Safeguarding Adult Review of Graham
Presented to the West of Berkshire Safeguarding Adults Board

On

22nd July 2020

1. Introduction

1.1 The West of Berkshire Safeguarding Adults Board made the decision to commission a Safeguarding Adult Review under Section 44 of The Care Act 2014. In the case of Graham, the Safeguarding Adults Review (SAR) Panel subgroup to the Board have selected a proportionate review methodology. The review will focus on extracting and drawing together any identified and additional learning rather than a full SAR methodology.

1.2 The review focuses on the specific concerns related to the decisions taken in the management of a safeguarding enquiry involving Graham, the implementation of The Mental Capacity Act 2005 (MCAc) in relation to the named person and the support provided to Graham and Ava, in their respective roles as service user and carer.

1.3 In the time period covered by this review, Adult Social Care Statutory Services in the Wokingham Borough Council (WBC) area was provided by two organisations – WBC and Optalis (a local authority trading company). Statutory responsibility for adult safeguarding was split across the 2 organisations. Whilst Optalis staff in The Brokerage and Professional Support Service (BPSS) led on and managed safeguarding enquiries, overall responsibility for signoff and closure of an enquiry sat with the Local Authority (LA).

1.4 This report will be published on the Board's website in anonymised form Learning from the SAR will be delivered locally by the Strategic Safeguarding Lead for WBC. However, the Board may consider how to implement learning identified in this review across other the other LAs in Berkshire.

2. Summary of Case

2.1 Details of the person subject to the Safeguarding Adult Review
Name: Graham (Pseudonym)

2.2 Family Composition
At the time of his death, Graham lived with Ava, his wife and main carer. Camilla, Graham's daughter from his first marriage lived locally. Ava also had a daughter who lived locally and visited the family on a regular basis. Her name is Eleanor.

2.3 Timeframe
The Safeguarding Adult Review (SAR) Panel on 13th June 2019 agreed that the timeframe under review will be from August 2015 to October 2018.

2.4 Evidence Provided for the Review
The following agencies, involved with Graham were requested to provide a chronology of events covering the time period August 2015 to October 2018.

- WBC
- Berkshire Health Foundation Trust (BHFT)
- General Practitioner (GP)
- A local day centre
- Home Care Agency

The information was used to provide a timeline of agency involvement. This allowed for the report writer to analyse key events and work with the practitioners involved in the case.

3. Overview of the Case

This section provides an overview of the work that was undertaken by WBC staff with Graham between August 2015 and October 2018. The overview incorporates chronologies from multiple agencies involved in Graham's life at the time in order to provide the full context of his situation at the time.

Graham was an 86 year old man diagnosed with vascular dementia and other comorbidities. Towards the end of his life Graham was dependent on his wife Ava to provide support for all activities of daily living including bathing, dressing, grooming, and toileting. He was no longer able to mobilise independently. He required assistance of two people and the use of mobility equipment for all transfers. Because of his cognitive impairment, Graham's ability to communicate his own views and wishes had deteriorated. He was dependent on Ava to maintain communication with the different agencies involved in his life.

In August 2015, Graham was in receipt of a care package of one hour per day of personal care support provided at home by a domiciliary care agency and two days a week at a local day centre. The LA commissioned a domiciliary care worker to offer assistance to Ava to help her to get used to using a standing hoist (for transfers). Occupational Therapist (OT) input had identified that Ava was struggling with supporting Graham to transfer from place to place (e.g. bed to chair and vice-versa). Ava agreed to this support on a temporary basis. Ava expressed reservations that Graham would lose what little independence he had left if the hoisting equipment was used.

A carer's assessment was completed with Ava in early August. In the assessment, it is recognised that Ava provides the following support – help with personal care, toileting, meal preparation, supporting Graham to attend health appointments (e.g. GP), maintaining his safety and support with mobilizing (i.e. transfers). In the assessment, Ava states that she would like support with using a hoist in the morning to ensure she is using the equipment correctly. She is found to be eligible for support from the LA as her assessed eligible needs indicate that she is unable to achieve the following outcomes:

- Unable to develop and maintain family or other personal relationships.
- Unable to engage in recreational activities.

The assessment concludes that as a result of not being able to achieve the specified outcomes there is a significant impact on the Ava's health and wellbeing. The assessor recommends that a sitting service from a local charity is maintained, as this allows Ava to take a break from her caring role. The service is means tested and as Graham's savings are indicated to be above the financial threshold (£23,500) he must pay for this care himself.

Soon after the care package commenced, the domiciliary care agency raised concerns (via telephone call to the allocated social worker) about Ava's inability to support with hoisting. The agency requested that the care package be changed to assistance of two domiciliary care workers with transfers. Effectively removing the main carer from providing the support that they offer around personal care. Further concern, was raised by OT (1) that a package of care had started without their awareness and against the initial advice they initially provided. The appropriate hoisting equipment (a Liko standing hoist) had not been ordered and the carers and Ava were using an unsuitable rotunda transfer aid. OT (1) and the domiciliary care agency carried out a joint visit to show Ava how to use the new standing hoist appropriately. OT (1) recommended an increased package of care consisting of 4 calls a day with assistance of 2 carers from the domiciliary care agency be put in place. Ava was reluctant to accept this support and felt she could manage on her own once she was proficient with the hoisting equipment. OT (1) recorded her disagreement with Ava's views but agreed to continue working with her.

During a supervision session, Social Worker (SW) (1) identified the need to carry out a Mental Capacity Assessment (MCA). The specific decision relating to whether Graham was able to consent to the care and support he was assessed as requiring. SW (1) contacted Ava to arrange a meeting for an assessment of capacity on 2nd September 2015. The recording indicates that Ava continued to be sceptical about the need for care and support as she felt that she could manage by herself. A case note recorded on 28th September 2015, indicates that the

MCA went ahead and Graham was found to lack capacity. There was no formal record of this MCA on the LAs' Case Management System. It was unclear what action was taken in Graham's Best Interests to enable him to receive the care and support he was assessed as requiring. Professionals continued to work with Ava despite her views potentially being indicators of neglect i.e. reluctant contact with the LA.

By late September 2015, Graham's physical health deteriorated and he was no longer able to weight bear. OT (1) visited Graham at home and observed Ava using the standing hoist. OT (1) records that Ava continued to hoist Graham incorrectly putting his safety at risk. OT (1) went on to record that Ava was unhappy with her professional opinion and did not agree with the assessment. OT (1) documents that Graham's inability to weight bear means that he now needed a hoist with full body sling to support him. On 21st September 2015, OT (1) records that she is considering the need to refer this issue as a safeguarding concern as she was worried that Ava would not comply with the recommendations made for the new hoist to be put in place. There was no record of a safeguarding concern being raised.

On 28th September 2015, the domiciliary care agency record that Ava appeared confused and forgetful in relation to which equipment was to be used to transfer Graham. OT (1) and her manager visited Graham on 29th September. During the visit concerns were addressed about Graham's continuing inability to weight bear and the need for a hoist with full body sling. Ava became upset during the visit and said that she would like to continue providing the support without help from the domiciliary care agency. Camilla, Graham's daughter was also present at this meeting and shared her own concerns with Ava about the impact of using the wrong type of equipment and her concern about her providing all of the care Graham needed without support. Camilla expressed concern that, although she fully supported Ava and Graham in their joint wish for Graham to be cared for at home until his death, that she felt that Ava was struggling to cope and was avoiding the help of the domiciliary care workers and District Nurses since she thought it to be a reflection of her own caring abilities. Ava was not a trained health carer and Camilla was becoming increasingly concerned that decisions in Graham's best interests were not being made since Ava's wishes were being allowed to take precedence.

Following the meeting OT (1) made an urgent request for a new SW to be allocated. This request was followed up again on 1st October and 12th October. By 22nd October 2015, Ava continued to refuse assistance and cancelled the remaining domiciliary care support. This meant that Ava was solely providing support to Graham despite her being observed not to be using hoisting equipment in the correct manner. OT (1) discussed raising a safeguarding concern with her manager. The manager did not feel that the case met the threshold for a safeguarding enquiry. OT (1) was asked to continue to work directly with Ava to ensure that prescribed equipment was being used appropriately and this should result in minimising the risk to Graham. There was a lack of commentary from the manager as to why she did not feel that the concerns raised by OT (1) met the threshold for safeguarding. The presenting issue could have been considered under a possible act of omission in relation to Graham's carer's inconsistency and reluctant contact with social care services.

It wasn't until 19th November 2015, that SW (1) contacted Ava. SW (1) explored the same issues raised by OT (1) (cancellation of care calls / hoisting equipment). Ava stated that she did not like to be restricted to specific call times, as set out in the care plan. Ava also stated that the hoisting equipment was having an adverse effect on Graham's health and safety without evidence to back up her opinion. SW (1) did not directly challenge Ava's views. Ava indicated her willingness to consider a Best Interests meeting to look at different options to meet Graham's care needs. SW (1) appeared to accept this view at face value.

Throughout these early interactions between different professionals and Ava, it becomes apparent that Graham's voice was missing, and his views were not represented. There is no reference in chronologies to Ava having formal powers granted to make decisions about Graham's personal welfare such as a Lasting Power of Attorney (LPA). This would have granted Ava, the ability to make decisions on Graham's behalf including whether he should continue to live at home with help from social services. Despite having no formal power, professionals continued to give weight to Ava's views and treat them as paramount. Given his recorded lack of capacity, the LA could have

considered whether there was an appropriate individual (such as his daughter Camilla) to represent his views. Camilla had been made aware from SW (1) that Ava had claimed that all of Graham's 3 children, including herself, were estranged from Graham and he had not seen them for many years. Camilla expressed concern at this since she spoke to her father weekly and visited monthly.

If at the time, it wasn't possible to engage with a separate family member to act as Graham's representative, a referral for an advocate would have provided Graham with someone (independent of his family) to represent his views. There was no record of any consideration of this.

Consideration could also be given to whether Graham's status as a self-funder meant that he was treated differently to someone whose care and support was funded by the LA. Graham was unable to arrange his own care and support and was therefore dependent on Ava to do this for him. This gave Ava a certain degree of power to act on his behalf. The LA should have recorded an MCA in relation to whether Graham could make a decision about accepting the care and support he was assessed as requiring. As discussed earlier in this report he was reported as lacking capacity to make such a decision, though no record of an MCA exists. SW (1) recorded on 30th November 2015 that Ava was willing to consider a Best Interests meeting to discuss Graham's care and support.

The Best Interest's decision-making process allows for everyone to share their views and for general agreement to be reached on a way forward. There was no record of any follow up after this case recording to determine whether the best interests meeting process was completed. Ava's views could have been taken into consideration and though these views differed considerably from that of the LA and may have caused a dispute, the LA could have tried to diffuse the situation using principles of conflict resolution. If this was unsuccessful the LA may have considered an application to the Court of Protection. There appears to have been a lack of engagement with other family members who may have been helpful during this process.

At the beginning of 2016, Graham was seen by OT (1) and District Nurse (1). OT (1) demonstrated (to Ava) the use of a hoist and full body sling. OT (1) reports that Ava is able to understand how to use the hoist correctly following training.

In Mid-February 2016, SW (1) visited Graham and Ava and agreed that he continued to require services (day centre and sitting service) but that this would be purchased directly from the service providers by Ava. SW (1) indicates in notes that a letter was sent out to the family informing them that Graham's case would be closed. This was the last significant involvement with a SW for the next two and a half years. Given concerns highlighted from August to November 2015, it was surprising to see a lack follow up from SW (1) and it is unclear how Graham's home situation was stabilised following the earlier identified concerns.

Contact with professionals is intermittent between February and July 2016. In April, Ava contacted the GP surgery and requested Zopiclone to be prescribed to help treat her insomnia. It is unclear from the chronology whether her condition was as a result of her caring role but this may have been an opportunity to ask Ava whether she would like a carer assessment. Graham was reviewed by a Parkinson Nurse in June. During the visit the Nurse and Ava discussed the possibility of increasing Graham's attendance at the day centre from 1 to 2 days a week. It is unclear who was to arrange for Graham to attend a local day centre for a further day per week. This was a missed opportunity for further discussion regarding an assessment of need (for Graham) and a carer assessment. It could be indicative that Ava was in need of further support. Graham was seen by OT (1) in late July. A review of Graham's mobility and transfers using the hoist indicates that OT (1) was happy that Ava was providing appropriate support with mobilisation.

On 11th August 2016, the local day centre reported that Graham had blisters all over his left leg including below his knee and on his foot. The blisters were reported to be weeping. The day centre contacted Ava and

arrangements were made to take Graham to see his GP. It appears that Graham was seen on 15th August (several days after the initial report) as the surgery notes are consistent with the initial report that Graham has cellulitis (a bacterial skin infection). A phone call from The GP (on 1st September) notes that cellulitis persists. It was unclear from the chronologies whether this was a call between Graham's carer and the doctor. On 14th September, Graham was seen in the surgery and prescribed antibiotics to treat his symptoms.

On 20th September 2019, OT (1) phoned the day centre for an update about Graham's health and wellbeing a senior member of staff from the day centre reported her concern that Graham hadn't been to the day centre for 4 weeks since he had been observed to have blisters on his legs. They stated that prior to this absence, Graham's participation in activities had declined and he was asleep a lot when at the day centre.

OT (1) reported that she continued to carry out regular reviews for Graham and intended to close his case prior to the concerns raised by the day centre. OT (1) agreed to follow up with Graham and Ava rather than close the case. OT (1) reports that her review in August indicated that Graham was still able to weight bear and that it was safe to use the standing hoist.

On 4th October 2016, OT (1) and her manager visited Graham at home. Graham was observed by both OT's during the visit. His carer demonstrated the use of his standing hoist and OT noted that there were no safety concerns with how the hoist was being used. Graham was noted to have cellulitis on his left leg. The OT comments that the GP is monitoring Graham's condition.

From October 2016 – May 2017 there is intermittent professional contact with Graham including involvement from his GP around flu vaccination. Ava contacted the OT team in May 2017 to report that the hoist was faulty. The hoist was replaced by a new one. This was the last significant contact that Graham and Ava had with the OT service for the next 12 months. For the rest of 2017 and into spring 2018, Graham continued to have little contact with services. On 10th May 2018, Graham's GP received a call (it is unclear whether this was from Ava) requesting 'Proshield' a cream which is used for treating moisture related skin damage.

In April 2018, Graham was attending the local day centre. At the day centre, staff noticed that Graham's groin was red and sore. Staff record that they reported this to Ava and the day centre manager. A month later (24th May 2018), staff report that his groin is still red and inflamed. The day centre manager made contact with the Berkshire Integrated Hub to report the concern. The day centre manager records that the Hub representative advised them that it wasn't their concern and that contact should be made with Graham's GP. On the day of the reported incident, OT (2) was (coincidently) present at the day centre. OT (2) advised the day centre manager to speak to The Hub again and ask for a District Nurse to visit Graham at home. The day centre manager records that The Hub representative was still not keen to take the referral. However, after OT (2) intervened the referral was accepted. Although the referral was accepted there is no documentation to prove that a District Nurse visited Graham as requested. OT (2) observed Graham's wounds and notes extensive moisture damage and on the inside of his groin.

Records show that the day centre manager also had concerns about Ava's memory. Reportedly, Graham's carer would contact the day centre about her husband but would then forget later in follow up conversation what had been discussed. This is the 2nd report within the chronologies of a person involved in Graham's care highlighting that Graham's carer had memory issues.

At this time, Graham's case wasn't open to a SW. The day centre manager was advised by The Optalis BPSS to make contact with the Community Older Adults Mental Health Service (COAMHS) as Graham's case appeared to be open to that team based on information contained in the LAs' Case Management System. COAMHS advised the day centre manager that Graham's case wasn't open to the team and that the day centre should refer the matter back to the safeguarding team within WBC. This would have been an opportunity joined up working

between COAMHS and BPSS. It was also an opportunity for the LA to carry out an assessment of need and a carers' assessment for Graham and Ava.

Graham's case was discussed at an allocations meeting on 1st June 2018. A decision was taken to carry out an assessment of need rather than follow up the case as a safeguarding concern. It was good practice, that the manager recorded their decision on the LAs' care management database. However, there is little analysis as to why this decision was taken. It did not appear that the information that had been passed onto social services, had been triaged effectively. Information gathering is a key stage of the safeguarding process. It is an opportunity to review the level of risk posed to the person at risk of harm. There was a lack of analysis or reasoning to identify why they had made the decision to allocate for needs assessment rather than open a safeguarding enquiry. It would have been good practice to consider 'the Six Principles of Safeguarding' especially with a focus on whether it was proportionate to consider a needs assessment rather than a safeguarding enquiry. Further to this, The Care Act 2014 statutory guidance advises that the first priority in safeguarding should always be to ensure the safety and well-being of the adult. A visit by a SW would have been essential when the safeguarding concern was reported. This could have determined whether or not Graham was safe, it is clear that this did not happen.

In allocating Graham's case, the service manager advised that an approach should be taken to try and persuade Ava to accept services for her husband. This puts the onus on the allocated SW to consider what Ava wanted rather than what Graham needed. On 11th June 2018, Graham was allocated to SW (2) Optalis BPSS. There was a delay as SW (2) didn't contact Ava until 27th June 2018. Given the perceived risk to Graham, it would have been good practice to make contact with Graham and Ava within a 2-3 working days of allocation. SW (2) records that Ava was happy to hear from social services as Graham's health had deteriorated and he was not eating well. SW (2) advised Ava that she should call the GP, if she was worried about Graham's poor appetite. At the end of the telephone conversation, SW (2) agreed to visit the next day (28th June). This visit would have been the opportunity to carry out a needs assessment. There was no evidence of a completed assessment on the LAs' case management system. A case note from SW (2) indicates that the assessment was completed and that Ava declined services. Graham's views are not recorded. SW (2) indicates that she would discuss the outcome of the assessment with her supervisor.

Supervision took place on 12th July, a case note from that date indicates that SW (2) and her supervisor discussed the findings from the assessment visit on 28th June. The supervision appears to be the catalyst for a safeguarding concern to be raised on 13th July. It was unclear from the chronology why there was a delay in identifying the need for a safeguarding concern to be raised. There was no record of a formal safeguarding planning meeting or discussion taking place. It wasn't clear who was leading this investigation or coordinating the LAs response. The planning meeting would have offered an opportunity to invite key professionals involved in Graham's care (e.g. District nurse, OT, GP) and to determine which organisation should take the lead on the enquiry, set out the aims of the enquiry and to delegate specific parts of the enquiry to each organisation as required.

It didn't appear that Graham was aware of the safeguarding concern being raised and there wasn't a record of a MCA on the LAs case management database. This should have been completed in order to document Graham's views and his capacity to consent to the safeguarding enquiry. As Graham's consent was not determined, there should have been justification from the safeguarding lead as to why the safeguarding enquiry proceeded. It would have been good practice to determine whether Graham required an advocate or whether there was someone else within his family who could have acted as his representative during the enquiry.

On 12th July, SW (2) made contact with the Berkshire Integrated Hub to ask about the progress of the District Nurse referral. SW (2) raised a concern that a District Nurse had not visited when the original referral was made in May. A member of the District Nursing team confirmed to SW (2) that a visit was not carried out at the time. This appears to have been because telephone contact with Ava had been made. Ava informed the District Nursing team that a topical cream being applied to Graham's groin had treated the sores. The District Nursing Team determined that a visit wasn't required as a result of this information. It appears that the District Nursing Team

may not have been given all the information they required, at the point of referral. An entry (12th July 2019) on the LAs' case management system implies that the District Nursing Team were made aware of the 'urgency' of the need for a District Nurse to visit Graham due to the state of sores on his groin. However, a second entry made the same day implies that the District Nurse Team were not aware of the day centre's concerns about Ava and therefore did not address this with her. It is difficult to ascertain what information had been passed onto the District Nursing Team by the LA and what is meant by urgent. Perhaps if the day centre concerns had been passed onto District Nursing then this may have changed the response that the team provided in terms of carrying out a visit.

The triage call was not documented on RIO and the District Nursing Team informed SW (2) of this. It is recorded that SW (2) didn't realise the original referral wasn't detailed enough for the District Nursing Team to understand that there was a safeguarding concern. It is also documented that SW (2) was concerned that Ava was not coping but had declined support. SW (2) was concerned that poor personal care may have contributed to the condition of Graham's groin. It is documented that adult social care were considering raising a safeguarding concern due to this. It is usual practice to document triage calls on RIO, an incident report (known as a Datix) should have been raised but wasn't regarding the missed District Nurse referral. The District Nursing Team agreed to make an appointment to visit Graham at home. This visit took place on 16th July and is documented below.

On 16th July, Graham's day centre requested that emergency services visit Graham at home to carry out a welfare check and examine his physical health. A paramedic was sent out to see Graham. The recording indicates that Ava did not have any help but is managing to hoist him from chair to bed. His bottom was reported to be red and sore but no broken skin was found on inspection. Graham was reported to be happy and interacted well with the Paramedic. Camilla (Graham's daughter) was also present, she raised concern about Ava's memory and the effect this was having on her caring role. It is recorded that Ava denied that she had a problem but was open to seeing her GP for an appointment. The paramedic concluded that the home was clear and Graham looked well cared for and that Ava did not require any help and felt able to cope with her caring role. A District Nurse visited Graham on 16th July as well. The District Nurse observed Ava using the standing hoist to assist Graham to stand to allow for observation of his groin. The District Nurse records that Graham's "bottom area looked a little red and sore but his skin wasn't broken". It was noted that all other areas were checked and that Ava was applying cream to Graham's groin and between his buttocks. It was noted that all areas were clean and that in the opinion of the District Nurse, Graham was being cared for appropriately. The District Nurse reported back to SW (2) that no follow up was necessary and that the District Nursing Team would discharge Graham. SW (2) informed the District Nurse that a safeguarding concern had been raised. SW (2) requested involvement from District Nursing in the safeguarding concern and for the case to remain open to the team. On 19th July 2019, District Nursing Team confirmed that Graham's case was now closed and the safeguarding concern should be followed up by social services. This would be considered normal practice as the District Nursing Team discharge patients, if there is no current nursing need.

SW (2) contacted 'Singing for the Brain', a musical therapy group that Graham and Ava usually attended. SW (2) was advised that Graham had stopped attending in June 2018. On 27th July, SW (2) requested Graham's GP to carry out a home visit to see Graham and assess his health and wellbeing. Instead, Graham and Ava were called into the GP surgery and seen there on 30th July. The GP notes that Graham appeared well and on examining his groin for sores there was no redness or soreness. GP agreed to speak to SW (2) to decide on what steps to take next.

On 1st August 2018, SW (2) visited Graham at home. SW (2) records that Ava had forgotten that they had the appointment but said it was fine to visit. SW (2) discussed safeguarding concerns with Ava. Graham's carer admitted that she felt like she "was failing" and was upset that a lot of different professionals had been visiting the home. She was particularly upset in relation to the sores present on Graham's body. Ava suggested they were from his commode which she uses to transfer him from room to room. SW (2) documents that Graham did not understand what was being discussed in relation to the safeguarding concerns. Graham was reported to look to

his carer for answers. Ava stated that she did not want to employ carers to look after Graham. Throughout the review, opportunities arose to explore Ava's views more deeply and to challenge them especially in relation to Graham's assessed need. This may be because allocated workers do not feel confident to challenge her views or to consider how best to ensure that Graham's voice is heard. Ava stated that she would be happy for Graham to start attending the local day centre again. Ava and Graham would have benefitted from support of an independent advocate to support them. Based on his own responses, Graham was assessed as being unable to make a choice about going back to the day centre. Ava stated that she would organise for Graham to attend the day centre, the next day. She also stated that she would like to go back to Singing for the Brain group.

The next day (2nd August 2018), Graham did not attend the day centre as planned. SW (2) contacted Ava who said she was expecting day centre staff to collect Graham from home and take him to the day centre. SW (2) indicated that the previous day, Ava had said she would drop him off at the day centre herself. Ava admitted that she was having a bad day and agreed that the day centre could collect Graham on 9th August. SW (2) also spoke to Camilla, Graham's daughter who suggested that she had a good relationship with her father and step-mother and that the couple wanted to stay together and didn't want to be separated. She said that she felt Ava was the best person to look after her father, but that she felt that Ava does not take criticism well. Camilla admitted that she and Ava (and the extended family) had some disagreements about how best to look after Graham. Camilla said she was in regular contact with her family including her stepsister Eleanor who lives across the road from Graham.

SW (2) spoke to Graham's GP on 2nd August 2018. She records that the GP advised that he would make a referral to the memory clinic for Ava, if she consented. GP records show that he was aware of the safeguarding adults concerns and would look at this issue when he carries out his visit.

On 8th August, SW (2) records that Graham's GP contacted her and informed that he had assessed Graham on 5th August and that his family were present and that Ava was 'very defensive' over the safeguarding concerns. The GP advised that there were no further issues with Graham's skin based on his observations. The GP requested to see Ava at the Surgery for a general review of her health and an exploration of whether or not she was experiencing memory issues using a mini mental state examination. SW (2) records that the GP was due to see Ava on 16th August. SW (2) records that the GP agreed to feedback to her by 22nd August 2018. Based on information contained with the chronology, there did not appear to be a response from the GP until 28th September 2018, SW (2) records that Graham's carer was referred to COAMHS by the GP. There was no further information recorded about the outcome of the referral, after this point.

A recommendation by SW (2) records that the safeguarding enquiry (opened on 12th July) could be closed. The outcome of the safeguarding enquiry is recorded as "whilst Graham was able to say that he wished for his wife to care for him, it is evident that he lacks the insight into the risks. Graham's family are now fully aware of the issues and will monitor the situation ongoing, along with the paid carers" The recommendation was sent to The BPSS Team Manager on 22nd August. In Wokingham, at the time of this review, safeguarding concerns open to Optalis required a second signoff by the Safeguarding Team Manager from WBC. The Safeguarding Team Manager did not agree with the outcome of the safeguarding enquiry. On 28th and 29th August – The Safeguarding Team Manager records "*Please reconsider the outcome of safeguarding adults' enquiry as a carer is not coping due to her own needs. Has a carer's assessment been completed? Assumption of capacity – worker informed no capacity assessment was conducted and person lacks capacity – contradictory information. No information if Lasting Power of Attorney is in place, reassessment of needs, capacity assessment around care and consideration in best interests*". Feedback to these comments from The BPSS Team Manager is recorded as follows – *Graham will remain open to the worker for longer term work, via the reassessment, whereby a carers assessment will be completed along with a MCA around his care and support and other aspects of his care, along with his finances. As previously stated his family will be supporting Graham and his wife through this process and the above actions will be addressed within the assessment process*". The split of responsibility for the safeguarding function between Optalis and WBC appears to have caused some inconsistency and tension between teams. A similar concern was raised within the Paul SAR (presented to SAB on 25th June 2018). The reviewer notes that as of November 2019,

the adult social care pathway is no longer divided between Optalis and WBC. The statutory safeguarding function has returned to the borough and is managed by a Safeguarding Strategic Lead employed by the council.

On 20th September, SW (2) records that Graham was attending the local day centre and that he came in late. The day centre manager informed SW (2) that Graham had “sores on his feet” and that she’d examined them. The day centre manager advised SW (2) that Ava’s memory appeared poor due to confusion about which day Graham should be attending. The day centre manager notes that Ava insisted on bringing him to the day centre herself as she cannot get him ready for the transport to collect him. There didn’t appear to be any further detail about the grading of the pressure sores or any reference to follow up treatment after these recorded comments.

Camilla visited her father on 20th September and found him to be tired but had no concerns. She examined his foot, as she usually did when visiting, since he had experienced foot swelling for many years and did not find anything to give concern. On 27th September, Graham was admitted to The Royal Berkshire Hospital under blue light procedures at mid-day. The GP records identify that Graham had experienced a possible stroke and that Ava was unable to manage current needs and appeared unaware of the level of illness. A safeguarding concern was raised as a result of information being sent by the GP and hospital. SW (2) spoke to the hospital and Graham was diagnosed with Pneumonia, sepsis and four pressure sores (including 1 at Grade 4). Case records indicate that Camilla was originally told (by Ava) that her father had passed away after being admitted for surgery. She was later contacted by SW (2) who confirmed that Graham was still alive. Camilla advised that Ava appeared to be confused but calm and unclear why she had informed Camilla that her father had passed away (when he hadn’t). SW (2) contacted Graham’s GP. It appears from case recording that Ava was referred to COAMHS and that she had missed a recent appointment to check her blood pressure. Graham’s condition was documented as very poor.

Graham passed away on 29/09/2018. Camilla asked SW (2) to find out whether District Nurses were involved with her father prior to his death as he had pressure sores on his toes that appeared to have been properly dressed. SW (2) contacted Graham’s GP on 5th October 2018. GP Surgery advised that Graham had not been seen by them between August and September. SW (2) appears to have tried to make contact with District Nurses to find out whether they had seen Graham but there were no further details of any discussion recorded within associated chronologies. On 10th October 2018, a safeguarding concern raised when Graham’s was admitted to Royal Berks Hospital was closed by the BPSS Team Manager. The manager indicates in her summary, “*In giving consideration, if this concern should progress to a s42 enquiry, I am of the opinion that there would be no public interest in doing so. Clearly Graham’s carer had not intentionally neglected her husband and it would appear that she herself requires an assessment in her own right and therefore no further action is required*”. Graham’s case was closed to SW (2) the same day.

4. Observations of Good Practice

- The OT Team worked with Graham in a person-centred way ensuring that he had appropriate mobility equipment in place and that his main carer was provided with appropriate training on how to use it.

- OT Team were persistent in trying to ensure that Graham received a needs assessment and the services that he was assessed as requiring.

- Overall there was good partnership working between SW (2) and Graham’s GP including information-sharing, joint decision making and coordinated action to assess, manage and reduce risk to Graham and his main carer.

- There was some evidence of multiagency coordination around Graham’s health concerns by his SW, GP, District Nurses and OTs (however this wasn’t always effective)

5. Observations of Poor Practice

The SAB Safeguarding Policies and Procedures can be found here:
https://www.berkshiresafeguardingadults.co.uk/

- Safeguarding concerns were raised but safeguarding procedures were not followed, examples of this were:
    - There was a lack of clear guidance and oversight of the safeguarding concern provided by the allocated safeguarding manager.
    - Graham views and desired outcomes were not sought or recorded and he appeared to be unaware that a safeguarding concern was raised.
    - The need for advocacy was not established, even though there was a clear need to consider it.
    - Given the level of concern raised at the information gathering stage it was essential that a SW visited to clarify whether he was safe or not, this did not happen until several weeks after the initial concern was raised.
    - A MCA should have been completed in relation to whether Graham could consent to the safeguarding concern going ahead.
    - There was a lack of a formal safeguarding planning meeting. This would have provided an opportunity for multiagency coordination and clear lines of responsibility for each part of the safeguarding investigation.
    - The outcome of the safeguarding enquiry was unclear and there was disagreement between Optalis and the Safeguarding Adult Manager for WBC at the case conclusion stage.

- Graham's views and wishes were not always considered. The views of his main carer were treated as paramount often at the expense of ensuring that Graham was receiving the support he had been assessed as requiring.

- The competing needs of Graham and Ava appear to have unduly influenced and distracted professionals from making appropriate best interest decisions.

- There was a record of interagency referral and liaison. However, there was a lack of focus on the presenting issues (skin breakdown and personal care) within this liaison.

6. Learning Points

- Graham's views and wishes were missing; Making Safeguarding Personal (MSP) principles were not applied.
- Disproportionate weight was given to Ava's views and wishes Ava's desire to care for Graham whilst admirable may have had unintended consequences such as his assessed needs not being met.
- During needs assessment it would have been appropriate to consider employing an advocate to represent Graham.
- There was a conflict that was not addressed satisfactorily i.e. Ava was named as the person alleged to have caused harm but was also consulted as Graham's representative as part of the safeguarding enquiry
- It would have been appropriate to consider appointing an independent advocate for both needs assessment and the open safeguarding enquiry.
- No wider consultation in regards to Mental Capacity or Best Interests decisions with Graham's extended family.

- Graham’s daughter was not informed about open safeguarding concerns although she may have been suitable to contact to act as Graham’s representative.
- Application of the MCAc was not consistent. There was no record of a MCA for specific decisions i.e. the ability to consent to care and support and safeguarding concerns
- There was a lack of effective planning around the safeguarding enquiry. Effective plans come from multiagency working with clear delineation between the roles and tasks of each profession, as part of that plan.
- Staff need support to understand the competing needs of the cared for person and carer and how these interact when a carer may have needs of their own.
- Staff did not appear to understand the appropriate intervention to apply when a carer has needs of their own – i.e. carers assessment / assessment of need.

7. Feedback from Camilla

“*Thank you for the time and effort you have taken for this report on my father. Overall, I felt that my father was not allowed to have his voice heard towards the end and best interests decisions were not made. Ava was heavily conflicted as NOK and didn’t appear to have a POA. Since two safeguarding’s had been raised against her in a space of 3 months, it was clear that my father was at risk. My comments went unheeded. It is particularly distressing for me, as a healthcare provider for the Midlands and North West, that the facilities and care I provide for others was not afforded to my father in his last few months. You mentioned that everyone has the right to a good death, which is one of the philosophies of my company. It is very hard for me to reconcile that with the experience that my father had in his last 36 hours when he was in much pain and very distressed, and this could have been largely avoided. I am very grateful that Social Worker (2) took the trouble to inform me that my father was still alive, which enabled me to be there during his last few hours.*

Glossary

ASH	Adult Safeguarding Hub
WBC	Wokingham Borough Council
BHFT	Berkshire Healthcare Foundation Trust
COAMHS	Community Older Adults Mental Health Service
OT	Occupational Therapy/Therapist
LA	Local Authority
MCAc	Mental Capacity Act
MSP	Making Safeguarding Personal
MCA	Mental Capacity Assessment
BPSS	The Brokerage and Professional Support Service
SAR	Safeguarding Adults Review
SW	Social Worker
SG	Safeguarding

Dan Simms
Principal Social Worker for Wokingham Borough Council and Royal Borough of Windsor and Maidenhead

WBC Action Plan as a result of this SAR

Action	Deadline	Progress Update
Further work required to consolidate the principles of Making Safeguarding Personal (MSP) and appropriate use of advocacy within the safeguarding paperwork and pathway and in the culture of safeguarding interventions.	2 December 2019	• Complete – Safeguarding (SG) paperwork revised to more clearly adhere to MSP and to embed it throughout the intervention supporting practitioners with outcome focused practice. • SG pathway revised with introduction of Adult Safeguarding Hub (ASH), ensuring MSP more clearly embedded from outset.
Ensure practice in safeguarding work is compliant with the MCA 2005, particularly in respect of undertaking formal, decision-specific capacity assessments where there is reasonable indication that capacity may be an issue	2 December 2019	• SG paperwork has been revised to ensure consideration of capacity to consent to a SG response and consent to share information is embedded in the appropriate place. • MCA template embedded in enquiry document as a form, with prompts for workers to utilise it wherein there are concerns about capacity for any relevant decision. • Compliance with this will be monitored via case file audits and in sign off.
Develop appropriate use of strategy discussions and meetings to ensure that all parties are clear on roles and responsibilities in any specific safeguarding response.	2 December 2019	• Implementation of the ASH has developed a mechanism for strategy discussions/meetings to be coordinated by ASH staff to facilitate handover to Enquiry Officer and SAM for ongoing enquiries. This should achieve greater consistency and effectiveness and will be monitored via case file audits and sign off.

Learning to be disseminated concerning working with competing needs of carer and cared for and how to weigh up and balance views, wishes and feelings of the carer where the cared for lacks capacity and Best Interests decision(s) are required	30 June 2020	In progress
A practice note to be published to support professionals with learning from this SAR.	September 2020	Completed 22/2/21
Review and update safeguarding training across the partnership to ensure lessons learned are embedded.	TBC	Will be considered for SAB Business Plan 21/22.
Learning from this SAR has been added to the Board's Learning from SAR/Audit Implementation plan.	October 2020	Completed 6/10/2020
The Board will write to Graham's family and confirm publication of this report.	January 2021	Completed Jan 2021
Targeted learning workshops to be delivered to workforce to share the learning from this SAR.	30 June 2020	In progress