuse, there is no record of this conversation in the hospital records. The Police have recorded that they were later advised by a hospital doctor that the bruising was consistent with medication that Anna had been taking. This information was shared by Sussex Police with ASCH on 26/02/2020. On

27/02/2020 Anna died, without regaining consciousness and having never spoken coherently to hospital personnel.

2.7.3. On 28/02/2020 the ESHT Safeguarding Lead contacted ASCH and reported that there was nothing in the hospital records about the bruising being accidental or consistent with medication and nothing recorded as to who had spoken to Sussex Police regarding this on 25/02/2020. Furthermore, the doctor on the ward considered that the bruising was unexplained. The same day, ASCH received a report from Sussex Police summarising their attendance at the hospital on 25/02/2020. This noted that '*it was difficult to ascertain cause or age of bruising due to anti-coagulant medication and levels of agitation*' and that it was considered that '*a large skin tear may have been caused by manual handling from nursing staff.'*

2.7.4. On 04/03/2020 the coroner's report included '*There were initial concerns regarding the injuries, however these are now not believed to be part of the cause of death and are not being investigated further by the police*.' Cause of death was noted as 1a) Sepsis and 1b) Pneumonia.

3. ANALYSIS - appraisal of practice against terms of reference with factors that helped or hindered effective service delivery.

3.1. How do practitioners share information about risk and co-ordinate safeguarding work between different agencies in East Sussex including how issues in this case were escalated and supervised across the agencies involved.

3.1.1. The most noteworthy feature of the work by different agencies throughout this period was the absence of any multi-agency meetings. Whilst safeguarding enquiries were initiated at no time was there a multi-agency strategy discussion or planning meeting. This meant that Sussex Police were peripherally involved and whilst there was communication between health professionals and ASCH staff there was never a meeting where all the agencies involved discussed, together, their safeguarding concerns regarding Anna.

3.1.2. The absence of Sussex Police was driven in the main by a view that Anna did not want there to be any prosecution of Daughter 1, either for the physical and emotional abuse that she experienced, or for the financial misappropriation of her money. Whilst Anna's wishes, and feelings needed to be known and understood that did not necessarily mean that they should be paramount. The police can and do prosecute without victim consent and their decisions in these circumstances are informed by the risk to society and the likelihood of successful court action. In this case there was a previous allegation regarding Daughter 1 being a risk of

financial abuse to adults other than Anna, and in that context the police needed to be involved in making judgements about the broader risk to society.

3.1.3. Another effect of the absence of meetings was that assumptions were made about other agencies actions and the potential protection that meant for Anna. Thus, the decision by ASCH to cease their safeguarding investigation in January 2019 was informed by a false assumption that the district nursing service would continue to visit, and that they would raise further alerts if they noted concerns. Similarly, the single agency visit by Sussex Police in October 2019 focussed on the state of the house and the physical condition of Anna's legs and was not informed by a more detailed understanding of the emotional and financial abuse that Anna had previously experienced.

3.1.4. A further aspect of the safeguarding work was the negative impact on Anna of her geographical moves in terms of continuity of knowledge and understanding of her needs and the risks posed to her by Daughter 1. The first GP practice had a good understanding of the family dynamics and as a result they made several safeguarding referrals that led to her admission to hospital and then into a care home. Unfortunately, their concerns were not coded effectively on the electronic GP records, which meant that when a GP from the third GP practice to become involved and visited the family home in December 2019, that professional was unaware of the previous history of abuse, including Anna leaving the care home without the agreement of ASCH. This meant that information provided by Daughter 1 was taken at face value and it is possible that indicators of safeguarding concerns were missed.

3.1.5. Similarly, the nurses dressing Anna's legs in December 2019 were also unaware of the previous history and therefore assumed that Daughter 1 would respond to their advice to contact the GP if the situation deteriorated. It is not possible to know whether there was deliberate neglect of Anna's needs at this time but the failure to attend the 'spirometer' appointment in January 2020 or to book a further appointment regarding her legs may have been significant in her deterioration. Anna was clearly in poor health when admitted to hospital in February.

3.1.6. There were meetings held between financial and ASCH staff within the Local Authority to discuss the concerns regarding Daughter 1's misappropriation of Anna's money, however the status of those meetings is unclear as there was never a formal safeguarding enquiry raised regarding financial abuse. The issues of financial abuse were uncovered after the first safeguarding enquiry regarding physical abuse was largely concluded. The financial abuse was a new concern and there was no attempt to convene a meeting of all the practitioners working with Anna to consider how best to safeguard her. This was also true later when the decision was made to pursue Daughter 1 regarding the care home fees. This

meant that the staff in the care home providing the day-to-day care and having most contact with Anna and Daughter 1 were not part of the key decisions that impacted on her safety. There were repeatedly assumptions made that Anna was safe in the care home without consideration of what powers the staff there had to maintain Anna's security.

3.1.7. Another effect of the absence of formal safeguarding meetings was that the major focus of staff concerns in October 2019 was on Anna's legs being dressed and the other risks of physical, emotional, and financial abuse seem to be forgotten. The reasons for this are unclear however for ASCH staff a relevant factor is their perception that health staff could more easily gain access to Anna than ASCH practitioners. For other agencies, their practitioners did not have a full oversight of the full risks posed to Anna as they were mainly recorded on ASCH files and whilst the social workers shared information with the old GP and district nurses the new health professionals working with Anna from December 2019 did not have that information.

3.2. Reasons for delays in instigating enquiries, particularly in relation to the safeguarding enquiry commenced in October 2019.

3.2.1. Prior to 2018 the major factor that affected progressing safeguarding enquiries more rapidly was Anna's denial that anything untoward was happening to her in Daughter 1's care. Issues were raised with ASCH in 2017 by both the JCR team and staff at the GP surgery but on both occasions ASCH staff took at face value Anna's denial of abuse and did not seem to consider that she might be fearful of disclosing whilst the daughter was present. There is no evidence of staff trying to meet with Anna.

3.2.2. The first GP practice should be applauded for their persistence in raising concerns about Anna. Similarly, the hospital social work staff spent considerable time in encouraging Anna to disclose the abuse she had experienced, and their effective and impressive work shows the way in which it is possible to enable abuse victims to disclose. This enabled an effective safeguarding plan to be developed that protected Anna in the short-term.

3.2.3. Later there was less effective practice which was influenced by a range of factors. The three-week delay in undertaking the capacity assessment in September 2019 was a result of annual leave by the worker combined with the need for a second member of staff to be involved in such an assessment. This delay was unfortunate as once Anna had moved back to live with Daughter 1 such an assessment was likely to be more difficult to achieve even if the staff had been able to gain access to see her.

3.2.4. The workers who were trying to contact Anna in October 2019 were reported to have been shaken by the threatening response by people at Daughter 1's house

and managers at the workshop suggested that this intimidation may have inhibited them from taking any further action. It is not clear why this was not addressed in supervision and there is no evidence of more senior management involvement that might have driven a more proactive response. One factor that was reported at the practitioner workshop was that the managers for this team had been involved directly in the Adult B case and were awaiting the outcome of that SAR report and this inhibited them from taking actions. It was also reported the workers involved became over-focussed on the health issues such as Anna having the dressings on her legs changed and therefore failed to address the wider safeguarding issues. It is clear from the information provided at the workshop that this 'tunnel vision' was not challenged in supervision as the managers were similarly diverted. The reasons for this are not clear but there may be a misconception about the ease with which health professionals can contact service users. This was not challenged because there were no multi-agency safeguarding meetings which could have enabled a wider discussion of the risks that could be faced by Anna and how these could be best addressed.

3.3. How legal routes to gain access to Anna were explored.

3.3.1. Immediately after Anna moved back to live with Daughter 1 in October 2019, ASCH consulted the Legal Department regarding options available to them to gain access to her. They were advised that court action could be taken but were given a clear message that such a route would be challenging. They were rightly advised to explore direct contact first, and only if that was unsuccessful to involve the police. This advice was followed and after the initial unsuccessful ASCH visit Sussex Police were asked to undertake a joint visit. Due to confusion by the police about the request this resulted in Sussex Police undertaking a single agency visit which appeared to suggest that there were no concerns about Anna's care. In fact, their visit only showed that at that point in time Anna was well and that she was not asking to leave. Given the previous history of Anna denying that she was being harmed whilst she was in the care of Daughter 1 this did not really address any of the concerns. Nevertheless, it undermined any further attempt that could be made by ASCH to escalate the matter and take court action.

3.3.2. ASCH clearly did reconsider the option of a joint visit with the police in early November 2019 and no-one is able to explain why this was not pursued further, as the case record indicates that Sussex Police were willing to undertake this. The fact that the request was not recorded by Sussex Police suggests they did not view it as a formal request but rather ASCH checking out potential future courses of action. It is unlikely that a joint visit at that time would have achieved significant action as Anna was unlikely to say she wished to leave and so any such visit would again only check her well-being at that point. It took two days in a safe environment for Anna to trust the hospital social worker and fully disclose her abuse so a single visit with Daughter 1 resisting any involvement was unlikely to be productive. There was also no reconsideration at this point of whether an

application could be made to the court for an order to obtain access. It is possible that this would not have been successful given the earlier police visit which seemed to indicate that Anna was not at risk of harm.

3.3.3. Effectively legal action needed to have been taken earlier to protect Anna. At the point that she moved to the care home there needed to be consideration of how she could be protected in the long term in that environment. There could have been consideration of whether an application for a Deprivation of Liberty (DOLs) order was needed. As assessment of Anna indicated fluctuating/disputed capacity this would have been challenging but not impossible. Furthermore, consideration of such an option may have identified other mechanisms for providing safeguarding protection. Early in the placement at the care home Anna had raised the possibility of returning to her daughter's care and at that point an assessment was needed of her capacity to make that decision and how she could best be protected. Without a DOLs authorisation there was no way that the staff in the care home could legally restrict Anna's contact with her daughter and once she was having regular visits to Daughter 1's home it was likely that she would be persuaded to return to her care. After the decision was made by the Local Authority to pursue Daughter 1 for the payment of the care home fees it was unsurprising that the daughter felt a way of avoiding these charges was for her mother to leave the care home. If legal interventions had been considered and pursued earlier, the contact with Daughter 1 may have been better managed, and her departure from the care home avoided.

3.4. What inhibited practitioners from responding to the hostility and aggression by family members.

3.4.1. As has been stated previously the practitioners were shaken by the hostility and aggression shown by family members. At the workshop managers reported that the staff concerned were experienced workers and that they were given support after the visit. This sort of aggression is not common, and most workers do not usually have to accommodate such behaviour from relatives. Police officers are more used to responding to aggressive behaviour and whilst they were agreeable to a joint visit, they recommended that ASCH staff should not visit alone which would have confirmed staff anxieties.

3.4.2. Whilst staff were affected by the hostile approach it is not evident that this directly impacted on their next actions regarding the safeguarding enquiries however it may have been a factor that encouraged a reliance on the district nurses being able to gain access. At the workshop social care staff reported that they considered health professionals were able to gain access to people more easily. There is no evidence that staff deliberately avoided visiting because of the threats that were made.

3.5. Information sharing about risks related to ownership of firearms by the family.

3.5.1. A factor of concern to ASCH staff was that when they visited Daughter 1 after Anna had returned to her care, they were unaware that the family held firearms,

and this potentially placed them at risk given the levels of aggression that the family showed. The information about the ownership of firearms was discussed at the MARAC meeting in 2017 and was therefore known to all agencies, however it is also evident that the record of that discussion that was distributed was brief, and the firearms issue was not immediately apparent. Furthermore, at this point the systems in place for recording and sharing MARAC discussions were not effective in many organisations, including ASCH. Staff at the workshop were clear that systems and procedures for recording and sharing MARAC information have been significantly strengthened and that therefore it is unlikely this breakdown in communications would recur. Clearly, if there had been a multi-agency meeting to plan how to make contact with Anna, the risk that family members posed to professionals could have been discussed across all agencies.

3.6. How Anna's cultural needs were identified and responded to.

3.6.1. All the professionals who had direct contact with Anna confirmed that her spoken English was particularly good, and she had no difficulties communicating in English with professionals. What was less well known or understood was that she could not read or write in English, so any written communication had to be read to her, presumably by her daughter.

3.6.2. ASCH staff working with Anna described how after she moved to the care home, they unsuccessfully attempted to engage with a local cultural group in the hope of providing her with contact with native speakers. It is also known that she had contact with old friends in Europe whilst in the care home.

3.6.3. There were times when Daughter 1 spoke with Anna in her native tongue, and on occasions staff in the care home perceived that in some of these conversations Daughter 1 appeared to be speaking aggressively but it was impossible to clarify this. Clearly Daughter 1 may have been able to use her knowledge of the language to engage Anna in conversations about returning to her care without staff being aware.

3.6.4. Throughout the period of the review Anna was depressed and there were also indications that her mental faculties were declining. It is known that while overall, speaking more than one language can delay many symptoms of dementia as being bilingual means an individual may have built up more 'cognitive reserve' than those who speak only one language, making their brain more resilient to changes as the dementia develops. However, people do experience changes, and someone who has spoken a second language for many years may start to drop in words from their native language, perhaps unknowingly. Over time, the language that is less familiar and not so deeply embedded tends to be lost first.[2] This is often the language that has been learned later. The extent to which this

[2] https://www.alzheimers.org.uk/dementia-together-magazine/june-july-2019/losing-your-english-reverting-your-mother-tongue-dementia

applied to Anna is unclear as there were assumptions made about her use of English. It is clear however that when she was under stress, such as when she was admitted to hospital in February 2020, she was speaking in her native tongue.

3.6.5. There was no attempt by staff working with Anna to clarify whether her good spoken English was matched by her understanding of written material in English. There was also little consideration of whether providing her with interpreters would have enabled her to trust and share information more easily despite it being known that much of her communication with Daughter 1 was in her native tongue. Whilst it would have been better practice to have involved interpreters it is not clear that this would have significantly changed actions or events as there is no evidence of significant communication breakdown.

4. THEMES from the review of agency implementation of the Adult B SAR recommendations relevant to SAR Anna

4.1. Mental Capacity and Empowerment

4.1.1. A key theme in the Adult B SAR was how effectively issues of capacity and consent were addressed, including the extent to which coercion and control was considered. The 'SAR B Recommendations Review' showed that significant work has been done by all agencies to use SAB resources, such as the Adult B SAR learning briefing or Making Safeguarding Personal (MSP) resources to share learning about mental capacity and empowerment. In many agencies such training is mandatory, and agency returns showed that the training often indicated a significant focus on practitioners seeing adults on their own. Some agencies also reported audits undertaken to show the impact of such training. This was less widespread however and an area for further development by many agencies would be providing evidence of changes in practice as well as delivery of improved training and supervision.

4.1.2. SAR Anna shows that capacity was more explicitly considered by practitioners in comparison with the Adult B SAR and there were several formal capacity assessments undertaken particularly around making financial decisions. There was less evidence however that coercion and control was considered, and this remains an area that requires further work. The degree to which an individual's capacity can be affected by long-term coercive behaviour is complex. Assessing whether this has occurred requires a sophisticated assessment which is underpinned by an understanding of the nature of such abuse and its long-term impact on behaviour.

4.1.3. An issue that this review did highlight was the complexity associated with assessing capacity which may fluctuate, and which can then result in contradictory assessments by different professionals. One example was when ASCH assessed that Anna did not have capacity to manage her finances but soon after this assessment OPG determined she did have capacity but chose not to exert it. Staff at the workshop indicated that it is not unusual for OPG assessments of capacity to differ from ASCH. This is an area that may warrant further

investigation. OPG assessments are inevitably based on limited contact and are not made over time. ASCH assessments may be stronger by virtue of their greater knowledge of the individual and their history. In this context there needs to be clarity about which assessment is prioritised. In this case the OPG assessment seems to have determined future actions by ASCH.

4.2. Understanding of history and multi-agency communication

4.2.1. Most agencies reported in the 'SAR B Recommendations Review' that understanding of history and multi-agency communication was a central theme within their safeguarding training programmes and that oversight of practice in this area was provided by supervision, team meetings, daily risk meetings, governance report and auditing processes. Reference was made to Sussex SABs Information Sharing Guide and Protocol[3] and to the SAB Escalation and Resolution Protocol[4] being shared with operational services. There was however little evidence in the agency review returns of the effectiveness or impact of this training or how it was known that practice was improving in this area.

4.2.2. SAR Anna has evidenced poor communication and liaison between professionals. The earlier enquiries did not involve safeguarding meetings or liaison with other involved professionals. The second enquiry had no inter-agency meetings and only involved ASCH. There was more multi-agency involvement in the third enquiry but no formal meetings, and it was only by the final enquiry in response to Anna's death that a series of more robust multi-agency safeguarding meetings took place. As previously stated, most agencies worked in parallel with little joint working.

4.2.3. There was a lack of continuity in the nursing service and GP service which had a significant impact on practitioners' knowledge and understanding of Anna's history. There was no continuity in nursing records and the absence of accurate coding in the GP records meant that the GP involved in the final stages had minimal understanding of Anna's previous history of abuse and Daughter 1's role in it.

4.2.4. Police input to safeguarding Anna was minimal because there were no multi-agency meetings held and this meant that when they undertook a welfare visit, they had limited understanding of the safeguarding issues. There were no joint visits made by police and ASCH which could have enabled better information-sharing and more effective practice.

4.3. Professional curiosity

4.3.1. The focus of the Adult B SAR was the degree to which practitioners understood family dynamics and whether there was consideration of disguised compliance. Returns from the 'Recommendations Review' reflected a growing awareness of professional curiosity, with some agencies specifically confirming this was included in safeguarding training pathways. The majority of concerns referenced awareness and use of the SAB learning briefing on professional curiosity and

[3] https://www.eastsussexsab.org.uk/documents/information-sharing-guide-and-protocol-2/
[4] https://www.bhsab.org.uk/wp-content/uploads/sites/2/2021/09/Pan-Sussex-SAB-Escalation-Resolution-Protocol-1.pdf

some returns highlighted the role of supervision, team meetings mentoring, case discussions and auditing in encouraging the use of professional curiosity. One agency noted that operational pressures may affect clinical supervision. Again, there was little evidence in the agency review returns of the effectiveness or impact of this training or how it was known that practice was improving.

4.3.2. SAR Anna showed that ASCH practitioners were intimidated by the family but nevertheless did not appear to fully understand the family dynamics nor consider the degree to which Daughter 1 was manipulating her mother despite considerable evidence of her lack of understanding of her mother's needs. There was little comprehension of Daughter 1's capacity to coercively control her mother even when she was in a safe place. This meant that no protections were put in place despite practitioners being aware that Daughter 1 wanted her mother to return to her care as early as April 2019. It is unclear whether this inactivity was due to a lack of understanding of the issues, or a feeling of powerlessness, possibly fuelled by a lack of confidence in the legal options available. It seems probable that the latter is true as the practitioners involved were all experienced and the managers involved in the workshop presented as having a good knowledge and understanding of safeguarding.

4.3.3. One area where there was a significant lack of curiosity by ASCH staff was regarding the wider family dynamics. There was considerable evidence that Daughter 2 and Daughter 3 had concerns regarding Daughter 1 and her control over Anna, but there was minimal contact made with them to discuss their concerns further. This is particularly true once Anna returned to live with Daughter 1 and there was no attempt made to contact the daughters to see if they had been able to gain access or consideration of whether Sussex Police could have assisted them in meeting with their mother.

4.4. Investigating the deaths of vulnerable adults

4.4.1. Returns from the 'Recommendations Review' about the Sussex Adult Death Protocol (ADP) showed that that the extent to which the ADP has been implemented into practice across agencies is limited. Whilst several returns acknowledged that the ADP has been positive in enabling another level of scrutiny for unexplained adult deaths, overall, the returns suggest that more work is required to ensure that staff have a consistent and comprehensive understanding of the criteria. Only one agency was providing specific training although another was going to include reference to the protocol in Think Family safeguarding training. There have been few referrals made under the protocol, which was launched in November 2020, which may reflect a lack of understanding of its role and function.

4.4.2. The ADP was not in place at the time of Anna's death however if it had been it is probable that the protocol would have been triggered. This may have led to more robust information sharing and risk assessment at an earlier stage.

5. LESSONS LEARNED – what this review shows about the safeguarding system as a whole.

5.1. Multi-Disciplinary working

5.1.1. The complete absence of multi-agency meetings was a significant feature of this case despite there being at several safeguarding concerns that warranted safeguarding enquiries being made. The Sussex Safeguarding Adults Policy and Procedures clearly state that '*A decision will need to be made as to whether a formal planning meeting is required, or whether a discussion, for example by telephone, will suffice. Planning should be seen as an ongoing process rather than a single event and can be undertaken as a series of conversations or meetings with relevant people and agencies...In some cases, the complexity of the situation will require a formal multi-agency meeting to be held.*'[5] Reasons for calling a formal meeting include (amongst other things):

- Risk sharing and safety planning.
- Co-ordinating criminal investigations and safeguarding enquiries.
- Reviewing outcomes and agreeing a safeguarding plan.

5.1.2. It is understandable that when the initial concerns about physical abuse were raised there was a decision not to hold a formal meeting as this enquiry required rapid interventions to maintain Anna safely in hospital and once that was achieved much of the multi-disciplinary working was best achieved through hospital discharge processes. This was not true when considering the financial abuse however and the absence of formal planning meetings effectively excluded Sussex Police from determining whether a crime had been committed and precluded the care home from contributing to the safeguarding planning. Later when Anna returned to live with Daughter 1 it is understandable that immediately actions would be agreed by telephone however, once it was clear that there was no easily achieved immediate solution, a planning meeting to consider options available would have been useful.

5.1.3. One effect of a lack of practitioner meetings is that it results in agencies working separately rather than together. Often there is parallel working, with some communication, but this is not joint working to mutually agree goals. Such practice has a potential for miscommunication because of misunderstanding about mutual roles and responsibilities. A greater knowledge of other agencies working mechanisms and methods is a positive by-product of joint working. In this case there was significant lack of understanding about the ways in which district nursing services were provided and the extent to which they were a protective factor for Anna. Given that pursuing safeguarding enquiries is not solely the responsibility of ASCH, holding a safeguarding planning meeting enables effective delegation of responsibilities where appropriate.

[5] https://sussexsafeguardingadults.procedures.org.uk/pkotz/sussex-safeguarding-adults-procedures/receiving-concerns-and-undertaking-enquiries#s2800

5.1.4. Another benefit of effective multi-agency working is that it can mitigate the detrimental effects of changes in service providers which impact on continuity of information/understanding about risks. This was a factor in this case but was also evident in Adult B. Multi-agency meetings enable a shared understanding of risks and better knowledge of the safeguarding plan which may compensate for less than adequate recording mechanisms. It enables challenge and support for practitioners who may be struggling to identify the best way to safeguard a vulnerable person.

5.1.5. The reasons why meetings were not held in this case were not clear. Front-line practitioners acknowledged that the safeguarding procedures did enable such meetings to take place but also said that they did not always happen. The major reason being given as to why they might not happen being pressure of work. This was also acknowledged as a factor by the Review Team who also confirmed that whilst planning meetings were happening their frequency could be improved.

5.2. **Working with the family– how to challenge effectively**

5.2.1. A clear feature identified in SAR Anna was the use of aggression by Daughter 1 and her family to control and intimidate workers. ASCH managers at the workshop reported that this was beyond the normal antagonism that workers were used to experiencing and that it did have a significant impact on their staff. The levels of threat and violence were clearly significant as evidenced by Sussex Police advising against ASCH making contact alone. Whilst this may have been an unusual circumstance there could be benefit for the agencies in the SAB considering how their staff can be best supported and whether agencies such as the police who may have greater experience can be of more assistance.

5.2.2. This review has also evidenced a need for practitioners to have a better understanding of coercion and control and how people may still be vulnerable to emotional abuse even when their physical safety has been achieved. This will require supervision being used as a tool to enable practitioners to challenge but may also require some additional training for staff and managers. It is positive that the abuse Anna was experiencing was identified as domestic abuse, however there was less understanding of the coercive and controlling nature of such abuse.

5.2.3. One aspect that may enable practitioners to intervene more effectively is a greater awareness and understanding of the possible legal processes that could be used to intervene to protect vulnerable people. There was little evidence of knowledge or faith in the capacity of the legal processes to be effective tools to intervene to protect Anna. There was no consideration of whether a Deprivation of Liberty (DOLs) application could have helped. This would have been challenging to achieve but there was a need for some control to enable staff in the care home to be able to manage more effectively the contact with Daughter 1. There were no reasons given at the workshop for why this was not considered

however legal intervention appeared to be something that was rarely considered in these circumstances.

5.2.4. Also relevant is closer working with wider family members. In this case there were three daughters with an interest in Anna, however there was limited contact with Daughters 2 and 3 despite them showing an interest in their mother and raising concerns about Daughter 1. It is both possible and probable that the daughters had significantly more knowledge about their mother's care, and it is possible that this information could have been useful in strengthening the ASCH case for legal intervention. Family members and friends usually know significantly more than professionals about what is really happening within the home, and it is for this reason their input should be encouraged and valued.

5.3. Separation between financial and safeguarding decisions

5.3.1. This review has identified that whilst there is effective joint working between Finance and ASCH staff when undertaking safeguarding enquiries, systems around other financial decisions may be less robust. The Finance Department has a legal duty to pursue debts and the decisions to take legal action are made at a senior level. It is not apparent that these systems allow consideration of safeguarding issues or that front-line staff are sufficiently involved to enable such concerns to be raised. Particularly there do not appear to be any processes built in to ensure that the safeguarding implications of legitimate actions to pursue debts are addressed. In this case there were clear safeguarding concerns associated with the decision to invoice Daughter 1 for the care home costs and these were raised by the front-line staff when they first contacted the finance department however it is not clear that they were sufficiently considered by the senior manager making the decision to take legal action to recoup the fees. The decision to invoice Daughter 1 was not wrong as the Local Authority has a legal obligation to pursue income when it is apparent it is due. There is also however an imperative to ensure that such action does not place a vulnerable adult at risk of harm. There is a need therefore for the systems in place to require consideration of all risk and how to mitigate it prior to making such decisions. This requires closer working between staff in ASCH and Finance when pursuing debts if to do so could place a vulnerable adult at risk of further harm.

5.4. Investigating the deaths of vulnerable adults

5.4.1. The Sussex ADP was not in place when Anna died and it is probable that if it had been there would have been better liaison between Sussex Police, ASCH, and the hospital staff. This would not necessarily have resolved all the issues as fundamentally there was some disagreement between clinicians about the nature of the bruising sustained by Anna and whether it was a result of natural causes or caused by trauma which could have resulted from physical handling. Discussion with the Review Team indicated that there is currently no specific local protocol for medical staff when evaluating whether a bruise is natural or could be the result of abuse. There is NICE guidance around this issue[6] but whilst this does

[6] https://cks.nice.org.uk/topics/bruising/management/management/

identify that there are several possible causes of bruising, including non-accidental injury, there is little in the section on differential diagnosis to clarify the circumstances in which non-accidental injury is a more likely cause. This means that clinicians may have differing opinions about the causes of bruises in the absence of clear explanations from the patient.

5.4.2. Furthermore, there is currently no formal system for resolving differences between clinicians when there is professional disagreement about the likely causes of bruises. There is no legal requirement for there to be a 'named doctor' with responsibility for safeguarding adults within a hospital which means that if there is conflict between clinicians there is no straightforward process for discussing and resolving contradictions. There are different systems in place for safeguarding children where there is a requirement for 'named' and 'designated' doctors who have expertise in safeguarding and are involved in more complex cases where there may be clinical disagreements[7]. Within all adult health settings there is a requirement for there to be to be a 'named professional for safeguarding adults[8]' but often these roles are fulfilled by nurses unlike in children's settings where there is an expectation that there should be both a 'named doctor' and a 'named nurse.'

5.4.3. The review team also identified that whilst the ADP clearly establishes a multi-agency process for investigating the deaths of vulnerable adults, there is nothing included about assessing the causes of bruising in vulnerable adults despite this being a feature of both the Adult B and Anna SARs. If a protocol regarding the assessment of the causes of bruising were to be developed it would need to be incorporated into the ADP.

[7] https://www.rcpch.ac.uk/sites/default/files/2019-08/named_doctor_for_child_protection_-_model_job_description_and_competencies_2019_0.pdf
[8] https://www.rcn.org.uk/professional-development/publications/pub-007069

6. CONCLUSIONS

6.1. The intention of this review was to evaluate the effectiveness of the implementation of the recommendations of the Adult B SAR as well as considering whether there was additional learning. The review has found that while there has been noteworthy progress made there are some areas of further development that are needed. Multi-disciplinary working was mixed with some examples of good intervention but more evidence of parallel working. Of greatest significance was the absence of formal planning meeting involving front line staff which led to assumptions about what was being done and the protection this afforded Anna. There is suggestion that such practice is not unusual and that therefore there is a need for the role of multi-disciplinary planning meetings to be promoted.

6.2. Generally the Anna SAR and the audit of the implementation of the recommendations from the Adult B SAR showed how difficult it is to know when practice has changed in response to new guidance, supervision and training. It is clear that all agencies have acted in response to the Adult B SAR however it is less assured that there has been sufficient cultural change to ensure practitioners are acting differently.

6.3. The review showed that there is greater awareness of the needs for formal assessment of capacity and improved practice in this area however there is also a need for better understanding of the impact of coercion and control on capacity assessments and for this to be considered when developing safeguarding plans. Furthermore, work with the wider family needs to be strengthened to enable staff to be able to better understand family dynamics and empowering them to challenge family members when necessary.

6.4. The review identified that there is good working between Finance and ASCH staff when assessing whether there has been financial abuse however there are no formal systems in place to guarantee a similar co-operative working when making and recording decisions regarding recoupment of debts from relatives. This means there is the potential for such decisions to be made without sufficient consideration of safeguarding risks to vulnerable adults.

6.5. Finally the review has highlighted some limitations in the processes whereby clinicians assess the causes of bruising in vulnerable adults which could undermine the effectiveness of the ADP.

7. RECOMMENDATIONS

7.1. That East Sussex SAB uses its routine audit systems to further evaluate the use and effectiveness of multiagency meetings when undertaking safeguarding work with vulnerable adults.

7.2. That East Sussex SAB requires all core SAB member agencies, through supervision (including safeguarding supervision) and training, to work with front line practitioners to enable better understanding of coercion and control within domestic abuse particularly when applied to older people. Furthermore, this training and supervision should focus on the ways in which legal interventions can be used to better protect vulnerable adults. Finally, the training and supervision should also focus on the relevance and importance of working closely with the whole family rather than just with those family members providing direct care.

7.3. That East Sussex SAB require the Local Authority to review the systems in place to make decisions about pursuing debts from relatives and consider how best to enable such decisions to consider any risks to vulnerable adults and how, in those circumstances, to develop plans to fully protect the individuals concerned.

7.4. The East Sussex SAB require that ESHT review the processes in place to evaluate bruising in vulnerable adults and develop systems to enable better reconciliation of clinical differences including whether a named Doctor for safeguarding Adults should be appointed. These processes to be incorporated into the ADP.

7.5. To recommend that East Sussex SAB raise the issue of the need for a Named Doctor for Safeguarding Adults in all hospital settings, at a regional level with a view to taking the matter forward for national discussion with DHSC policy leads in accordance with the National Escalation protocol for issues from SARs.

7.6. That East Sussex SAB should consider how to develop mechanisms whereby they are able to evaluate the effectiveness of how each member agency has achieved organisational change and understanding from SARs, as well as implementing their recommendations.

Fiona Johnson

14th January 2022

1. APPENDIX 1: Terms of Reference: Anna

2. Background to this SAR

1.1 Under section 44 of the Care Act 2014 there is a duty for Safeguarding Adult Boards (SABs) to 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 together more effectively to protect the adult. If the SAR criteria are not met but the relevant SAB feels that there are lessons to be learnt, an alternative review may be undertaken.

1.2 The purpose of conducting a review is to enable members of the SAB to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
- Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

1.3 This SAR referral was received on 2nd February 2021 from Adult Social Care and Health, and the recommendation of the SAR Subgroup to undertake a SAR was endorsed by the SAB Independent Chair on 26th March 2021.

1.4 The statutory requirement under Section 44 of the Care Act was met. However the SAB noted that this referral reflected a number of parallels with the Adult B SAR published in East Sussex in February 2020, and as such has made the decision to conduct this review in a proportionate manner to draw on how the learning from the Adult B SAR has been embedded in practice as well as to explore additional areas of learning specific to this case.

3. Ethos of the Review

2.1 This review will be holistic and considered in a fair and open manner. It will be objective in its approach and 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.

4. Scope and Methodology for the Review

3.1 This review will take a hybrid approach and undertaken as two parallel pieces of work:

1. An audit on how the relevant actions of Adult B have been embedded and what impact they are having on practice and adults with care and support needs.

2. A learning event involving frontline practitioners and their managers, with specific focus on the 2 safeguarding enquiries held from 2017 to 2020 and how learning from Adult B can be further embedded and include the following additional points relevant in this case:

    a. how cultural needs were identified and responded to.
    b. consideration of delays in instigating enquiries, particularly in relation to the safeguarding enquiry commenced in October 2019
    c. what inhibited practitioners from responding to the hostility and aggression by family members.
    d. information sharing about risks related to ownership of firearms by the family.
    e. how legal routes to gain access to Christina were explored.
    f. how issues in this case were escalated and supervised across the agencies involved.

3.2 The focus of the review will involve specific consideration of the two safeguarding enquiries held from 2017 to 2020 at the learning event and more broadly as part of the audit activity the period from Christina's death

on 27th February 2020 until the present day in terms of how learning from the Adult B SAR has been embedded.

3.3 The naming convention for this case will be to use the fictitious name of Anna to maintain confidentiality.

3.4 The review will have a particular focus on the following research questions in this case:

a) How well has the learning from Adult B been embedded in general safeguarding practice?
b) How effective are practitioners at intervening when faced with hostility and aggression from carers?
c) How well do practitioners share information about risk and co-ordinate safeguarding work between different agencies?

3.5 A chronology of information from Adult Social Care records, obtained through the work undertaken by the SAR Subgroup in considering the referral, along with information from GP and District Nursing records will inform the preparatory work for the learning event.

5. **Liaison with the adult's family members**

3.6 In line with Making Safeguarding Personal the Reviewer, in consultation with the SAB, will give consideration as to the most appropriate way of enabling contact with family members of the deceased to have an opportunity to contribute to the review.

Overview Report

3.7 An overview report will be produced for the SAB by the lead reviewer, which will bring together the findings from the audit and outcomes from the learning event.

3.8 The report will be shared with the SAR Subgroup prior to presentation at the SAB for oversight and assurance.

6. Agencies involved in the Review

4.1 Agencies that were involved in this case will be asked to contribute to this review. SAR Panel members will include the following agencies:

- Adult Social Care and Health (ASCH), East Sussex County Council (ESCC)
- Sussex Police
- NHS East Sussex Clinical Commissioning Group (CCG)
- East Sussex Healthcare NHS Trust (ESHT)
- Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit Brighton & Hove and East Sussex

4.2 The SAR Panel will consider additional agency representatives who need be part of the SAR Panel and / or attend the learning event, such as the Office of Public Guardianship, the Care Home manager, and the financial assessment team in ASCH.

4.3 The lead reviewer for this SAR is Fiona Johnson, who will be responsible for the facilitation of the learning event and producing an overview report combining the outcomes of the audit and learning event. Fiona Johnson will also take on the role of SAR Panel Chair and will be supported by David Kemp (Chair of the SAR Subgroup), George Kouridis (Head of Safeguarding, ASCH) and Delyth Shaw (SAB Development Manager). Member of the SAR panel will also assist in the process.

4.4 It is critical to the effectiveness of this review process that the correct management representatives attend any scheduled events and meetings. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations

that emerge. They should not have had any direct involvement in the case or supervision of those professionals that were.

7. Media strategy

5.1 All agencies involved in the review will alert their media / communications officers of the review at the outset of the process. If there are any media requests, agencies will direct these to the SAR Panel Chair and SAB Manager who will direct these to the press officer in the Communications Team at ESCC. At the end of the review a media strategy meeting will be held to consider publication of the overview report, which will involve all relevant media / communication leads across the agencies involved and a coordinated press statement will be prepared.

5.2 The SAB is responsible for the handling of the report and for all feedback to staff, family members and the media.

8. Confidentiality

6.1 All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

6.2 All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this thematic review and for the secure retention and disposal of that information in a confidential manner.

6.3 It is recommended that all members of the Review Panel set up a secure email system, e.g. Egress. Confidential information must not be sent through any other email system. Documents not on secure email must be encrypted and password protected.

9. Appendix 2: Glossary of Terms and Abbreviations

ASCH: Adult Social Care & Health in this context services provided by East Sussex County Council Adult Social Care and Health

DASH: Domestic Abuse, Stalking and Honour Based Violence – DASH checklist is a tool

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to MARAC and what other support might be required.
- To provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.

To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses,' which underpins most recognised models of risk assessment

CQC: Care Quality Commission - The independent regulator of health and social care in England

GP: A doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.

IDVA: Independent Domestic Violence Advisor - The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners, or family members to secure their safety and the safety of their children

MARAC: Multi-Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

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

OPG: The Office of the Public Guardian in England and Wales is a government body that, within the framework of the Mental Capacity Act 2005, polices the activities of deputies, attorneys and guardians who act to protect the financial affairs of people who lack the mental capacity for making decisions about such things.

SAB: Safeguarding Adults Boards - 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 because 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.

SCARF: Single Combined Assessment of Risk Form – this is the mechanism by which the Police share information with other relevant agencies particularly Adult social care.

SECAmb: The Southeast 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).

VAAR: The Vulnerable Adult at Risk section of the SCARF should be completed by an officer or member of police staff for every incident that involves a safeguarding concern relating to a vulnerable adult.

a. Appendix 3: 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), Care Act 2014
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
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Mental Capacity Act 2005 Code of Practice
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

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

Decision-making and mental capacity NICE guideline Published: 3 October 2018
www.nice.org.uk/guidance/ng108