Tameside Adult Safeguarding Board Partnership

Safeguarding Adult Review

RE: Cheryl

Executive Summary

Contents	Page number
1. Introduction	3
2. Terms of Reference of Review	3
3. Family and background information	4
4. Analysis	4
5. Overall Quality of support offered by Agencies	4
6. Assessment of Clients & Families in Making Care Decisions	6
7. Assessment of Mental Capacity	7
8. Follow up of people who have not been brought to appointments	8
9. Recognition & Response to Safeguarding of Adults	8
10. Good Practice	9
11. Learning	9
12. Recommendations	11
13. Conclusion	11

1. Introduction

Section 44 of the Care Act 2014 stipulates that the Safeguarding Adult Board (SAB) has a responsibility to authorise the commissioning of a Safeguarding Adult Review (SAR). A review is required to be undertaken if the Board considers that there is significant learning to be gained across partner agencies.

Cheryl was a 74 year old lady who died from natural causes at home in Tameside in 2020. A request was made to Tameside Adult Safeguarding Partnership Board (TASPB) after some concerns were raised about the standard of care which Cheryl received in the final part of her life. The criteria for consideration for a Safeguarding Adult Review had been met. A multi-agency panel reviewed information held by agencies who cared for Cheryl and a decision was made that it was evident that lessons could be learnt about the care received by Cheryl.

2. Terms of Reference of Review

The Review Team agreed that the following elements needed to have further scrutiny so that learning could be made. These elements are:

- Quality of support offered to Cheryl and her family with respect to consideration of their understanding and ability to make decisions.
- Professional curiosity of practitioners.
- The opportunity of carers' assessments and the perception of the role of family as carers.

Making safeguarding personal approach applied. In this context consideration was given to:-

- Supportive decision making.
- Professional approach to explore power and balance.
- Discussions regarding pathways of care.
- Assessment with Mental health and links with Mental Capacity.

- Opportunity to explore examples of good practice to identify lessons to apply to future practice.

3. The Family and Background Information

Cheryl lived with her husband, in their home in Tameside. The husband appeared to be Cheryl's main carer although there is no evidence that support for Cheryl outside of family networks was ever assessed further. In a conversation with the author, the husband said the couple were very much dependent upon each other. They had made a promise to each other that in the event of declining health of either person, that external services would not be accessed to care for the person. The husband described his wife as a "private person" and was likely to have been uneasy at accepting help with her care.

Very little information appears to be known by agencies about Cheryl or her husband. Prior to retirement the couple had both worked. They had been resident at their home address for a long period of time.

The husband informed the author that the couple had been married for a significant period of time. They had not had children but did maintain contact with wider family and Cheryl's mother. The couple had undertaken regular holidays with some close friends. The husband said that the couple had a joint interest in the development of a device which possibly could be instrumental in improving world wide spread of some viruses.

Information gathered from the chronology gives the impression that Cheryl's presenting verbal communication difficulties encouraged practitioners to seek history from her husband rather than Cheryl. The GP confirmed that neither Cheryl nor her husband routinely made contact with the surgery.

Cheryl sadly died in July 2020. It is believed that Cheryl died as a result of chronic Left ventricular Failure, Ischemic Heart Disease and Diabetes Mellitus.

4. Analysis

Guided by the terms of reference for this review specific themes emerged following a systematic analysis of all the available information and with the review steering group. Exploration of each theme enabled rigorous examination of practice and identification of opportunities to improve multi agency adult safeguarding practice in Tameside.

5. Overall Quality of Support Offered By Agencies.

There is evidence from the review that although there was robust medical assessment of symptoms made by health practitioners, there was little service intervention once the diagnosis of vascular dementia and cerebral infarction had been made. There is no evidence that the impact of Cheryl's health symptoms on her day to day living were assessed. There is evidence that practitioners did make her husband aware of the support which could be offered but once her husband did not seek out additional help for Cheryl no one appeared to check that he was able to meet her needs. There is no evidence that any practitioner made effort to speak to Cheryl in her own right and so no assessment was made of Cheryl's needs apart from those that were voiced through her husband. Rather than Cheryl being the centre of care she appeared to be on the periphery and practitioners lost sight of her as their client.

Her husband's ability to undertake her care appeared to have been taken on face value and no person appeared to make further enquiry as to the nature of the care which was being provided. There was little evidence of professional curiosity as to whether what was said was being provided was actually being delivered by her husband or indeed the appropriateness of that care in meeting Cheryl's needs.

Her husband spoke of his distress after his wife's death and had been concerned that practitioners had raised concerns on the day of her death about his ability to meet his wife's needs. Her husband believed that he had cared for Cheryl and had met her needs. He believed that the resuscitation procedure may have caused Cheryl's death. In addition since her death a copy of the post mortem report was shared with her husband but it is unclear which agency has shared this information or the appropriateness of doing so without a practitioner who was able to explain relevant terminology to him was ever considered.

There is evidence that the North West Ambulance Service had raised their concerns about the nature of the care which was being delivered to Cheryl. This service does not, however, have the remit to monitor the ongoing care of an individual. However, they did raise their concerns to agencies who would have been able to make this happen. These services were adult social care, GP and the acute hospital services but it initially appeared that these concerns were not pursued. The Review Panel discussed that the North West Ambulance Service arrangements for referral to other services for any service provision are currently combined under the heading of "safeguarding referral". There is therefore a possibility that practitioners from the Acute Trust and Adult Social Care did not view the referral for further assessment of Cheryl from the ambulance service as being a clear safeguarding concern. Some changes have since been made in services to reflect this with safeguarding to be viewed as a thread in all referrals. The Panel reflected that work is continuing to ensure that all referrals from the Ambulance Service have clearly been reassessed to ensure that all elements of the concerns expressed and referred by the service have been addressed.

There is little evidence that full assessment of the home environment was ever made. Assessments seem to occur away from the family home and practitioners did not investigate further Cheryl's living conditions. Assessments were for specific needs rather than the overall context in which the couple were leading their lives. Her husband's ability to care for Cheryl was taken at face value by practitioners even when concerns had been raised by the Ambulance Service. The Ambulance Service raised concerns after they have visited the property in October 2019 about the possibility of self-neglect but again this does not appear to have been pursued.

Her husband had disclosed that he was finding it hard to meet Cheryl's needs and this was recorded in the referral at this time. He was directed for support services rather than practitioners assisting him in contacting services. Since speaking with her husband it is clear that it was likely that there would have been reluctance on the part of the couple to accept help. However, this does not mean that there ought not to have been the offer to assess Cheryl's needs as agencies or have frank conversations with her husband and Cheryl as to the nature of the decline in Cheryl's health and what may be required in the future.

During 2018 the ambulance service documented that they believed that Cheryl did not have the mental capacity to make decisions for herself. This was eighteen months prior to a diagnosis of vascular dementia and cerebral infarction been made. Even though this was reported, there does not appear to have been any response made by the Emergency Department or by the GP to initiate steps for a formal diagnosis of Cheryl's mental capacity.

When the diagnosis of vascular dementia was made in July 2019 Cheryl's needs were only assessed in the context of her husband's ability to provide care. There is no evidence of Cheryl's voice in any part of the chronology of information provided for this review.

6. Assessment of Clients and Families in Making Care Decisions

Although Cheryl had a diagnosis of vascular dementia made in 2019, there was little evidence as to the reason that she had suffered with very poor communication for a considerable period of time prior to this diagnosis having been assessed.

Her husband had reported to ambulance services one year earlier that Cheryl had memory loss for some time and that he had not sought medical intervention on her behalf as he was trying alternative methods of control of her symptoms. Although the ambulance service made referral to other health and social care services, raising their concerns, it appears that no further action was undertaken by the practitioners from these agencies.

The reason for this inaction appears to be that her husband was stating that he was competent in caring for his partner. Cheryl's needs seem to have been seen from her husband's perspective. Her husband has, however, since confirmed that he did feel that he was meeting the needs of his wife although had he known of the support available to them they may have considered access to that care. Practitioners did not appear to recognise that their duty of care was to Cheryl and that this ought to have at the minimum required an assessment of her needs with a further assessment of her husband's ability to meet the needs.

This inaction was likely to have been because her husband appeared to be stating, both verbally and non- verbally, that there was no need for external help in their lives and practitioners believed that there was no right for intervention into family life. There appears to be confusion as to the rights of the family and the rights of the individual and there needs to be further analysis of this perspective. Practitioners directed her husband to where he could receive help but did not undertake arrangements on Cheryl's behalf. There appears to have been no assessment of

Cheryl's mental capacity by any service other than those which were necessary for specific interventions to be undertaken. For example the ambulance service assessed capacity and appeared to have considered Cheryl's best interests on all episodes of care. It is unclear how the Integrated Care NHS Foundation Trust (ICFT) had been able to undertake assessments such as the cardiac assessments/ investigations when there is no evidence that Cheryl was able to consent to such care being undertaken.

There was not a carer's assessment in place. This was likely to have been omitted because there had been no prior assessment of Cheryl's care needs and her husband had not requested such help. Her husband had been directed by other agencies to make contact with Adult Social care. A referral was not made by the GP or by other health services, so there was no requirement to undertake such an assessment.

Her husband appears to have been assessed by health practitioners as being competent to manage his wife's health care needs without professional support. They did not appear to question his ability to meet her needs and so the helpfulness that any assessment of her health needs may have had on improving the quality of care to Cheryl and support to her husband was lost. The Mental Health Trust suggested that a care package needed to be in place after the diagnosis of vascular dementia had been confirmed but this package was limited to giving information to her husband of the help which was available rather than making referrals themselves on the family's behalf. In addition the care package appeared to have been offered to support her husband's caring of Cheryl rather than helping Cheryl in meeting her care needs. Practitioners were seeing her husband as the client rather than Cheryl.

7. Assessment of Mental Capacity

There is evidence within the chronology that Cheryl was said to lack mental capacity to make decisions about her care. This view appeared to have been made by the Ambulance Service who were attending to Cheryl during emergency acute episodes of her care and at times when she had previously suffered a traumatic episode. On the whole the information that ambulance practitioners received from her husband about Cheryl was the key determinate in the decision having been made.

In August 2019, a dementia assessment took place by the GP practice. This appears to have been undertaken away from the couple's home environment. Although there is evidence that the issue of lasting power of attorney and "Do not attempt cardiopulmonary resuscitation" (DNACPR) were discussed with her husband, Cheryl's care needs do not appear to have been documented and it appears that her mental capacity was not assessed. Again, similar to the mental health trust her husband was guided as to the services which he could access to support his care of Cheryl but there does not appear to be a recognition by the practitioner that Cheryl required more support than her husband could on reflection realistically provide. The fundamental reason for this was that no service undertook an assessment of her needs.

In line with themes which have been identified in other safeguarding adult reviews with respect to mental capacity, there appears to have been lack of understanding by practitioners of the procedures which need to be undertaken when assessment of mental capacity is required for clients. Whilst there is clear evidence that safeguarding teams are working with their respective organisations to ensure practitioners have access to training and revised policy and procedures, this finding will be made a recommendation of this review.

8. Follow up of people who have not been brought to appointments.

A consistent finding in safeguarding reviews for both children and adults is the practitioner response to those who are described as “not attending appointments”.

This issue of non-attendance of appointments, in health services particularly, has usually been taken from the perspective of the financial implications for health services when clients do not attend hospital appointments. This has led to the practice of some areas of health, especially acute hospital trusts, removing potential and actual clients from consultant lists if the client fails to attend on more than two occasions. This is often without further investigation as to the potential reason why the person has not attended. A key theme, consistently identified with respect to children’s non-attendance, is that there is an overall reliance for children to be brought by an adult.

This too is the case for some adults who are in need of care and support. However, often adults who do not attend appointments are regarded as non- compliant. For Cheryl it appeared that her husband was making decisions on behalf of his wife rather than agencies ensuring that a relevant assessment was being undertaken of what was in Cheryl’s best interests. Practitioners from all services did not appear to demonstrate any “professional curiosity” as to how and why her husband was making the decisions about the health care which was required for Cheryl. There is no record of Cheryl’s wishes. In addition there is no assessment of her husband’s ability to make decisions on behalf of his wife.

The failure of clients being brought to appointments has been a recurrent theme of both child and adult safeguarding reviews. Procedural guidance has recently been published within the Greater Manchester area and a recommendation will be made through this review that it is implemented across all agencies.

9. Recognition and Response to Safeguarding of Adults

Cheryl had a number of long term health conditions identified in the final year of her life although she had presented with some symptoms for a significant period prior to her death. There was evidence that she lacked mental capacity to meet those needs. There was little recognition from services, apart from the ambulance service, that she required additional help to meet her needs. There was an assumption, made by practitioners, that her husband was meeting her needs and there was no curiosity as to why he was not asking for further help to manage his wife’s needs or any rationale documented as to why he may have preferred to meet those needs by himself. In addition there was no assessment undertaken which could demonstrate his own level of understanding of what Cheryl’s needs were or how he had been undertaking her care. There was no evidence that safeguarding of Cheryl needed to be considered. As with the above point there was a lack of professional curiosity and it appears that Cheryl did not receive the help and support to meet her health and care needs.

Safeguarding too appeared to have been considered to have been an “add on” by practitioners who were making assessment of Cheryl. Although the Ambulance Service had identified that there was evidence of self-neglect within the home environment and Cheryl had some unmet health needs the possibility of safeguarding concerns was not considered. The Panel discussed the need for agencies to see all elements of their work “through the lens of safeguarding” rather than an additional consideration.

10. Good Practice

The Ambulance Service consistently made good assessment of Cheryl and her needs and appropriately reported concerns to the relevant services who could provide Cheryl and her husband with the care which the ambulance service believed to be necessary. Unfortunately other services, whilst being sympathetic to Cheryl and her husband, appeared to review Cheryl’s care needs from her husband’s perspective. This had the impact of Cheryl not receiving health care which was necessary to support her and there is no evidence that her wishes and feelings had been ascertained. She became peripheral to her care rather than being at the centre.

11. Learning

Meeting the care needs of clients who have identified deteriorating health conditions requires that practitioners from all agencies are respectful of family life and work with carers to ensure that the needs of clients can be met. This includes ensuring that the carer is supported to undertake a role which is likely to become more demanding over time. Practitioners who are making assessments of clients are required to assess needs which are expressed as well as those which remain nonverbal. Adopting an approach to assessment of potential and actual clients which mindfully considers any safeguarding concerns is necessary. Rationales which clients and their families may have for refusing care need to be explored. This will need to include an understanding of beliefs with respect to health and social care as well as past experience.

In addition there is a need to be mindful that clients and their families may either be unaware of the support which may be available to help them or may have health beliefs which mean that they are reluctant to accept help. It is unclear whether Cheryl and her partner were refusing support or if they were unaware of services which were available to help them.

Cheryl was diagnosed with a number of medical conditions which compromised her health and which meant that she was increasingly unable to meet her care needs independently. Her husband had disclosed information to practitioners on a number of occasions about his wife's diminishing capacity to meet her needs independently and although immediate medical treatment was provided, there were missed opportunities from all agencies to develop a care package to support either Cheryl or her husband in ensuring that those needs could be met.

To some extent and from some information provided by practitioners, it may have appeared that her husband did not require such help. The key learning of this review, however, was that there is a need for professionals to make full assessment of the understanding of both the client and their families of health need and how specific medical conditions may progress. In addition health beliefs of individuals need to be explored. There is no scope to make assumption that the client or their carer do or do not require help and support. Any reluctance for professional involvement in the care of individuals needs to be verified. This review identified that there was no sense of practitioners being aware of the wishes of Cheryl with respect to her illness or those of her husband. There were many missed opportunities to seek such information. The multi- agency chronology sadly identified that potentially Cheryl did not receive support to meet her needs and so the quality of her care was compromised. There was a lack of professional curiosity.

In addition her husband's ability to care for his wife was not effectively assessed and so he was not offered active support as Cheryl's carer. There is potential that this lack of support may impact on the health of the surviving partner.

Her husband discussed this issue with the author. Her husband said that he had been distressed on the day of his wife's death and believed that practitioners had believed that he had failed to care for his wife appropriately. His beliefs were contrary to this view in that he believed that he was fulfilling his wife's wishes to have little intervention from agencies.

In each meeting which agencies had with Cheryl there is little evidence that her needs and wishes were explored directly with her? The Memory Clinic assessment identified that Cheryl had significant deterioration in her ability to communicate directly. This was likely to be as a result of her deteriorating health conditions. Although there is recognition by the Panel that practitioners did attempt to communicate directly with Cheryl at the time of her assessment, they took no further measures when it was clear that she was unable to communicate independently from her husband.

For the most part her husband appeared to speak on her behalf. This would not be unreasonable. However, there is very little evidence that the history provided by her husband about his wife's health included any account from Cheryl, prior to communication difficulties, about her wishes and feelings including how she may wish for her care needs to be met. Her history is known through her partner. Services did not know the client well enough to accept that she necessarily agreed with her husband's perceptions of her needs or that she understood her deteriorating health. She did not appear to have a voice and she was not the centre of care, she appeared on the periphery. There appears to have been no attempt made by any service to ascertain these. Although the review has identified that her husband had been carrying out the wishes of his wife i.e. for external intervention in her care to be minimal, this ought to have been documented and considered by all agencies who were making assessments of her care.

Some services documented that Cheryl lacked capacity to consent to her care and treatment. However, there are no formal mental health assessments for Cheryl and agencies did not ascertain what care may have been in her best interests.

12. Recommendations

There is a need to ensure that all assessments made by agencies caring for people who are in need of support adopt a holistic, person centred approach and that wishes and beliefs of the client are fully documented and guide the assessment.

The capacity of family carers to undertake the role of meeting the health and care needs of their loved ones needs to be formally assessed by all agencies.

Clients and/or their carers, need to be helped directly to be referred to other service to access further help and support. Practitioners will on occasion be expected to make referral on behalf of the client and carers as necessary.

Consideration of actual and potential safeguarding concerns needs to be considered in all assessments being undertaken by practitioners working in all agencies.

All agencies are required to ensure that Greater Manchester guidance with respect to non-attendance of appointments by people who are in need of care and support is implemented within their organisations.

13. Conclusion

Cheryl died unexpectedly potentially from a number of chronic health conditions. There appears to have been little known by agencies about Cheryl. She had been diagnosed with deteriorating health needs but there is no information available which demonstrates any support provided by services to help her or her husband to meet these needs. The voice of Cheryl was absent as a client. Sadly she was inadvertently on the periphery of her care.

The Panel discussed that the opportunity to reflect on what ought to be seen as good practice requires us to understand and consider the opportunities and restraints for professionals carrying out their roles in real time. The Panel termed this hindsight bias.

Her husband appears to have been regarded as a caring competent person who was acting on behalf of his wife to ensure that she was able to have the best care possible to meet her needs. There is nothing which has been identified within the safeguarding adult review which would dispute that this perception of practitioners was not real. This view has since been confirmed by her husband in discussion with the author. The impact of this belief by professionals, however, was that no assessment was required as potentially no intervention was required from services.

Current development for national policy in health and social care support direction that health and social care resource needs need to be available to wrap around the family but are not necessarily required to take over the role of carers and the client in meeting need on their behalf. However, needs and wishes for appropriate interventions do need to be assessed by professionals across the agencies. This does not appear to have occurred for Cheryl.

There is also a need to ensure that multi agency assessment of needs of potential and actual clients and their families pay due regard to ensure that the client is able to access high quality support to meet their individual need and that carers are supported to carry out their role. It is unclear whether communication with her husband reassured practitioners that there was no need for further intervention from services.

Whilst assessments were made as to the care required by Cheryl, these were undertaken on a single agency basis and were focused on the clinical care and tasks identified, rather than an overall assessment of how ill health was impacting on the way in which Cheryl and her husband were required to live their lives.

Lastly there is some concern about practice by professionals which does not appear to consider legislative frameworks which underpin service provision. For example there remains concern about the assessment of mental capacity of clients which impacts on the ability of the individual to consent to treatment. Consideration of potential safeguarding concerns were not considered as no full assessment was made of the care which Cheryl potentially required.