Version 5:

Cheshire East Safeguarding Adults Board

Safeguarding Adults Review: JANE

Published November 2022

SAFEGUARDING ADULT REVIEW

Report into the circumstances surrounding the death of Jane.

Report produced by Richard Proctor
Independent Reviewer and Author.

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ACKNOWLEDGEMENTS

This Safeguarding Adults Review would not have been possible to undertake without the co-operation and information supplied by those agencies who provided care and support for Jane. This contributed significantly to the production of the final report and helped to identify recommendations for improvement.
This report reflects the combined views of the SAR Panel who have invested their time, commitment, and expertise throughout this process. The input and professional support provided by the Safeguarding Adults Board Manager and support team was invaluable throughout this process.

11th May 2022.

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1. Introduction

1.1 Statutory Framework

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)

b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and

c) the Safeguarding Adults Board knows or suspects the adult has experienced serious abuse or neglect and there is concern how the partner agencies have worked together to protect the individual.

The decision to undertake a Safeguarding Adult Review (SAR) in relation to this case was made by the Independent Chair of the Board on the 17th December 2020 whom after considering the circumstances of the case was satisfied that the criteria to undertake such a review was met.

The timeline period for the review to consider was identified as the 1st January 2020 up to the 5th December 2020.

2.0 Service Involvement

The review was informed by information provided by the following agencies and departments.

Cheshire East Council

Cheshire Police (CP)

Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

Cheshire East Council Carers Hub

Cheshire East Council Care4CE Dementia Reablement

GP Surgery.

3.0 Pen Picture of Jane.

Jane was aged 63 when she died. The SAR understands she was a married woman and had two adult sons.

She was diagnosed with Frontotemporal Dementia in 2018 and was provided with support by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) in relation to her condition.

Jane lived in her own home with her husband who was her primary carer. It was reported that she suffered from incontinence and that her husband managed her personal care needs.

There is limited personal information known to the SAR regarding Jane, as a consequence of her family declining to contribute to the review owing to the distress, they felt it would cause to them.

4.0 Summary of significant events

4.1 On the 23rd March 2020 as a consequence of the COVID19 pandemic the United Kingdom entered into a national lockdown, where the general public were ordered by Central Government to stay at home, protect the NHS and save lives.

4.2 On the 14th April 2020 Cheshire Police (CP) attended at a garden centre in Jane's hometown. This following a report of her climbing over a fence to enter the closed premises and repeatedly spitting at a worker at the premises. The police officers in attendance observed that Jane was wearing male shoes that were too big for her and when they attempted to speak to Jane, she was reluctant to engage with them. One of the officers remained with Jane whom it was apparent was starting to walk towards her home. This officer walked alongside her, whilst the other officer after ascertaining her address went to speak with her husband. It was explained to the officer by Jane's husband that she regularly went out for walks and that assessments for dementia had been delayed owing to the COVID19 pandemic. Jane subsequently returned to her home safely. In response to this occurrence the officers submitted a Vulnerable Person Assessment (VPA) detailing the circumstances of the incident.

4.3 On the 15th April 2020 Cheshire East Council (CEC) Adult Social Care Contact Team received the VPA submitted by CP on the day previously. In response CEC contacted Jane's husband who explained his wife was putting herself at risk and that he was finding the situation upsetting. There was no information recorded by CEC as to the risk that was perceived by Jane's husband to be present. He explained that Jane had no context of the COVID19 regulations in place at that time and that she enjoyed walking twice per day. He reported believing that she was in the final stages of frontotemporal dementia and had been supported previously by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) Adult Community Mental Health Team (CMHT). Jane's husband informed CEC that Jane was able to cook, and whilst able to wash herself, she was incontinent and refused to have a shower or bath. When asked by the CEC worker if a social care needs assessment could be

provided, Jane's husband refused to allow this to be conducted. A social care needs assessment as detailed within the Care Act 2014 states that where it appears to a local authority that an adult may have needs for care and support, the authority must assess whether the adult does have needs for care and support and if the adult does what those needs are. Jane's husband did consent to contact being made by CEC with Jane's GP and CWP.

Care Act 2014 (legislation.gov.uk)

The CEC worker contacted Jane's GP who explained that Jane was under the care of the CWP CMHT and had last been reviewed by this team in November 2019. In response Jane's GP submitted a referral letter to CWP Adult Community Mental Health Team requesting that Jane's follow up appointment currently scheduled to take place in May 2020, be expedited.

The CEC worker contacted CWP CMHT and spoke with a Mental Health Practitioner. The CEC worker shared information regarding the incident at the garden centre with the Mental Health Practitioner. The Mental Health Practitioner responded by stating that medication management was not appropriate in managing Jane's social needs and the provision of a COVID19 awareness lanyard should be considered. This because it was believed that Jane had no understanding of the current government restrictions which permitted individuals to exercise once daily. The Mental Health Practitioner recorded that they would discuss the case with their manager and contact the CEC worker once that had taken place. There is nothing recorded in the CWP records to evidence any such contact taking place to update CEC on the outcome of the discussion with the CWP manager.

The CEC worker contacted their duty Social Worker and updated CP in relation to the action taken.

The CEC worker then contacted Jane's husband to update them regarding the actions taken. Jane's husband advised the CEC worker that he was struggling and required some form of break. In response the CEC worker provided him with contact numbers for a local volunteer scheme helping to provide support to others during the COVID19 pandemic. No Carers assessment as per the Care Act 2014 was offered to be undertaken despite Jane's husband reporting that they were struggling and that he required a break.

No visit to Jane's home address was undertaken by the CEC worker to assess and consider how to manage the current risks posed to Jane. There was no apparent consideration of the Section 11 Care Act 2014 duty following Jane's husbands' refusal to permit a social care needs assessment to take place as no assessment of Jane's Mental Capacity was undertaken. The Care Act 2014 states that where an adult refuses to have a social care needs assessment the local authority is not required to carry out the assessment but cannot rely on that refusal if the adult subject to the assessment lacks mental capacity to refuse the assessment and the local authority believes carrying out the assessment would be in the individual's best interests as per the Mental Capacity Act 2005.

Care Act 2014 (legislation.gov.uk)

Mental Capacity Act 2005 (legislation.gov.uk)

4.4 On the 5th May 2020 the CWP Mental Health Practitioner held a face to face follow up appointment with Jane. There was no information recorded as to the outcome of the appointment other than a further appointment being arranged for the 7th May 2020. CWP have no record of the appointment on the 7th May 2020 taking place.

4.5 On the 22nd September 2020 Jane's GP contacted Jane's husband by telephone. This following the receipt of a letter from the local parish church expressing concerns regarding Jane's welfare. The letter detailed concerns that Jane whilst attending the church services is presenting as confused and agitated. The letter described her behaviour as out of character where for example when receiving the eucharist, she would spit it out following placing it in her mouth. Additionally the letter reported that in line with the current COVID19 restrictions in place at that time she was refusing to provide any details in relation to "track and trace", wear a mask or sit where allocated. The letter additionally detailed her being sighted in the village wearing inappropriate clothing for the weather conditions such as heavy coats and woollen hats on hot days.

Jane's husband reported to the GP that he is of the opinion that she is gradually becoming more confused and continues to experience shooting pains over her whole

body. Jane's husband informed the GP that his two sons provide some support and whilst Jane is doubly incontinent is able to clean herself. Jane's husband reported having no recent contact from CWP. In response the GP sent a letter to CWP requesting Jane have a mental health review. This letter was received by CWP on the 25th September 2020.

4.6 On the 25th September 2020 CP were contacted by the same garden centre as described at **4.2.** The garden centre reported that Jane had visited the centre that day and had been taking food from customers plates together with "taking bites" out of their food. They further reported that the previous day Jane had been spraying hand sanitiser at people and shouting at children in the premises. It was reported despite the current COVID19 restrictions in place at that time that she was not wearing a mask and when challenged by staff regarding her behaviour that she was confrontational by almost spitting in their faces. The officer in attendance submitted on the 3rd October 2020 a VPA detailing the circumstances of the incident. There is no information provided to inform the SAR to indicate why the submission was delayed.

4.7 On the 30th September 2020 a telephone review of Jane's case was undertaken by CWP by contacting Jane's husband. Jane's husband reported that her mental health had deteriorated over the previous six months and whilst still possessing a good appetite she had difficulties in swallowing. Jane's husband reported that Jane would wake up in the night take herself downstairs and outside, though he stated she did not leave the home at night. Jane's husband confirmed she had two long walks per day, and he was able to take care of her personal care needs. He reported no concerns regarding her mood or her suffering from depression. Jane's husband reported having support from his sons but felt he would require help from services soon. A plan was established by CWP to review Jane's case in three months. There was no evidence of CWP undertaking an assessment of Jane's presenting risks or the establishment of a risk management plan so as to manage or mitigate any of the presenting risks.

No "face to face" contact took place between CWP and Jane which was not in accordance with CWP's COVID19 policy and guidance at that time, as the clinical

need to visit Jane in person was apparently made out following the information provided by her GP. Consequently, there is nothing to indicate an assessment of Jane's mental capacity as per the Mental Capacity Act 2005 being undertaken with regards to her care and treatment.
Mental Capacity Act 2005 (legislation.gov.uk)

4.8 On the 5th October 2020 the CEC Adult Social Care Contact Team received the VPA created by CP following the events that occurred on the 25th September 2020**.** In response a CEC frontline worker made telephone contact with Jane's husband. He reported having no knowledge of this incident. He informed the worker that Jane was not aggressive at home and that he felt he managed her well, although that he is feeling lonely and isolated. Jane's husband reported that she walks twice daily and was banned from the local supermarket following an altercation with a staff member. He stated that his sons visit once or twice on a weekly basis, and he agreed to contact being made with Jane's GP and CWP so as to discuss if there is a requirement for medication to be provided for Jane. The CEC worker contacted CWP and spoke with the duty worker who confirmed receipt of the letter from the GP sent on the 22nd September 2020. The duty worker agreed to discuss Jane's case with her allocated CWP worker and consultant.
No home visit was undertaken by CEC to assess the risks or consider how to manage the safety concerns regarding Jane's current behaviours. No carers assessment was offered to Jane's husband or apparent consideration of the previous contact made in April 2020 to inform any risk assessment.

4.9 On the 6th October 2020 CWP made telephone contact with Jane's husband. The most recent incident at the garden centre was discussed. Jane's husband reported that they managed well at home, that he undertook most of the housework, though Jane cooked most of the meals. He reported that he had observed a decline in Jane's short and long memory over the preceding twelve months which was reflected in her inability to recognise people or remember the names of close family members. It was agreed that a review of Jane's mental health would be undertaken though there was nothing to evidence the information of this decision being shared with CEC.

4.10 On the 8th October 2020 CWP were unsuccessful in contacting Jane's husband so as to arrange a home visit to undertake an assessment of Jane's mental health.

4.11 On the 13th of October 2020 the CWP Clinical Lead with the consent of Jane's husband as per the COVID19 guidance in place at that time, visited Jane at home. The Clinical Lead upon attendance saw that Jane was asleep in the lounge and recorded that she was casually dressed with no signs of self-neglect. The clinical lead considered it best to not awaken Jane and spoke with Jane's husband.

Jane's husband informed the Clinical Lead that Jane went out most days and because she has been banned from a local supermarket, he accompanied her shopping. Jane's husband reported Jane being very impulsive. To demonstrate this Jane's husband provided examples where she would push him out of the way if she needed to get something from the kitchen and push her trolley into other shoppers at the supermarket, rather than waiting in queues. Jane's husband reported she was verbally aggressive and argumentative towards him if he is unable to accommodate her needs immediately. He informed the Clinical Lead of not being certain as to where she went on her walks, but did not think she was disorientated, as she always returned home. Jane's husband reported suspecting she may have fallen on occasions whilst walking. This owing to rips in her clothing. As far as he was aware Jane's husband reported believing Jane had the ability to cross the road safely. It was confirmed by Jane's husband that she currently had no prescribed medication in relation to her dementia condition. The Clinical Lead advised they would speak with medics regarding the prescribing of medication to assist in managing her impulsive behaviour and increasing agitation. Jane's husband confirmed he was the primary carer with some support from his sons and that Jane required full assistance with dressing and some personal care needs owing to urinary incontinence. He reported undertaking all the cooking and cleaning in the home.

There was nothing evident to demonstrate the Clinical Lead engaging with Jane so as to assess her mental health or any assessment of her mental capacity regarding her ability to make informed decisions regarding her current care and treatment.

The Clinical Lead referred Jane's case to the CEC Dementia Reablement Team to explore the use of assistive technology and the installation of door sensors. There

was a request made that the Reablement Team discuss with CEC Social Care the support which may be provided for Jane's husband as her carer together with consideration of Jane receiving a home care support package. The Clinical Lead discussed with Jane's husband the "Herbert Protocol" and provided the documentation so as to enable this to be completed. The "Herbert Protocol" is a risk reduction tool to help the police in their search for people with Dementia who go missing. It encourages carers or family members of adults living with dementia to collate information on those who are vulnerable recording this within the Herbert Protocol form, which can be given to the police if the individual goes missing.

Dementia Reablement Service (cheshireeast.gov.uk)

https://www.cheshire.police.uk/herbertprotocol

The Clinical Lead made a referral for support to be provided by the Continence Service and after discussions regarding medications with medics Jane was prescribed with a course of Memantine Medication which would be reviewed in four weeks. Memantine medication is used to treat Alzheimer's disease which is the most common form of Dementia.

https://www.nhs.uk/conditions/alzheimers-disease/treatment/

Following the visit, the Clinical Lead completed a risk assessment informed by the discussion with Jane's husband where it was detailed that there was no mood disorder, no delusions or hallucination present. It was recorded that Jane did not drive, no wandering behaviours were reported but there was an increased risk of aggression towards her husband and the general public. It was confirmed that Jane did not smoke or misuse alcohol.

4.12 On the 19th October 2020 the CWP Clinical Lead reviewed and updated Jane's risk assessment. This assessment identified risks of self-neglect, falls, danger from fire, exploitation, poor physical health, tissue viability problems as a consequence of her incontinence and social isolation owing to her inappropriate behaviours.

4.13 On the 20th October 2020 following receipt of the CWP referral, the CEC Dementia Reablement Team contacted Jane's husband. Information and advice were provided regarding assistive technology and trackers. Jane's husband refused a visit from the Team explaining his wife becomes agitated when people visit the

home. Jane's husband reported he felt that he was managing at the moment and the Team worker explained that he could contact them at anytime should he feel Jane or himself required further support.

4.14 On the 3rd November 2020 Cheshire East Carers Hub (CECH) contacted Jane's husband following a referral made requesting a carers assessment be undertaken. Jane's husband confirmed he was supporting his wife who had Dementia and that he would welcome support in his caring role through the provision of a carers assessment as per the Care Act 2014.
Cheshire East Carers Hub (Young and Adult Carers) - Live Well Cheshire East
https://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

4.15 On the 13th November 2020 the CWP Clinical Lead made a referral to the Community Bladder and Bowel Service and a CECH support officer contacted Jane's husband. The CECH support officer "signposted" Jane's husband to the Deafness support network, together with arranging an appointment with him to complete a carers assessment.
https://services.eastcheshire.nhs.uk/bladder-and-bowel?back_cID=231

4.16 On the 19th November 2020 a CECH Carer's Assessment and support officer spoke with Jane's husband on the telephone to complete a Carer's Assessment and a "Living Well" funding application.
The Care Act 2014 identifies that where it appears to the Local Authority that a Carer who may have needs for support, that the Local Authority must assess whether the carer does have needs for support and if the carer does what those needs are.
The "Living Well" fund permits Carer's to apply for funding to promote their own Health and Well Being, so as to enable them to continue in their caring role.
Jane's husbands support plan with CECH included signposting him to the Herbert Protocol. CECH offered him further support which he declined.
Care Act 2014 (legislation.gov.uk)
https://www.cheshireeast.gov.uk/livewell/looking-after-someone/carers-of-adults/carers-assessment.aspx

4.17 On the 23rd November 2020 CECH submitted the Carer's Assessment to CEC. The Carer's assessment detailed safety concerns in relation to Jane becoming angry and referred to the previous incidents where the police had been involved. However, these issues of concern were not escalated by CECH or CEC and the suggested support plan that was developed did not address the risks or safety issues posed.

4.18 On the 24th November 2020 the CWP Clinical Lead made telephone contact with Jane's husband to review the effectiveness and Jane's compliance with the previously prescribed Memantine Titration medication. Jane's husband informed the Clinical Lead Jane had refused to take the medication. This despite his best attempts in encouraging her to take it. Jane's husband reported that things were okay and that he had received forms from the Dementia Reablement Team. He informed the Clinical Lead of receiving support from CECH and did not require anything else at this time. The Clinical Lead asked Jane's husband if he required a home visit but stated he was okay at present. The Clinical Lead reminded Jane's husband he could telephone CWP if he required any further support and he confirmed he would do so if required.

4.19 On the 5th December 2020 Jane's husband informed CP that his wife had been out walking and not returned home as expected. Despite extensive "Missing from Home" enquiries conducted by CP including reference to the completed "Herbert Protocol" documentation, Jane could not be located. Tragically, she was discovered several hours later by British Transport Police having died following being struck by a passing train, after venturing on to a railway track.

5.0 Methodology

SAR methodology is non- prescriptive within the Care Act with the overall aims that the review is conducted wherever possible in a timely and proportionate manner.
The chosen methodology to undertake this SAR was a blended approach of action learning with a more in-depth analysis of agency involvement. This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those practitioners involved at the time as well as key family members.
The process undertaken was as follows,

5.1 Panel Membership

A Safeguarding Adult Review (SAR) panel was established consisting of senior managers from lead agencies with no previous involvement in the case to support the progression of the SAR. These individuals were identified to have authority to effect change in their own agency and have the appropriate level of professional knowledge to support the SAR.

Cheshire East Safeguarding Adults Board have commissioned the Independent Reviewer and Author of the SAR to produce an independent report. The Reviewer and Author were not involved in the delivery of identified services; line management for any service, or any individual mentioned within the report. They are a former senior police officer experienced in undertaking SARs on a national basis.

The author and panel agreed terms of reference as detailed below to guide and direct the review. They undertook responsibility to look openly and critically at individual and agency practice; to identify whether this SAR indicates changes could and should be made to practice and if so, how these changes will be brought about.

In this case agencies involved in supporting Jane produced chronologies in relation to the agreed timeline, which were shared with the independent reviewer and author.

5.2 Terms of Reference

The purpose of the review is to consider:

- How effectively did agencies work together to safeguard the individual in light of the known risks, and was there evidence to suggest that agencies shared a common understanding of risk?
- Did the increase in concerns leading up to the individual's death receive an appropriate and effective response from agencies?
- How effectively was the husband in his role as Jane's carer supported by agencies?
- Was there effective co-ordination of the individual's care and support needs throughout the scoping period?
- Did the COVID19 pandemic inadvertently impact upon agency responses in relation to managing the perceived risks presented by Jane?
- Were there areas of good practice?

5.3 Family Involvement

It was identified as a priority by the SAR panel to include family members in helping to shape and inform this review. Contact was made by the Safeguarding Adults Board with one of Jane's sons. He stated that none of the family wished to contribute to the SAR as they believed it would be too distressing for them. They further added that speaking on behalf of the family, that they were content with the care and support provided and efforts made by agencies in Cheshire East to safeguard Jane. Consequently, it was decided so as to respect the families wishes, no further contact would be made.

5.4 Action Learning Event.

This event took place with multi-agency staff participation from several key agencies involved in providing care and support for Jane.

The key objectives of the event were established as,

- To consider what worked well.

- What could we have done better?
- What are our recommendations for improvement?

The event was focussed on three separate time periods where it was considered some of the significant events and themes had occurred during the timeline set for the SAR.

5.41

The first area of focus featured upon the significant events that occurred between 14th April 2020 and the 7th May 2020.

What worked well?

Discussions took place regarding the use of the "Herbert Protocol" which was felt to have been of benefit in this case.

The impact of the COVID19 restrictions was raised by practitioners as having created a culture of nervousness where guidance was constantly being changed. Practitioners reported that the COVID19 pandemic created pressure upon people, and it was felt that staff did the best they could at the time. It was suggested that Jane's husband's resistance for assessments to be undertaken, may have been down to the perceived negative media coverage surrounding deaths in hospitals and care homes. COVID19 restrictions were felt by practitioners may have contributed to in this case to the absence of Mental Capacity assessments being undertaken.

It was recognised that the CP response in ensuring Jane returned home safely following the incident at the garden centre on the 14th April 2020 was good practice.

Practitioners considered that the staff at the garden centre responded appropriately to the incidents involving Jane and it was highlighted that several shops and businesses in Cheshire East are part of the dementia awareness initiative. This initiative encourages businesses to raise awareness of dementia amongst its employees and it was considered appropriate for the Safeguarding Adults Board to become more involved in such initiatives.

It was acknowledged that the CEC first point of contact worker had undertaken work in contacting agencies and organisations to gather information which demonstrated good partnership working.

It was noted that the GP had requested support from CWP and there was a multi-disciplinary response, which included the CEC Dementia Reablement providing information and advice.

What could we have done better?

There was a concern highlighted that “professional curiosity” may not have been consistently applied in attempts to safeguard Jane. This was evidenced regarding the conflicting positions Jane’s husband adopted, where he would reference his wife’s care needs then refuse any help or assessment. It was felt that this position was not fully explored, and consideration could have been given to referring to Section 11 of the Care Act 2014 if it were deemed Jane lacked mental capacity and at risk of experiencing abuse or neglect.

Care Act 2014 (legislation.gov.uk)

The importance of professional curiosity in safeguarding adults | Research In Practice

There were concerns that agencies and practitioners took Jane’s husbands word that everything was okay and there should have been more attempts made to communicate with Jane.

It was strongly felt there were several occasions when decisions were being made regarding Jane’s ongoing care and treatment when an assessment of Jane’s mental capacity should have been undertaken, despite what the husband was saying.

It was reported by practitioners that they felt more support and at an earlier stage could have been provided for Jane’s husband, although it was acknowledged a Carers assessment referral had been submitted in October.

It was considered there was a lack of risk assessment and planning which could have led to a multi-agency professional meeting taking place to formulate a risk management plan. It was considered this may have stimulated best interest decisions to have been considered as per the Mental Capacity Act 2005.

It was considered more training and assurance regarding the application of the Mental Capacity Act was still required.

It was additionally considered that greater time could have been spent with Jane’s husband explaining the benefit of a social care assessment and because he observed her behaviours everyday may not have been able to appreciate the risks that were present through her behaviour.

What are our recommendations for improvement?

Recommendation 1.

Cheshire East Safeguarding Adults Board should consider ways it can promote and support the Dementia Awareness initiative in its work as a board.

Recommendation 2.

Cheshire East Safeguarding Adults Board drawing upon learning from this case should develop practitioner guidance of the requirement to apply "professional curiosity" in safeguarding practice as detailed within the research in practice for adults' guidance.

Recommendation 3.

Cheshire East Safeguarding Adults Board drawing upon learning from this case should assure itself through application of their quality assurance framework that the Mental Capacity Act 2005 is being consistently applied within the Cheshire East Safeguarding Adult's partnership.

5.42

The second area of focus featured upon the significant events that occurred between the 22nd September 2020 and the 5th October 2020.

What worked well?

It was identified that the COVID19 pandemic restrictions limited "face to face" contact with Jane, owing to a requirement for only essential visits to take place at that time. However, practitioners considered that the pandemic restrictions had actually encouraged practitioners to work much more closely together with other agencies in relation to safeguarding This had resulted in a positive impact upon partnership working.

It was recognised that in response to the incident involving Jane as described **4.6** that CP had submitted a VPA so as to raise awareness of the concerns to the CEC Adult Social Care Team.

The proactive response by the GP in contacting CWP requesting Jane receive a mental health review, following the receipt of a letter from the parish church expressing concerns for Jane's welfare as detailed at **4.5,** was identified as good practice.

What could we have done better?

It was considered that COVID19 restrictions resulted in many practitioners working from home and consequently presented the risk of decisions being made in isolation without always the opportunity of peer and supervisory support. The additional complications of technology not always functioning correctly was also recognised as an additional barrier for some at this time.

What are our recommendations for improvement?

There were no recommendations for improvement identified.

The third area of focus featured upon the significant events that occurred between the 13th October 2020 and the 5th December 2020.

What worked well?

It was identified that when Jane was visited at home by the CWP Clinical Lead as described at **4.11** a risk assessment was undertaken to assess Jane's presenting risks.

What could we have done better?

It was recognised that there was no evidence of the presenting risks being assessed from a multi-agency perspective. This presented a risk that assumptions could have been made those other agencies were managing the risks posed to Jane when this may not have been the true position.

It was considered that Jane's case could have been potentially referred to the high-risk forum. This may have enabled a multi-agency risk management plan to have been established to manage the presenting risks posed by Jane from a multi-agency perspective.

Concerns were raised that Jane's voice was not heard by agencies. This resulted in the information received and actions taken reflected her husband's wishes and feelings, to the exclusion of Jane.

It was again identified that mental capacity assessments should have taken place so Jane's capacity could be assessed regarding her ability to make informed decisions regarding her care and support.

What are our recommendations for improvement?

The issues regarding Jane's voice being unheard and the high-risk forum are addressed within the analysis section, with appropriate recommendations for improvement detailed within that section.

5.5 Documentary Review

- Relevant agencies provided chronologies of service involvement within the identified timeline.
- The chronologies were used to create a multi-agency chronology.
- The Care Act 2014.
- Mental Capacity Act 2005.
- Mental Health Act 1983.

6.0 Analysis

6.1 How effectively did agencies work together to safeguard the individual in light of the known risks, and was there evidence to suggest that agencies shared a common understanding of risk?

6.11 There is evidence of agencies working together to safeguard Jane in light of the known risks.

As detailed at **4.3** CEC were notified by CP of their concerns regarding Jane's behaviour following the submission of a Vulnerable Person Assessment (VPA). CP frontline officers are expected to submit a VPA where there is concern for an "adult at risk." An "adult at risk" is described in the Care Act 2014 as an adult who has needs for care and support, is experiencing or at risk of abuse or neglect and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The VPA was considered by CEC and in response they made enquiries with Jane's husband, her GP and CWP who were supporting Jane with her condition of Dementia. This resulted in Jane's GP submitting a referral letter to CWP requesting that her current planned mental health appointment be expedited. The CWP Mental Health Practitioner agreed to discuss Jane' case with their line manager and contact CEC once this conversation had taken place, however there was nothing recorded to evidence this update to CEC was ever provided.

Conversations held by CEC with Jane's husband indicated he was resistant to Jane receiving a social care needs assessment as per the Care Act 2014. This despite husband informing CEC he was predominantly her sole carer, that Jane suffered from incontinence and that he was struggling to cope. Jane's husband informed the CEC worker that his wife was putting herself at risk though it is unclear as to whether he was referring to her breaching the COVID19 pandemic restrictions in place at that time or from other factors. There was no evidence of a risk assessment being undertaken by CEC so as to assess the potential risks posed to Jane which may have led to the formulation of a risk management plan, to help manage or mitigate the risks posed.

6.12 As detailed at **4.8** CEC were notified by CP of their concerns regarding Jane's behaviour following the submission of a Vulnerable Person Assessment (VPA). The VPA was considered by CEC and was recorded as a community contact. In response CEC made enquiries with Jane's husband. He informed CEC that Jane was not aggressive at home, and he believed he was managing her needs. CEC once again contacted CWP who confirmed receipt of a recent letter received from Jane's GP as a result of events as detailed at **4.5.** There was no evidence of a risk assessment being undertaken by CEC to assess the potential risks posed to Jane which may have led to the formulation of a risk management plan, to help manage or mitigate the risks posed.

In response to the submission of the VPA, CEC established contact with Jane's husband to gather information regarding Jane's current presentation. CEC once again contacted CWP, where it was agreed the new information would be brought to the attention of Jane's CWP allocated worker and consultant.

The Cheshire East Council Safeguarding Adults Procedure details that where there it is established that there is no Section 42(2) Care Act 2014 duty to make further enquiries, the practitioner must still consider and record how any identified risk will be mitigated. It further details where information is gathered that indicates that there is a high risk of abuse or neglect, consideration should be given to convening a multi-disciplinary safeguarding meeting so risks can be assessed, and a risk management plan established. Had risk assessments been conducted and the risks assessed to Jane were deemed to be high, a multi-agency meeting could have been held with involvement from all agencies supporting Jane, so as to enable a multi-agency risk management plan being established so that agencies could work together in managing or mitigating the risks posed to Jane.

Care Act 2014 (legislation.gov.uk)

Recommendation 4.

Drawing upon learning from this case Cheshire East Safeguarding Adults Board should assure itself where concerns are raised to Cheshire East Council regarding an adult who may be at risk of abuse or neglect and those cases are deemed not to reach the Section 42(2) Care Act 2014 duty, that risk assessments are being undertaken to consider how any identified risks are

being managed or mitigated as per the Cheshire East Council Safeguarding Adults Procedure.

6.13 As detailed at **4.5** there is evidence of Jane's GP escalating their concerns regarding Jane's recent behaviour to CWP requesting a mental health review to be undertaken.

In response CWP as detailed at **4.7** undertook a telephone review of Jane's mental health by discussing her condition with her husband. Jane's husband identified that he was of the opinion Jane's mental health had deteriorated over the preceding six months and reported that she took two daily long walks. Jane's husband identified having some support from his sons but felt he would require help from other services soon. No "face to face" contact was made by CWP with Jane despite the information that had been provided by the GP which indicated a clinical need to do so, as per CWPs COVID19 policy and guidance in place at that time.

The CWP's clinical risk assessment policy promotes working in the spirit of collaboration based on a relationship between the service user and their carers. From the information provided to inform the SAR there was no evidence on this occasion of CWP undertaking an assessment of Jane's presenting risks in line with CWPs Clinical risk assessment policy. This may have enabled a risk management plan to be established by CWP so that suggested actions may be taken by Jane, Jane's husband, or other practitioners in response to any crisis.

Recommendation 5.

Drawing upon learning from this case Cheshire East Safeguarding Adults Board should assure itself that where an individual presents with identified risks, that CWP are undertaking risk assessments, to enable the development of risk management plans so preventative action may be taken by the service user, carer, or other relevant practitioners in response to any crisis.

6.2 Did the increase in concerns leading up to the individual's death receive an appropriate and effective response from agencies?

6.21 As detailed at **4.11** following recent telephone contact with Jane's husband who reported a decline in Janes long and short-term memory over the preceding twelve months Jane was visited at home by the CWP Clinical Lead. Upon attendance the CWP Clinical Lead found Jane asleep in the lounge of her home. They recorded that there were no signs of self-neglect and considered it best in the circumstances not to awaken Jane from her sleep. This resulted in her not being spoken to by the CWP Clinical Lead. Whilst the SAR does appreciate the decision not to awaken Jane was made in what was considered by CWP in Jane's apparent best interests, NICE guidance recommends involving people living with Dementia to be involved in decisions about their care.
Recommendations | Dementia: assessment, management and support for people living with dementia and their carers | Guidance | NICE

6.22 There is an apparent pattern during the timeline of this SAR of agencies solely relying upon the views of Jane's husband as to what care, treatment and support Jane required. This is evidenced for example in relation to the husband refusing to allow a social care needs assessment to be conducted by CEC as detailed at **4.3** this following him reporting his wife to be incontinent and refusing to take a shower or bath. It is also identified at **4.12** when following CWP referring Jane to the CEC Dementia Reablement Team to consider the provision of assistive technology, Jane's husband refused a visit from the team and no such technology was provided, which may have assisted safeguarding Jane from harm.
Where concerns were raised by CP to CEC regarding Jane's behaviour as detailed at **4.3** and **4.8** Jane was never spoken to by CEC or is there any evidence of her wishes and feelings being considered in the actions that were taken.
The Care Act 2014 places "Adults at Risk" at the centre of all decision making to ensure that their desired goals and outcomes are recognised. Such an approach is referred to as "Making Safeguarding Personal" and championed by Cheshire East Safeguarding Adult's Board. The board list one of their strategic priorities as to listen

to people who have been subject to abuse or neglect, and to seek assurance that people are able to be supported in the way that they want, are empowered to make decisions, and can achieve the best outcomes.
This approach did not apparently occur in Jane's case, whose voice appeared to be silent to inform the care and support she was provided with.
Making Safeguarding Personal (cheshireeast.gov.uk)

Recommendation 6.
Drawing upon learning from this case Cheshire East Safeguarding Adults Board should promote the value of agencies working in a personalised manner in line with the principles of "Making Safeguarding Personal" together with seeking assurance through the application of the Board's Quality Assurance Framework that the principles of "Making Safeguarding Personal" are being consistently applied by agencies of the Cheshire East Safeguarding Adults partnership and that they ensure the voice of the service user is heard where appropriate and not just the voice of family members.

6.23 As described at **4.11** when the CWP Clinical Lead visited Jane at her home they referred Jane's case to the CEC Dementia Reablement Team. This so the provision of assistive technology may be considered including the installation of door sensors. Assistive technology refers to devices or systems that help maintain or improve a person's ability to do things in everyday life. The CWP Clinical Lead after confirming Jane was not currently prescribed medication advised they would speak to medics regarding whether medication may assist in managing Jane's impulsive behaviour and increasing agitation. The Clinical Lead discussed with Jane's husband the" Herbert Protocol" and provided him with documentation to be completed should Jane ever go missing. The consideration of the provision of medication, referral to the Reablement Team regarding the use of assistive technology and promotion of the" Herbert Protocol" the SAR identifies as good practice in attempting to reduce and manage the presenting risks posed to Jane.
After completing the visit, the CWP Clinical Lead completed Jane's risk assessment in accordance with CWP's clinical risk assessment policy. They recorded there were no wandering behaviours reported but that there was an increased risk of aggression

towards Jane's husband and the general public. As detailed at **4.12** the risk assessment was reviewed and updated by the Clinical Lead which identified further risks of self-neglect, falls, danger from fire, exploitation, poor physical health, tissue viability problems and social isolation. There was no evidence provided to the SAR that demonstrated a risk management plan being established to manage these identified risks. Further referrals were made to CECH for a carers assessment to be undertaken, together with seeking support for Jane from the continence service and community bladder and bowel service.

As detailed at **4.18** telephone contact was made by the CWP Clinical Lead to review both the effectiveness and Jane's compliance with her Memantine medication. It was reported by Jane's husband that she had refused to take the medication. After Jane's husband declined a home visit the CWP Clinical Lead reminded him that he could contact CWP at any time should he need to do so. There is no evidence of a review of Jane's risk assessment being completed by the CWP Clinical Lead following the sharing of this information or recorded consideration and response to the potential risks posed to Jane through non-compliance with her medication.

As identified in the review of Jane's risk assessment it was identified that she may have been at risk of self-neglect. Self -neglect is defined in the Care Act 2014 as a wide range of behaviour including neglecting to care for themselves and or their health or surroundings and includes behaviour such as hoarding**.** The report of her refusing to take her prescription medication was apparently not considered to be a potential safeguarding concern in relation to self-neglect and no safeguarding concern was raised to CEC by CWP as per the CEC Safeguarding Adults Policies and Procedures. By raising such a concern CEC would have been able to gather information from partner agencies and then decide if further action was required to safeguard Jane.

Recommendation 7.

Drawing upon learning from this case Cheshire East Safeguarding Adults Board should communicate to the Cheshire East Safeguarding Adults partnership of the required criteria of when to raise a Safeguarding Concern to Cheshire East Council.

6.23 Cheshire East Safeguarding Adults Board hold a multi-Agency Policy for the case management of high-risk self-neglect cases which involve an individual who may be at risk of severe injury or death from their level of self-neglect or lifestyle choices. In such cases practitioners are able to refer cases to be considered in a multi-agency forum so that senior managers are aware of such cases and can ensure practitioners have appropriate support together with providing a multi-agency framework to monitor and manage risk. Had a referral to this multi-agency forum been considered it may have enabled the potential risks posed to Jane being considered and managed from a multi-agency perspective.
http://www.stopadultabuse.org.uk/pdf/multi-agency-complex-safeguarding-policy-and-guidance-pdf.pdf

Recommendation 8.
Drawing upon learning from this case Cheshire East Safeguarding Adults Board should communicate to the Cheshire East Safeguarding Adults partnership the existence and access pathway of the Complex Safeguarding Forum.

6.24 The Mental Capacity Act 2005 details that people must be assumed to have capacity unless it is established, they lack capacity. The Act states a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. The Act further clarifies that a lack of capacity cannot be established merely by reference to a person's age or appearance or a condition or an aspect of their behaviour which might lead others to make unjustified assumptions about the individuals mental capacity. The Act further states a person is not to be treated as unable to make a decision unless all practicable steps have been taken to help them do so. For an individual to be deemed to lack mental capacity it means they are unable to make a specific decision at a specific time.

6.25 Jane was diagnosed with Frontal Temporal Dementia in 2018 and currently according to NHS information is an uncurable condition. It is a condition that can cause mental health problems caused by gradual changes and damage in the brain. However, this should not have automatically led to agencies assuming that owing to Jane's condition she automatically lacked mental capacity. There is no evidence provided during the timeline of this SAR of agencies undertaking any mental capacity assessments at the time in relation to specific decisions made in relation to her care and treatment, or of any steps taken to involve her as much as possible in the decision-making process.

These include at **4.3** when Jane's husband refused a social care needs assessment for Jane to take place, at **4.11** regarding decisions taken regarding the prescribing of medication by CWP and at **4.13** following contact being made by CEC Dementia Reablement Team when Jane's husband refused allowing the team to visit Jane.

Learning regarding the lack of application of the principles of the Mental Capacity Act 2005 should be addressed through the application of **Recommendation 3.** generated at the Action Learning event.

6.3 How effectively was the husband in his role as Jane's carer supported by agencies?

6.31 As described at **4.3** when contacted by CEC, Jane's husband provided information that whilst Jane could cook, she was incontinent and whilst able to wash herself refused to have a shower or bath. He then describes how he is struggling and requiring a break of some type.

6.32 As detailed at **4.5** when contacted by the GP, Jane's husband reported his two sons provide some support to him, but the extent as to how much support they provided was not fully explored.

6.33 As detailed at **4.7** when contacted by CWP, Jane's husband again reports having support from his sons but anticipated he would soon require help in his role as Jane's carer.

6.34 As described at **4.8** when contacted by CEC Jane's husband reported being visited by his sons once or twice per week and that he was managing Jane's needs but was feeling lonely and isolated.

6.35 As detailed at **4.14** Cheshire East Carers Hub contacted Jane's husband to discuss if he would welcome any support in his role as Jane's carer. A carers assessment was subsequently completed as per the Care Act 2014. However, no additional support was able to be provided to Jane's husband owing to the close time proximity of the assessment taking place and Jane's death.

The Care Act details that where it appears to a local authority that a carer may have needs for support (whether currently or in the future), the authority must assess whether the carer does have needs for support (or is likely to do so in the future), and if the carer does, what those needs are (or are likely to be in the future).

A carers assessment provides the local authority an opportunity to assess and record the impact caring has on an individual's life together with identifying if additional support is required. A carer as described by the Care Act 2014 is an adult who provides or intends to provide care for another adult. It is apparent that Jane's husband would be categorized as her carer.

The NHS recognise the positive impact carers such as Jane's husband have on society and estimate from a cost benefit perspective that the support provided by friends and family members to ill, frail, or disabled relatives is equivalent to £119 billion every year.

Whilst Jane's husband may have given the impression to practitioners of being able to support Jane with her personal needs and that he was supported by his two sons in his role, the impact of caring upon his well being does not appear to have been fully investigated. If assessments at an earlier stage had been offered and undertaken, additional support may have been able to have been provided to Jane's husband in his role as Jane's carer. The SAR identifies that whilst Jane's husband on occasions reported to be managing well and had some support from his sons this may have led practitioners forming an over optimistic view of the situation. The SAR recognises that practitioners should have applied greater professional curiosity in questioning the information provided by Jane's husband of the impact upon his well-being as Jane's carer. This may have enabled any concerns to have been identified together with

leading to a better understanding of the actual situation. This should be addressed through the application of **Recommendation 2.**

Care Act 2014 (legislation.gov.uk)

NHS commissioning » Carer Facts – why investing in carers matters (england.nhs.uk)

Professional curiosity in safeguarding adults - Social Care Online (scie-socialcareonline.org.uk)

Recommendation 9.

Drawing upon learning from this case Cheshire East Safeguarding Adults Board should communicate to the Cheshire East Safeguarding Adults partnership of the circumstances of when a Carers Assessment is required to be undertaken.

6.4 Was there effective co-ordination of the individual's care and support needs throughout the scoping period?

6.41 For individuals living with a condition of Dementia NICE guidance recommends that people have a single named coordinator to coordinate their care who should develop a care and support plan for the individual. There is evidence as detailed at **4.3** of CEC liaising with Jane's CWP allocated worker to discuss recent concerns relating to Jane's behaviour. The CWP allocated worker stated they would discuss Jane's case with their manager and update CEC accordingly. There is nothing to evidence any further contact being made by CWP with CEC on this occasion to share information as to the outcome of the discussion with their manager.

Quality statement 4: Coordinating care | Dementia | Quality standards | NICE

6.42 As described a **4.4** CWP records indicate the CWP allocated worker held a face-to-face appointment with Jane. The only outcome recorded was for a further appointment to be arranged for two days later. There is nothing recorded in CWP records to evidence this appointment taking place.

6.43 Dementia NICE guidance recommends that any developed care and support plan should be agreed reviewed and developed with the individual, carers, and relevant professionals. There is no information provided to inform the SAR that demonstrates such activity taking place though there was evidence of CWP liaising with Jane's husband and of the GP making referrals to CWP regarding Jane's mental health.

6.43 Following a visit to Jane's home by the CWP Clinical Lead as described at **4.11,** there is strong evidence of the coordination of Jane's care by the Clinical Lead through the making of referrals to the CEC Dementia Reablement Team and the Community Bladder and Bowel Service. The coordination by the CWP Clinical Lead of Jane's care and the raising of referrals to access additional support the SAR identifies as good practice.

6.5 Did the COVID19 pandemic inadvertently impact upon agency responses in relation to managing the perceived risks presented by Sylvia?

6.51 During the Action Learning Event several practitioners spoke openly of the challenges they faced during the pandemic. They described the situation in the first few months of the pandemic of constantly changing guidance which informed them as to what they could and could not do. Managers encouraged practitioners wherever possible to work from home and avoid any unnecessary face to face contact. This resulted in decisions sometimes being made in isolation without the usual supervisory oversight and guidance.

6.52 In the timeline period of this SAR the author has identified at least ten changes to the government guidance in relation to COVID19 which may have directly impacted upon the practice of Health and Social Care workers. This ever-changing operational landscape may have created a climate of uncertainty as to how to respond to concerns raised by the general public.
covid-19-timeline-march-2022.pdf (keoghs.co.uk)

6.53 However, the SAR has found no evidence to indicate that the pandemic inadvertently impacted upon agency responses in relation to managing the perceived risks presented by Jane.

6.6 Were there areas of good practice?

The SAR has identified several areas of Good Practice during the timeline of this SAR which are detailed as follows.

As described at **4.2** where the CP officer walked alongside Jane to ensure she returned home safely.

As described at **4.3** where the CEC Point of Contact demonstrated good partnership working. when following the receipt of the VPA from CP, enquiries were made with several relevant agencies, so as to establish the current situation regarding Jane.

As described at **4.5** where the GP following the receipt of a letter highlighting concerns regarding Jane's behaviour, they responded by requesting a mental health review be undertaken.

As described at **4.11** where the CWP Clinical Lead promoted the use of the Herbert Protocol with Jane's husband in the eventuality of her going missing from home.

As described at **4.11** where the CWP Clinical Lead coordinated Jane's care through the raising of referrals for support with her care needs.

6.8 Equality and Diversity Considerations

The Equality Act 2010 protects people from discrimination in society owing to the protected characteristics they may display as described in the Act. One of the protected characteristics is Disability.

Jane owing to her condition of Dementia may have been considered to have had a disability if it caused physical or mental impairment which had a substantial and long-term adverse effect on her ability to carry out normal day to day activities.

The SAR has failed to identify any evidence to indicate that Adult B did not receive the appropriate level of care and support from agencies owing to this potential protected characteristic.

7. RECOMMENDATIONS.

Recommendation 1.
Cheshire East Safeguarding Adults Board should consider ways it can promote and support the Dementia Awareness initiative in its work as a board.

Recommendation 2.
Cheshire East Safeguarding Adults Board drawing upon learning from this case should develop practitioner guidance of the requirement to apply "professional curiosity" in safeguarding practice as detailed within the research in practice for adults' guidance.

Recommendation 3.
Cheshire East Safeguarding Adults Board drawing upon learning from this case should assure itself through application of their quality assurance framework that the Mental Capacity Act 2005 is being consistently applied within the Cheshire East Safeguarding Adult's partnership.

Recommendation 4.
Drawing upon learning from this case Cheshire East Safeguarding Adults Board should assure itself where concerns are raised to Cheshire East Council regarding an adult who may be at risk of abuse or neglect and those cases are deemed not to reach the Section 42(2) Care Act 2014 duty, that risk assessments are being undertaken to consider how any identified risks are being managed or mitigated as per the Cheshire East Council Safeguarding Adults Procedure.

Recommendation 5.
Drawing upon learning from this case Cheshire East Safeguarding Adults Board should assure itself that where an individual presents with identified risks, that CWP are undertaking risk assessments, to enable the development of risk management plans so preventative action may be taken by the service user, carer, or other relevant practitioners in response to any crisis

Recommendation 6.

Drawing upon learning from this case Cheshire East Safeguarding Adults Board should promote the value of agencies working in a personalised manner in line with the principles of "Making Safeguarding Personal" together with seeking assurance through the application of the Board's Quality Assurance Framework that the principles of "Making Safeguarding Personal" are being consistently applied by agencies of the Cheshire East Safeguarding Adults partnership and that they ensure the voice of the service user is heard where appropriate and not just the voice of family members.

Recommendation 7.

Drawing upon learning from this case Cheshire East Safeguarding Adults Board should communicate to the Cheshire East Safeguarding Adults partnership of the required criteria of when to raise a Safeguarding Concern to Cheshire East Council.

Recommendation 8.

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Recommendation 9.

Drawing upon learning from this case Cheshire East Safeguarding Adults Board should communicate to the Cheshire East Safeguarding Adults partnership of the circumstances of when a Carers Assessment is required to be undertaken.