Wolverhampton Safeguarding Together (WST) Learning Lessons Briefing – Edith

The Review

This Learning Lessons briefing has been created as the result of a Safeguarding Adults Review Committee (SARC) learning review completed in August 2019 into the death of Edith in July 2018.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Background Summary

Edith was 80 years of age and was a widow with no children. She had moved in to live with Mr A in his one bedroom flat after her health started to get worse. This was to avoid having to go into residential care. She had been living there for about eight years at the time she died.

Safeguarding concerns about possible self-neglect and / or neglect had been raised when she was admitted to hospital the year before her death. She was discharged home with a package of support, but this ended at Edith's request in February 2018.

In July 2018 she was admitted to hospital again following a 999 call from Mr A's family who reported that Edith was slouched in her wheelchair and had been hallucinating. Paramedics found her in an unkempt state with pressure ulcers on her right ankle (Grade 3) and buttock (Grade 4). Edith sadly died five days later due to sepsis, community acquired pneumonia and frailty of old age.

Areas of Good Practice

- The clinical care provided by health professionals in hospital and in the community, which met all expected agency standards
- The first Care Act assessment carried out by hospital social worker 2 which identified Edith's support needs and designed the care package

- The alertness of the home carers in spotting the signs of possible deterioration in Edith's skin integrity, and immediately reporting this to the GP practice to request referrals to the district nurses
- The efforts made by the home care agency to raise concerns with both Mr A and adult social care about the possible risks that would flow from the reduction and then ending of home care support, and the removal of the pressure relieving bed
- The persistence of the social care assessor in insisting that she saw Edith on her own when carrying out the February re-assessment

Key learning themes arising from the review

1. Escalation of concerns

No consideration was given to arranging a multi-agency meeting when the home care was ended in order to consider the potential risks and the concerns about Mr A's apparent influence on Edith's decision. There were no agreed multi-agency procedures in place for professionals to meet to share information, and formulate multi-agency support, unless these met the criteria for being considered under the formal adult safeguarding procedures. It was recognised that home care agencies have a valuable contribution to make and are increasingly becoming the "eyes and ears" for statutory agencies in monitoring a situation and reporting any changes or concerns.

What has changed?

There are now much closer working relationships between social care staff and district nurses, which is resulting in early discussions and more joint visits. In one district this has been enhanced through co-location of staff and the possibility of replicating this in other districts is being explored.

Monthly multi-disciplinary meetings are now taking place in each district with a core membership of social care staff, district nurses and the community matron. Situations like Edith's would now be raised at such meetings.

Arrangements for convening "concerns" meetings have also been proposed. This would mean that any professional or agency can call a meeting where they believe that risks are escalating, or prevention is required. This is a step which can be taken by home care agencies and community health professionals who in the past might not have seen this as a legitimate step they can take.

Within the hospital there are daily multi-disciplinary meetings (called team huddles) which look at the next steps required to facilitate discharge. There are also "huddles" taking place in the community social work teams. This is a forum where members of the team and other professionals can help each other with complex situations and to come up with creative solutions.

2. Safeguarding and mental capacity

One of the most important areas of learning from this review is for professionals to be able to recognise and respond to the possibility of coercive control, particularly when it is hidden, and its potential impairment on a person's mental capacity when making

decisions about their care and treatment. Professionals involved with supporting Edith did not sufficiently consider the possibility of domestic abuse, which includes controlling and coercive behaviour. When Edith shared her fear of Mr A's reaction, an assessment should have been carried out by hospital staff using the Safe Lives (DASH) risk assessment tool. Applying some professional curiosity at this stage could have led to a greater understanding of the situation and was a missed opportunity.

The possibility of financial abuse also needed to have been given more consideration when the home care support was cancelled given the concerns about charges, the inability to pay and the fact that Edith's wish to cancel support was always initially raised by Mr A or Mrs D. However, it was recognised that there were ongoing challenges for professionals in engaging with Edith and ascertaining her wishes and feelings. There were several references to Edith appearing unwilling to talk whilst in hospital in July 2017 and once she returned home the opportunities to talk to her alone were hampered by the limited space in the flat and Edith being aware that Mr A was nearby.

The decision made by adult social care to close Edith's case after the February reassessment did not follow the regional guidance on self-neglect. This guidance makes clear the actions that should be taken when a person / informal carer declines support. Respecting the wishes of a person who is deemed to have mental capacity does not mean passive acceptance. Where risks are high there should be consideration about how to monitor the situation. There should also be robust risk assessment in situations of possible self-neglect when professionals consider a person's decision to be unwise.

In situations where a person is considered to be at serious risk of abuse and/or neglect, but the person has not lost mental capacity the local authority should explore with their legal team what powers may be available by the High Court in exercising its inherent jurisdiction to make orders to protect the person.

What has changed?

Following a recent domestic homicide review (DHR) some action has already been taken to address this. The Clinical Commissioning group (CCG) has embedded the learning from the DHR into the Safeguarding Adults Level 3 training for primary care professionals and featured in two bespoke training sessions provided by a drama group commissioned by the CCG in 2018.

The Domestic Violence Forum continues to provide free multi-agency training on coercive control and domestic violence. Over 200 GP practice staff have been trained in over 51 practices and the impact has seen GPs and surgery staff completing DASH risk assessments with patients recognised as experiencing domestic abuse, and where the risk level is sufficiently high. GP referrals are being made to Multi-Agency Risk Assessment Conferences (MARAC). 73 individuals across 37 organisations have received bespoke multi-agency coercive control training.

The hospital continues to encourage staff to take a proactive approach in checking whether there are possible domestic abuse issues, and this is included in their safeguarding training.

3. Gathering and sharing accurate information

Agency information held about Edith and who she was living with and being supported by was inaccurate and contradictory at times. There was uncertainty about how she and Mr A were related. Social care believed him to be her nephew, however health records referred to him as nephew, husband or partner. Similarly, there were contradictory records about Mr A's daughter, with references to her being Edith's step daughter, niece or great niece. No agency held any information about Edith's brother, her next of kin, who should have been involved in urgent discussions about her condition and end of life care.

When Edith was admitted to hospital in July 2017, the hospital did not check her GP details and so her discharge letter was sent to an old GP practice. The correct surgery did not receive the letter, which included information about her treatment and follow up actions, until over a month later. The Tissue Viability and Dementia service had her correct GP details but neither updated the central clinical web portal system. The GP information was only changed after Edith's death.

There was also concern about hospital doctors pressing ahead with plans for Edith to go home without an appreciation that a care package and equipment needed to be organised for a safe discharge. The discharge letter also did not include any details about the conclusions reached in respect of the safeguarding concerns raised, although it referred to self-neglect being a factor for the pressure ulcer which resulted in her admission. The letter also did not include any details of the home care package nor any reference to the original intention that the GP carry out a follow up visit to see how Edith was managing at home and consider if any further memory assessments were required.

What has changed?

There is already some facility for sharing essential medical information with other healthcare providers being able to access the GP summary case record. The possibility of creating a shared health and social care record is also being piloted nationally.

The home care agency has started to complete a care passport for each person they support. This is in an electronic format so it can be shared quickly and easily.

Recommendations

1. WST should seek assurance that where it is known or suspected that neglect or self-neglect may be placing a person at risk, but assessments or services have been refused or prevented, professionals should always:

    a. Consider whether there is a need to initiate formal safeguarding enquiries and, where necessary, draw up a safeguarding plan
    b. Make a detailed record of the reasons for any decision not to initiate safeguarding enquiries

2. WST should be assured that where it is identified that a person may be experiencing unintentional neglect by an informal carer:

    a. The reasons for this are explored fully with an assessment of the carer's

circumstances, willingness and ability to meet the person's needs
   b. A carer's assessment is offered to identify their own health and care support needs

3. WST should seek assurance that there is evidence that multi-disciplinary meetings, and multi-agency "concern" meetings are:

   a. Securing the involvement of all relevant agencies
   b. Enabling home care agencies to contribute their knowledge and perspectives
   c. Providing effective early intervention to reduce risk and are identifying potential safeguarding issues

4. (WST) and the Safer Wolverhampton Partnership should seek assurance from its statutory partners that across the partnerships that:

   a. Professionals are equipped, through guidance and training, to recognise the indicators of possible coercive control and where this may be affecting a person's ability to make significant decisions such as those about their care and treatment
   b. There are quality assurance processes in place to support effective and consistent practice in the use of trigger questions and the multi-agency risk assessment tool for cases involving domestic abuse, and in particular cases involving coercive control;
   c. That relevant professionals have access to updated legal guidance, including reference to current case-law, on the different legal options which are available to protect adults at risk who may be victims of coercive control

5. WST should seek assurance that all relevant agencies are approached when additional information is being gathered to inform the response to formal safeguarding concerns that have been raised and are informed of the decisions made.

6. WST should seek assurance from the relevant statutory partners that they are satisfied that agencies are applying robust systems and processes to maintain up to date information about a service user's GP, and contact numbers / email addresses for family members or informal carers to be contacted when circumstances require this

7. WST should request a report from the relevant statutory partners on the options, such as the use of health and care passports, to enable essential information about a person and agency involvement, to be accessible to professionals making home visits, or when the person is seen in a clinical setting.