# SAFEGUARDING ADULTS REVIEW

## Report in Respect of Person D

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Consultant in Health and Social Care and Independent Chair of a North West England Safeguarding Adults Board.

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**Acknowledgements**
I should like to thank all those who contributed to this Safeguarding Adults Review (SAR), particularly Person D's three daughters and his niece.
The management of SARs places significant responsibilities on what is often a small and very busy group of Safeguarding Board staff. I should like to thank those staff for their diligent work and support throughout this Review.

| 1. | Introduction, Brief Summary, and Reason for this Safeguarding Adults Review (SAR) |
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| 1.1 | Person D, an 89 years old man was admitted to Sheffield Teaching Hospital Foundation Trust (STHFT)[1], on 2nd January 2019. He died in the early afternoon of 3rd January 2019. |
| 1. 2 | The cause of his death was recorded as:<br>• sepsis with acute on chronic[2] kidney disease<br>• pneumonia<br>• old age and frailty<br>• ischaemic heart disease<br>He had a permanent pacemaker in situ and was severely underweight (Cachexia)[3]. |
| 1.3 | Person D was a white British man, one of 2 brothers. His wife had died many years previously. He had 3 daughters and a son. He was close to his brother who he kept in regular contact with. |
| 1.4 | Person D's family described him as, "a very proud gentleman", who lived in the Sheffield area for most of his life and was employed as an engineer for most of his working life. He also served in the Royal Navy. |
| 1.5 | He had some health issues throughout his life due to what his daughters as they grew up believed was probably as a result of an eating disorder, though a medical diagnosis of this does not appear in any recent health records[4]. His daughters believed his issues with food might have been as a result of various traumas; separation as an evacuee, experiences in the Navy, and his father's death |
| 1.6 | He lived alone with support from family members following his wife's death. He began to show signs of delirium and amnesia and had a short hospital admission to Nether Edge Hospital (Michael Carlisle Centre). He had some contact with a support worker and a community psychiatric nurse (CPN) following his discharge. Whilst towards the end of his life he was described as sometimes confused he never had a diagnosis of dementia nor was his capacity to make his own decisions questioned. |
| 1.7 | In July 2017 he was admitted to the Northern General Hospital (STFHT) with an acute episode of confusion, incontinence, and dehydration. Family members were concerned about his ability to care for himself, but he was reluctant to accept support. |
| 1.8 | When discharged from Northern General Hospital, Person D went to live |

[1] STHFT is a large NHS Acute Trust with 17,000 staff. It consists of 5 Hospitals and Community Services. It provides specialist and Regional services and is a Major Trauma Centre.

[2] Chronic kidney disease exacerbated by an acute flare up

[3] Cachexia is weight loss and deterioration in physical condition. Cachexia is not starvation; but starvation may be part of cachexia.

[4] https://www.nhs.uk/conditions/eating-disorders/

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| | with his son, daughter-in-law and 2 young grandchildren. His daughters expressed concerns about this arrangement, initially described as temporary, as they believed their brother's house was not accessible and would not meet his needs for privacy and dignity; moreover, given his own responsibilities for his young family, their brother would not be able to look after their father properly. However, Person D stated to hospital staff that he wanted to live with his son, and staff considered that he had capacity to make that decision. |
| 1.9 | Whilst at his son's house Person D received assessment, treatment and assistance from a number of professionals including: OT/Equipment and Adaptation service; his GP practice; regular, and an increasing frequency of visits, from District Nurses/assistants to monitor and treat his pressure areas. There was also support from a dietician as his nutrition was poor and his weight was low (52kgs/just over 8 stone), |
| 1.10 | Some of the staff visiting him at his son's house had concerns about his living conditions and personal care: cluttered sleeping area, no accessible toilet/bathing facilities, no proper heating for a number of months, evidence of a poor diet and increasing time spent in bed. |
| 1.11 | There were also some concerns about his safety, including potential fire risk, as he was unable to get out of the house without assistance, and he was unable to open the door to let people in. There were a number of occasions when the district nurses had arranged a visit with his son, but he was out so they were unable to get in to attend to Person D. |
| 1.12 | Some professional staff also developed concerns about the impact of caring for Person D on the grandchildren, who were witnessing disagreements between their parents over their ability/capacity to continue to care for granddad. |
| 1.13 | In March 2018. following some discussion of shared concerns between the occupational therapist (OT) and a district nurse (DN), a safeguarding concern was sent to the Sheffield Adult Social Care (ASC) First Contact Team and telephone contact was made with the family by a social worker. It was assessed that the family needed social care support rather than a safeguarding investigation, but Person D and his son subsequently declined such support, as they had done on his discharge from hospital. Person D's capacity to make the decision to live with his son was not questioned. Whilst a Carer's Assessment was undertaken on one occasion by a district nurse, Person D/his son said they did not want external care workers. It is unclear whether Person D's daughter-in-law was asked if she agreed with that decision. |
| 1.14 | Person D continued to be offered a range of health interventions, (though these were not always taken up), including regular blood checks, and towards the end of 2018 he was diagnosed with borderline diabetes. |

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| 1.15 | On the morning of 2nd January 2019 a district nurse made a visit to Person D to take a blood sample at the GP's request. She was concerned that Person D's son was initially reluctant to allow the visit, particularly as he told her his dad had been unwell for a few days. She was very concerned about Person D's unkempt appearance and poor physical state. Medical help had not been called even though his son said he knew his dad was not well, and she was also concerned about the cluttered environment in which he was living. Initial clinical examination indicated that he was suffering from hypothermia and there was a suspicion of sepsis. The DN arranged for an ambulance to take him to STHFT and later submitted a Safeguarding Concern to Sheffield Safeguarding Service. Person D died in hospital on the afternoon of 3rd January 2019. |
| 1.16 | Following his death, the lead nurse for Safeguarding at STHFT also made a referral to South Yorkshire Police regarding possible wilful neglect and informed HM Coroner's Office of the circumstances in which Person D was found at his son's home. |
| 1.17 | Person D's health conditions confirmed his status as an adult, who was potentially at risk, with health and support needs. The circumstances of his death and the number of agencies that had some involvement with him indicated that there may have been good reason to suspect his death might have been contributed to by neglect from family carers and from health and social care agencies. |
| 1.18 | Following investigation Sheffield Police concluded there were no grounds for criminal charges against anyone and the Coroner decided that the circumstances of Person D's natural death in hospital did not necessitate an inquest. The Sheffield Safeguarding Adults Partnership did, however, conclude that the criteria for a Safeguarding Adults Review (SAR) were met. |

| 2. | Purpose of and Methodology for this Serious Adults Review (SAR) |
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| 2.1 | The Sheffield Safeguarding Adult Partnership Sub-Group met on 17th May 2019 and, based on information that had been gathered from agencies, it was agreed that Person D had been an adult at risk with health and support needs. They also agreed that the circumstances surrounding his death raised concerns over the effectiveness of partner agencies working together prior to his death. A recommendation was made to the SAB Independent Chairperson and it was agreed by the Chair that the criteria for a SAR were met and a Review should be undertaken. |
| 2.2 | The Statutory Guidance to the Care Act 2014 Act states that Safeguarding Adults Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect[5], whether known or suspected, ***and*** there is concern that partner agencies could have worked more effectively to protect the adult. |
| 2.3 | The purpose of a SAR, as described very clearly in the Statutory Guidance is so "lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[6]. |
| 2.4 | There is no single prescribed method to conduct a SAR. The Statutory Guidance places emphasis on local decision making with a focus on 'what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected'. |
| 2.5 | The methodology agreed by the SAB was to require agencies involved with Person D to produce a chronology (collated and combined by SAB staff) of events and interventions over an agreed time period. Agencies were also asked to produce a report following conducting individual management reviews (IMRs) that considered and evaluated professional practice and made recommendations for practice improvements where needed. |
| 2.6 | A Practitioner Workshop for staff who had some involvement (direct and/or oversight of practice) with Person D was arranged with the Reviewer. |
| 2.7 | Family members were identified and invited by letter to meet with the Independent Reviewer |
| 2.8 | IMRs were provided by all agencies that had some relevant involvement with him. |

[5] Neglect does not need to be intentional to be considered for a SAR
[6] Care and Support Statutory Guidance to Care Act 2014 published 24th March 2016 https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

<table>
<tr><td></td><td></td></tr>
<tr><td>2.9</td><td>I was appointed to be the Reviewer as an independent person[7] with substantial experience of safeguarding adults work and conducting similar reviews, to lead the SAR and provide this report.</td></tr>
<tr><td>2.10</td><td>SAR Panel<table>
<tr><td>Independent Chair</td><td>Sheffield Adult Safeguarding Partnership</td></tr>
<tr><td>Head of Safeguarding</td><td>Sheffield City Council</td></tr>
<tr><td>Safeguarding Board Manager</td><td>Sheffield City Council</td></tr>
<tr><td>Safeguarding Lead</td><td>NHS Sheffield Health & Social Care</td></tr>
<tr><td>Lead Nurse - Safeguarding Adults</td><td>NHS Sheffield Teaching Hospitals</td></tr>
<tr><td>Designated Professional Safeguarding Adults</td><td>NHS Sheffield Clinical Commissioning Group</td></tr>
<tr><td>Service Manager</td><td>Adult Social Care Sheffield City Council</td></tr>
<tr><td>Operations & Development Manager</td><td>Council Housing Service, SCC</td></tr>
<tr><td>Domestic Abuse Strategic Manager</td><td>SCC DACT</td></tr>
<tr><td>Designated Doctor</td><td>Adult Safeguarding, NHS CCG</td></tr>
<tr><td>Detective Sergeant</td><td>South Yorkshire Police</td></tr>
<tr><td>Safeguarding Officer</td><td>South Yorkshire Fire & Rescue</td></tr>
<tr><td>Case Review & Policy Officer</td><td>South Yorkshire Police</td></tr>
<tr><td>Service Manager, Community Law</td><td>Sheffield City Council</td></tr>
</table></td></tr>
<tr><td>2.11</td><td>Chronologies and Individual Management Reviews (IMRs carried out by senior staff who had no direct involvement with Person D) were provided from the agencies listed below:<br>1. Sheffield Teaching Hospital Foundation Trust [8]<br>2. Sheffield Clinical Commissioning Group (GP Practice)<br>3. Sheffield Adult Social Care (Access and Prevention: Equipment and Adaptations; and First Contact Team)<br>4. Yorkshire Ambulance Service</td></tr>
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[7] I 'independent, author' have never been an employee of any organisation in Sheffield or of any of the organisations providing services to Person D or his family.

[8] Sheffield Teaching Hospital Foundation Trust (STHFT) is a large NHS Acute Trust with 17,000 staff. It consists of 5 Hospitals and Community Services. It provides specialist and Regional services and is a Major Trauma Centre. The District Nursing/Community Nursing Service is part of the Trust.

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| 2.12 | Further information was also provided by the OT following the practitioner meeting; from the Practice Safeguarding Lead GP; and from a District Nurse.<br>The Sheffield Children's Social Services MAST (Multi-Agency Support team) provided a short report of their involvement with the family of Person D's son including during the period Person D was living with the family. Concerns were also raised by other organisations about the children's welfare. |
| | **Terms of Reference – Key Lines of Enquiry for the SAR** |
| 2.13 | The timeframe for the SAR was agreed from 19/07/2017, when Person D had a significant hospital admission, until his death on 03/01/2019, though some significant events prior to that start date were identified and information was provided and considered.<br>It was agreed based on information available at the beginning of the Safeguarding Adult Review that the key lines of enquiry/terms of reference for the Review would focus on the following areas:<br>1. Was the response to the safeguarding concern of the 23/3/2018 compliant with policies and procedures relating to safeguarding?<br>2. Were there other occasions when a safeguarding concern should have been made?<br>3. Was appropriate and person-centred support offered to Person D and his family in relation to him being cared for at home? What support networks were in place? Did any agency ask for his views on his care needs and provision?<br>4. Was a carer's assessment carried out and were the family signposted to other sources of support?<br>5. Were all family members able to contribute to the decision to care for Person D at home and was sufficient notice taken of the difference of opinion between family members about their ability to provide appropriate care.<br>6. Were Person D's personal care needs being attended to appropriately?<br>7. How compliant with expected practise was the routine care by the GP and what difference would additional oversight from the GP have made in ensuring appropriate medical intervention and care provision were in place?<br>8. Was Person D's mental capacity assessed in line with the Mental Capacity Act Guidance and did he have capacity to make important decisions including that he didn't need outside agency care?<br>9. When Person D declined support from the Short Term Intervention Team (STIT) following his admission to hospital in July 2017, did agencies ask appropriate questions, maintain contact and highlight any potential risks?<br>10. Were the concerns of professionals shared and acted upon appropriately including those of the Occupational Therapist? |

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| | 11. At what point was Person D's deterioration apparent to agencies and were there missed opportunities to intervene at an earlier stage? |
| | **Family Involvement in the Review** |
| 2.14 | The purpose of meeting family members/relevant others as part of a SAR is to enable them to share information that they believe pertinent to the Review; have their concerns and views taken into account; and identify any suggestions for improvements in systems and practice they would like to come out of the Review. Most relatives want to see that improvements will be made so that some of the negative things their relative experienced will not be repeated. |
| 2.15 | Letters were sent to Person D's 4 children. inviting them to meet with me (SAR Author). His three daughters agreed to a meeting and all attended on 18th September 2019. |
| 2.16 | Person D's daughters reflected, when they looked back at their dad's life that he had some health issues due to an eating disorder, possibly anorexia/bulimia[9]. They believed these issues may have been caused by his experiences as an evacuated child and possibly in the Navy. |
| 2.17 | They described their mother as a very elegant lady who died as a result of pancreatic cancer in 2013. They said their dad ate less following his wife's death and began neglecting himself and his home; however he was reluctant to accept assistance from others. He was showing some signs of confusion and had a hospital admission. |
| 2.18 | When he was still living in his own home, one daughter said she visited him once a week. He appeared fine and would take part in conversations. Latterly, he became less talkative and gave one-word responses. |
| 2.19 | Their dad was close to his brother, who lives in London. He met up with his brother regularly. Person D's daughter said that in June/July 2018, when she and her dad met with his brother, was the last occasion that she saw her dad looking well. |
| 2.20 | The daughters confirmed that their dad was a member of a small faith group and attended meetings locally. However, they didn't observe that the members of his faith group were in much contact with him when he became ill and was living at his son's house. |
| 2.21 | Person D's daughters confirmed that there was no Power of Attorney (PoA) for either Property and Financial Affairs or Health and Welfare in place for their dad. They said their brother hadn't wanted that, though he described himself as his dad's next of kin even though he was the |

[9] There is no diagnosis of anorexia or bulimia on any agency records though there was concern about his nutrition and low weight.

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| | youngest of the siblings. |
| 2.22 | The three sisters said they felt concerned about the physical circumstances of their brother's home, which was not adapted to meet their dad's needs, and also the quality of the care their dad was receiving. They also felt increasingly excluded from having contact with him. |
| 2.23 | All the daughters believed that their brother's house should have been vetted for its suitability as a home for their dad: it had no accessible toilet/bathing facilities; had no central heating for a long period of time; it was cluttered; and there were young children who needed space and attention. They did, however, say dad would not have the heating on when at his own home and refused to go to day activities organised for him as they were 'too expensive'. He would always state that 'everything was all right' at his son's, and he was not willing to live with a daughter who offered him a more spacious and accessible home with her and her partner. |
| 2.24 | When their dad was admitted to hospital on 2nd January 2019, his daughters visited the hospital and were shocked by his condition, and commented on the visibility of his pacemaker wires under his skin, and that he appeared not to have eaten or had anything to drink for some time. |
| 2.25 | The three sisters were suspicious of their brother's motivation to have their dad live with him and believed it was partly because he and his family were struggling financially. These suspicions were echoed by a wider family member, though there was recognition that Person D consistently said he wanted to live with his son. |
| | **Practitioners' Workshop** |
| 2.26 | The Statutory Guidance to the Care Act 2014 states, "professionals should be *involved fully* in reviews and invited to contribute their perspectives *without fear of being blamed for actions they took in good faith".* |
| 2.27 | Sheffield adopted the good practice, (now becoming more standard practice and being seen as a sign of a quality SAR by the Social Care Institute for Excellence (SCIE)[10]) of listening to/bringing together practitioners who had contact with the person who has died or experienced serious harm and/or those with some responsibility for quality and development in organisations. The purpose is for staff to share their experience and consider what they/their organisations might have been done differently that could have provided better outcomes. |

[10] www.scie.org.uk/safeguarding/adults/reviews/library/project - in order to access the Quality Markers you may need to register (free) with SCIE

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| 2.28 | 11 staff attended the meeting in addition to the Safeguarding Adults Board manager and the senior business support officer who later provided notes of the event. Further information and the views of those staff (some sent in after the meeting) and some of their reflections are included later in this report in section 4. |
| | **Parallel Processes, Investigations, Inspection Reports** |
| 2.29 | There were no additional reports provided for this SAR and no parallel statutory investigations into practice were undertaken. |

| 3 | Case Summary: Key Events and Interventions. |
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| 3.1 | The timeline for detailed consideration of key events and interventions was agreed as from 19/07/2017, when Person D had a significant hospital admission, until his death in early January 2019. |
| 3.2 | Some agencies had records of contact prior to July 2017, which have relevance to the analysis and findings of this SAR and are briefly described below. |
| 3.3 | In March 2013, following his wife's death, Person D was described as recovering from a short period of illness and was living independently with informal support from his family. He showed an interest in attending some community activities. However, on 24th April he was admitted to Northern General Hospital, and was diagnosed with a severe depressive episode with psychotic symptoms. He was treated with anti-depressant medication and had access to occupational and physiotherapy on the Older Adults Psychiatric ward. He was discharged home on 06/06/13 after several home visits with ward staff to support him. |
| 3.4 | During his hospital stay it is recorded that he had a mental capacity assessment to consent to treatment which concluded that he had capacity. |
| 3.5 | On discharge from hospital he received support from the Older Adults Functional Intensive Community Service and a referral was made to Adult Social Care for support with meals and taking medication. |
| 3.6 | On 21/01/14 Person D attended an appointment with the Older Adult Consultant Psychiatrist and he was discharged. His mental health episode was diagnosed as acute delirium coinciding with the death of his wife. |
| 3.7 | Whilst in hospital in 2013 Person D attended appointments at the Sheffield NHS Memory Service[11] on 27th November and 19th December. No specific concerns were identified. |
| 3.8 | Following discharge some issues emerged about him not taking his medication and one of his daughters contacted the hospital, but, before any supports were put in place, another daughter reported the situation had improved. |
| 3.9 | There are no further relevant events recorded until July 2017. |
| | **Period 1 19/07/17- 28/08/17: Hospital admission, discharge and start of community health assessments and living at son's house.** |

[11] The Memory Service is run by Sheffield Health and Social Care (SHSC) and works to increase the number of people who receive early assessment and diagnosis of dementia. They provide support, treatment and medication for patients and support for their carers.

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| 3.10 | 19/07/17: Person D was admitted from his own home to the Emergency Department (ED) at Northern General Hospital[12], with an acute episode of confusion, incontinence and dehydration. He was thin and frail and unsteady on his feet. A tumour was suspected and he was admitted to the Frailty Unit[13]. Medical notes indicated that he had anaemia, hypertension, and that an **atrial fibrillation (A/F)[14] pacemaker was in place**. |
| 3.11 | It was recorded that he lived alone and spent 3 nights a week at his son's house. One of his daughters told ward staff that he was not caring for himself and he needed carers. |
| 3.12 | 21/07/17: Person D was assessed as being medically fit for discharge as a CT scan showed no tumour and his chest infection was responding to antibiotics. However, a daughter raised concerns with a nurse about a discharge to her brother's home, stating that there was no suitable bed and he would be left alone as her brother would be at work. |
| 3.13 | Person D's discharge was delayed, whilst there were discussions with his son, who said he wanted to care for his dad but also wanted some help with his personal care, medication and meals. He said he intended to build a wet-room/accessible toilet for dad. A referral was made for an Occupational Therapy (OT) assessment. |
| 3.14 | The family disagreement about the discharge destination was recognised by staff and the OT recorded in their assessment that Person D gave 'valid consent' and was deemed to have capacity to make a decision to go to his son's house for a short term stay and then make a decision about returning to his own house. |
| 3.15 | A referral was made to the Sheffield Social Care Service Short Term Intervention Team (STIT) to support the discharge and also for an assessment for assistance with meals, bathing, dressing, managing continence and commode emptying. |
| 3.16 | 02/08/17: Person D was discharged to his son's house after receiving some treatment for urinary retention and constipation. Person D does not appear to have had any further direct contact with Northern General Hospital until he was admitted on 2nd January 2019 and died the next day. |
| 3.17 | 02/08/17: Sheffield City Council (SCC) staff made a visit to Person D's house to learn later that he was staying at his son's house and were informed by the family that Person D didn't require any care services. |

[12] Sheffield Teaching Hospital NHS Foundation Trust (STHNHSFT)
[13] Frailty Assessment Unit which has been purposely designed to provide the most suitable environment to care for frail and older patients."
[14] **Atrial fibrillation** is a heart condition that causes an irregular and often abnormally fast heart rate. https://www.nhs.uk/conditions/atrial-fibrillation/

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| 3.18 | 04/08/17: Person D, accompanied by his son, was seen for a post-hospital-discharge review, at his son's GP practice, where he had transferred following his discharge from hospital. There were some concerns that Person D was unaware of his faecal incontinence, and the GP referred him to the Continence Service. He noted that Person D's memory seemed better but his cognition (attention to and understanding of what was being said to him) was variable and advised that, if that continued, he should be assessed again. He weighed 52kg (just over 8st) and his blood pressure was low. |
| 3.19 | Also on 04/08/17 an occupational therapist (OT) and a district nurse (DN) from Sheffield Integrated Care (SIC) visited Person D at his son's home. The OT noted the presence of the 2 grandchildren. Person D's son reported his dad had had 2 falls since discharge and was slightly confused, but that he wanted dad to stay with them permanently. He described his dad's admission to hospital in 2013 showing signs of delirium and amnesia following the death of his wife. |
| 3.20 | Following the visit SIC staff made referrals for provision of a range of services and equipment including: a Blue Badge parking permit; a wheelchair, a ramp and a downstairs toilet facility; luncheon clubs; Community Dietetics Service, and the Community Continence Service; a high risk mattress and profiling bed[15]and a Memaflex pressure relieving cushion. Referrals were also sent to the Adult Social Care Equipment and Adaptations (ASC E&A) Service, and the Department for Work and Pensions. |
| 3.21 | 24/08/17: the DN called to provide catheter care and noted that Person D had reddening of skin, and a pressure area risk assessment using the Waterlow[16] scale indicated the risk was very high. His blood pressure was low (a high falls risk indicator) but no postural drop[17] was identified. He was unable to shower himself, had difficulty going to the toilet and was incontinent of faeces but he could wash and dress himself. Person D and his son said they could manage and did not want any carers. Community Nursing documentation states a Carer Needs Assessment was completed and concluded that the family wished to meet his needs without external support. |
| 3.22 | 27/08/17: the Incontinence Team visited Person D and documented that, "he changes himself but often denies faecal smearing – no pads required. Son reports he can be confused – was orientated during the visit". |

[15] **Profiling beds** are an electric care **bed** used in care homes and care at home to assist elderly and disabled users with mobility and their carers with nursing

[16] https://www.nice.org.uk/guidance/cg179/chapter/1-Recommendations

[17] Postural hypotension (also called orthostatic hypotension) is a condition in which a person's blood pressure drops abnormally when they stand up after sitting or lying down. Not all people who have this condition have symptoms, but it can lead to dizziness, light-headedness and fainting, and possible falls. https://www.nice.org.uk/advice/esuom20/ifp/chapter/What-is-postural-hypotension

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| 3.23 | The online professional referral form to the Equipment and Adaptations (E&A) service requested assessment for provision of a downstairs toilet, door ramps to outdoors to help with wheelchair access. As no urgency was indicated the request went on the waiting list, which at that point was 12 weeks. |
| 3.24 | 28/08/17: a dietician visited Person D and noted "Very low weight: very small appetite; gradual weight loss over 5 years. Food is readily available, discussed fortified diet. Review 6 weeks, may need to continue Scandishake"[18] |
| | **Period 2 September 2017 to March 2018 – Concerns over access for professionals, missing blood tests, delayed collection of medication.** |
| 3.25 | 26/09/17: the DN made an arranged visit to do a pressure area check and to measure for a wheelchair. On arrival Person D was alone and could not open the door as he could not find a key. A rearranged visit, took place on 29th September with his son present. A similar no-access visit took place on 13th October at 5.30pm. |
| 3.26 | 26/10/17: the GP practice nurse sent a letter to ask Person D to make an appointment for blood tests. No response was received and in the monthly GP Practice meeting Person D was discussed, and it was decided to suspend some medication (Spirolac/Epleron) until the blood test was completed. Later in November, blood tests were done and no concerns were noted. |
| 3.27 | 20/11/17: the pharmacist informed the GP Practice that no one had collected Person D's weekly medication pack (NOMADs). |
| 3.28 | 04/12/17: Person D was seen at Hallamshire Hospital to test his bladder function. Due to improvements he no longer needed a catheter and DNs were able to reduce the frequency of their catheter care visits. |
| 3.29 | Between 26/01/18 and 200/2/18 the Occupational Therapist (OT) from the Adult Social Care Equipment and Adaptations Service rang Person D's son on several occasions to arrange an assessment visit but contact was not achieved. A letter was then sent and responded to by Person D's son and a visit arranged. |
| 3.30 | 01/02/18: Person D had a fall in which he sustained a small skin tear to his arm. He attended the Emergency Department at Chesterfield Royal Hospital. The wound became infected and took many months to heal, necessitating an increased frequency of DN visits. |

[18] **Scandishake** Mix is a high energy, powdered oral **nutritional** supplement for the dietary management of malnutrition caused through illness

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| 3.31 | 20/02/18: a dietician visited Person D and recorded a weight gain of 2.1 kg since October 2017. She also recorded, but without any detail, that Person D received "good support from family." |
| | **Period 3: March to May 2018 – Safeguarding concerns: house conditions, inadequate personal care, family tensions, access to house by professionals, concern for children** |
| 3.32 | 06/03/18: after some delay the ASC Equipment and Adaptations OT visited Person D at his son's house and carried out an assessment. Discussions took place about the provision of a stair lift and level access shower, which would have been assessed for funding (means-tested) under a Disabled Facilities Grant[19]. However, Person D's son said they wanted downstairs facilities in an extension, which would be more expensive and require assessment for an 'Off-Set' grant, which would require additional finance from the family. The OT had some concerns about the environment Person D was living in. The boiler had not been working for 6 weeks. However, when she spoke to Person D and his son separately, both confirmed that he wanted to stay at his son's house. |
| 3.33 | 08/03/2018: the OT raised her concerns with a District Nurse. These concerns were that the house was very cold and cluttered, Person D was wearing multiple layers of clothing and there was an odour of faeces. She also had concerns about Person D's grandchildren living in that environment. |
| 3.34 | 09/03/2018: following the conversation with the OT, the DN team leader visited to monitor Person D's pressure ulcer risk and found all areas intact. She took the opportunity to speak to Person D's daughter-in-law whilst her husband was out. She said her husband was doing the best he could but would not admit he was struggling. Managing Person D's personal hygiene was the key issue, particularly faecal incontinence, which she said occurred once or twice a day. A commode was in place but Person D wouldn't use it and struggled to get up the stairs to the toilet. He did pass urine into a bottle. He was being taken to his own house to shower and stayed at his daughter's house every few weeks. She felt they needed help. When her husband arrived, he said he was OK with meals and medications but would consider help with personal hygiene, though thought dad only had faecal incontinence every 3 days. The DN spoke directly with Person D, who was embarrassed but said he would accept assistance if available. |
| 3.35 | The DN was also concerned about the children in the house. She informed Sheffield's Children Social Care (SCSC) and Adult Social Care. After discussion advice was given and she completed a Safeguarding Adult Concern Form which was submitted to the Local Authority First Contact Team by the STHFT Safeguarding Team on the 23/03/2018. |

[19] https://www.sheffield.gov.uk/home/disability-mental-health/disabled-facilities-grant

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| 3.36 | 20/03/18: the DN visited but was unable to get in but could see Person D in his bed. She telephoned his son and raised concerns about the locked door and offered advice but he said he didn't want a key safe that had been suggested before. He said there a key was in the back door and dad could get out that way into the garden if there was fire. |
| 3.37 | 21/03/18: the OT phoned Person D's son to arrange a visit. During their conversation Person D asked the OT to check a referral he had made for his daughter to MAST. His daughter had some difficulties with learning. The OT did this and passed on the advice that the family needed to follow up their concerns with their GP |
| 3.38 | 22/03/18: the OT had a further telephone conversation with the DN team manager. She reported that Person D was locked in the house when she visited. There was no gas supply to the property and no indication when it would be resolved. However, Person D and his son both confirmed that they did not want additional care support. |
| 3.39 | Person D had attended the GP practice on several occasions since September 2017 particularly in relation to his slow-healing infected arm. On 22/03/18 the DN made the GP aware that they were submitting a safeguarding concern and wanted the GP's opinion on Person D's capacity as his son had said his dad had dementia, but the DN did not think there was any memory loss or lack of understanding. The GP confirmed, "*Capacity assessment not required at this stage as not displaying any issues of memory or understanding*". |
| 3.40 | 03/04/18: the OT visited to discuss 'realistic options' for adaptations. Person D was in bed covered by an electric blanket as there was still no heating in the house. The OT had a discussion with his son and daughter-in- law where they both identified they were struggling They both agreed that an accessible shower would help with Person D and they would accept a carer to assist him. A social worker was assigned to carry out an assessment on the 5th April after a call from the OT. |
| 3.41 | Screening of the referral was undertaken by the social worker and included a telephone discussion with the OT. When asked whether she was making a safeguarding referral or request for assessment, the OT is recorded as saying that she did not feel Person D's son was abusing him but was just not able to support him with his personal care needs. It was stated that the GP had said "there was no diagnosis of dementia and he doesn't feel capacity assessment is required". |
| 3.42 | The Safeguarding Social Worker spoke to Person D on the telephone and noted he was able to explain the history leading up to him living with his son. He said he was happy there and wanted his family to look after him. He was asked about formal care support and he said that he didn't want that and was happy for his son to look after him. The screening did not include any discussion with Person D's daughter-in-law or son (his |

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| | carer). The screening did not include how Person D's personal care needs were to be met. |
| 3.43 | The OT sent a detailed letter to Person D confirming the discussions that took place on her visit and setting out the options in relation to adaptations and funding. She said she would wait to hear from him about what he and his son wanted to do next. |
| 3.44 | 09/04/18: a health care assistant tried to gain access to see Person D, but he was alone and unable to unlock the door. She later had a telephone discussion with Person D's son and discussed assisted housing for his dad but he said he did not want dad to move out and did not want help. A similar 'no access' visit was attempted on 10/04/18. |
| 3.45 | By 22/05/18 the wound on Person D's arm had finally healed, which meant DNs were visiting less frequently. |
| | **Period 4 June to November 2018 - Access to Person D; potential deprivation of his liberty; potential fire risk involving a child; missed health appointments; and pressure ulcer development.** |
| 3.46 | 10/07/18: the DN visited but was unable to gain access. His 10 year old grandson was with Person D and said there was no key so he couldn't let the nurse in. There is no evidence that there were any safeguarding concerns raised in relation to Person D or the child. |
| 3.47 | 24/07/18: the DN called to check Person D's left heel, as it had begun to show development of a pressure ulcer and a pressure relieving 'Devon Boot' had been supplied. The DN was informed that Person D had gone away for 11 days[20]. |
| 3.48 | 24/08/18: the GP was informed by the Cardiology Service that Person D did not attend for his pacemaker test and the battery was likely to be running low. This was discussed at the regular GP Clinic multidisciplinary clinical meeting, and it was agreed that, as Person D was housebound. a home visit for the pacemaker check should be arranged. |
| 3.49 | 18/10/18: the DN visited and carried out a review and gave Person D a 'flu vaccination. Faecal incontinence was reviewed; a pressure ulcer check revealed that all areas were intact but his sacrum pink from moisture, and barrier cream was ordered. Falls' risks were noted as rugs/ mats were covering cables in Person D's room and a discussion was held with his son about the risks. It was noted that his dad had been seen by the dietician for advice, but that he preferred his current regime of supplement drinks and a soft diet. |

[20] Other information suggest this was at a daughter's home

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| 3.50 | Two 'no access' visits (reminders sent by text the previous day) took place from a phlebotomist – 15/11/18 and 22/11/18. It was unclear whether Person D was in the house. Access was successful on 24/11/18. |
| 3.51 | Person D's incontinence problems increased during this period and the DN ordered pads to be supplied. Person D was described as in denial about incontinence. Concerns also began to emerge about indicators of diabetes. |
| | **Period 5 December to January 3rd 2019 - Borderline diabetes confirmed. General serious deterioration over Christmas/New Year period with no request for GP visit. Death on 3rd January** |
| 3.52 | 04/12/18: the GP Practice sent a text to Person D's son and a letter to Person D to arrange a telephone appointment with the GP about the need for blood tests within the next 3 weeks.<br>. |
| 3.53 | 13/12/18: during the DN's visit to take a blood test, a Waterlow risk assessment and pressure ulcer prevention care plan were put in place. Person D is recorded as saying he was able to mobilise but was spending more time in bed; however no pressure damage was identified so a routine visit was planned for one month later |
| 3.54 | 18/12/18: a Health Care assistant visited to take further blood samples, as there had been an error at the laboratories. The blood sample was taken successfully but no other documentation about Person D's condition was completed and no concerns were raised by the Health Care assistant. This was the last time any professional had any face to face contact with Person D, until 02/01/2019 when a district nurse visited Person D. |
| 3.55 | 21/12/18: the GP phoned to discuss the blood results with Person D, who asked the GP to discuss the results with his son. |
| 3.56 | 28/12/18: Person D's son rang and told the GP that his dad ate lots of cakes and drank high calorie drinks. The GP explained that given the result was 'borderline diabetes' this could be controlled with some minor changes to diet. There was no mention of Person D being unwell at this point. |
| 3.57 | 02/01/19: at the request of the GP, a DN, rang and spoke to his son at 9.30 am. His son advised that Person D was unwell and suggested the appointment might be re-arranged for another day. He said he had not contacted a GP though his dad was not eating or drinking and had a fall 3 weeks previously and had hit his head (wound now healed). There was no reference to this by the Health Care Assistant, who visited on 18th December, nor in the telephone conversation with the GP on 21st December.<br>He said he had been thinking about calling the GP but agreed the DN could visit. |

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| 3.58 | On arrival the DN found Person D groaning, weak, with severe oral thrush, a thick brown plaque on his teeth, very dehydrated and unable to swallow any medication, and morning tablets were seen to be still on his tongue. His son reported that Person D may also have the start of pressure damage to buttocks. The environment was very cluttered and contained a plastic milk bottle with urine in it. Person D was unkempt, with greasy hair and dirty hands and nails. His son said it was a week since he washed after he had soiled himself and, when asked, said dad had not passed much urine. |
| 3.59 | Although very drowsy, Person D thanked the DN for looking after him. The DN attempted to stand Person D to review his pressure areas and put his pyjama bottoms on but he was too weak to stand. His son said he had tried to get dad upstairs on New Year's Eve as they had had a party but dad was too weak. |
| 3.60 | The DN took observations using the Sepsis screening tool: hands cold, unable to feel radial pulse; and could not get manual blood pressure as the cuff was too big for Person D's arm.<br>Oxygen saturation was 68% and there was blueness to his lips. Temperature was 34.8 degrees C and re-checked at 35.2 degrees C indicating hypothermia. |
| 3.61 | The DN made a 999 call at 10.17am and Yorkshire Ambulance Service (YAS) double crew arrived at 10.41am. The YAS crew notes confirm the findings of the DN and they took Person D to Northern General Hospital. The YAS notes record that "Person D's consciousness improved with treatment and he knew where he was when he arrived at hospital". |
| 3.62 | YAS had telephoned a pre-alert through to the Emergency Department (ED) at the Northern General Hospital to inform them to prepare resuscitation, warmed intravenous fluids and a bear hugger (heated blanket used to treat hypothermia). |
| 3.63 | On arrival at hospital ED at 12.13pm Person D was assessed by medical staff immediately. He was given intravenous antibiotics and warmed fluids. His respirations were 10 per minute, temperature was 34.6 degrees C and his blood pressure was 62/40 mmHg.<br>He had a soiled but dry (no urine passed) continence pad in situ and was consequently catheterized. |
| 3.64 | He was diagnosed with severe septic shock, dehydration and severe acute kidney injury. He also had oral thrush and oral plaque preventing the removal of his dentures[21] and was suffering from hypothermia. |

[21] Medical advice sought during the SAR stated, "It is difficult to specify with any certainty how quickly plaque would have built up: Person D was noted to be severely dehydrated, his son reported that he had not been washed for one week and that he had stopped eating and drinking. Given this and Person D's poor physical state, the progression of indicators of poor oral hygiene could be rapid but having sought advice from several

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| | Medical staff discussed Person D's poor prognosis with his daughter, and her husband, who were advised that the situation was grave and that Person D was unlikely to survive. |
| 3.65 | A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was completed in agreement with the family. Person D was transferred to the Frailty Unit and passed away on 03/01/2019 at 13.45 hours. |
| 3.66 | Medical opinion was that on the balance of probabilities Person D would most likely have died at home on 02/01/2019 had the DN not visited and called 999. |
| 3.67 | On return to her office base the DN informed the Deputy Community Nurse lead of her concerns about the signs of visible neglect and her unease about conversations with Person D's son and also an exchange between him and his wife.<br>Her concerns were:<br>• The physical state of Person D as described above, which indicated neglect of personal hygiene, nutrition and hydration, and medication, which was not just of recent origin<br>• His son's reluctance initially for the DN to visit and concerns over not seeking medical attention when his dad fell and hit his head 3 weeks earlier, and more recently when the GP had spoken to him. His son giving conflicting information about Person D's mobility. The DN was unable to get Person D to stand as he was too weak and yet his son reported he had heard his dad mobilizing to the toilet earlier that morning. The DN believed that was "highly improbable"<br>• His son's general responses to her that suggested he was not recognizing the serious of his dad's health presentation. |
| 3.68 | On advice from her manager the DN contacted the STHFT safeguarding team for advice and completed a Safeguarding Concern form, which was received on 3rd January 2019. |
| 3.69 | The lead nurse for safeguarding at STHFT also made a referral to South Yorkshire Police regarding possible wilful neglect and informed the Coroner's office of the circumstances of Person D's death. |

nursing colleagues including an end of life specialist it would, on the balance of probabilities, be a 'few days' at least".

| 4 | **Findings and Analysis** |
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| 4.1 | The Practice Guidance developed by the Social Care Institute for Excellence (SCIE) to assist agencies carrying out Safeguarding Adult Reviews (SARs) as required by the Care Act 2014, suggests that a SAR is needed to achieve understanding of the following[22]:<br><br>1. What happened?<br>2. Were there any errors or problematic practice and/or what could have been done differently?<br>3. Why did those errors or problematic practice occur and/or why weren't things done differently?<br>5. Which of those explanations are unique to this case and context, and what can be extrapolated for future cases to become findings?<br>6. What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases? |
| 4.2 | Section 3 of this Report sets out some of the key events and interventions in Person D's life, while this Section 4 looks at the professional practice and the systems/organisational context in which some of that practice took place, and whether things could have been done differently and potentially have led to better outcomes. Section 5 will consider what actions might prevent similar harm to adults at risk in the future. |
| 4.3 | With the benefit of hindsight, this SAR can identify four key areas of potential concern about health and care practice that could have been done differently, and comments on the context and systems in which the practice occurred. These areas cover the 11 questions posed in the Key Lines of Enquiry/Terms of Reference set out at the beginning of the SAR process. |
| | **Key Concern 1. Safeguarding: recognising, reporting, responding, and managing safeguarding concerns**: (TOR questions 1, 2,10)<br><br>• *Was the response to the safeguarding concern of the 23/3/2018 compliant with policies and procedures relating to safeguarding?*<br>• *Were there other occasions when a safeguarding concern should have been made?*<br>• *Were the concerns of professionals shared and acted upon appropriately including those of the Occupational Therapist?* |
| 4.4 | The IMR author for Sheffield Adult Social Care concluded that the decision-making about the Safeguarding Concern submitted on 23rd March 2018 was not fully compliant with Safeguarding Adults Guidance. |

[22] www.scie.org.uk/safeguarding/adults/reviews/care-act

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| | In reporting her concerns to the Sheffield ASC First Contact Service in March/April 2018, it is recorded that the OT said she did not believe Person D's son was abusing him but he was unable to manage his dad's personal care needs. This led to a care needs and support assessment being arranged rather than a Care Act Section 42 safeguarding enquiry/investigation. |
| 4.5 | The IMR author points out that Section 14.7 Care Act Guidance[23] identifies that abuse or neglect does not need to be deliberate to warrant action in relation to safeguarding and the IMR author quotes the relevant section of the Guidance;(it is) *"important to recognise unintentional abuse or neglect and this may include the impact of stress on the carer's ability to care for another person".* The IMR author suggests that more familiarity with this section of the Guidance might have led to a decision to undertake a S42 enquiry and, crucially, arrange a face to face contact with Person D and his son and daughter-in-law. A visit to the family home would have enabled an assessment of the living environment and Person D's specific needs and allowed a direct discussion with him about what he wanted and consideration of any evidence of mental capacity deficits. It would also have been an opportunity to listen to concerns from his son and daughter-in-law, and make suggestions for carer support that took into account their own and their children's needs. |
| 4.6 | When Person D/his son said in the telephone assessment conversation with the social worker that they did not want an assessment of his dad's personal care needs, there is no record of any questioning about what they were going to do to manage the consequences of the faecal incontinence, which was clearly an issue, particularly for Person D's daughter-in-law. There also does not appear to have been any discussions with the GP about the cause of the faecal incontinence and whether there were other solutions to manage the impact of this on Person D and those he was living with. Records indicate that there was a continence assessment in early 2018 that suggested Person D did not meet the eligibility criteria for free incontinence pads, though these were provided towards the end of his life. There is no information that cost of pads was an issue for Person D, though there is evidence that he had refused services in the past because of their cost. |
| 4.7 | There also does not seem to have been any exploration of Person D's daughter-in-law's concerns. There seemed to be no curiosity about the negative impact on the children of continuing to live in a malodorous and increasingly cluttered house. |
| 4.8 | Following the enquiry into the safeguarding concern, the district nurses were asked by the care assessment social worker, who had talked to Person D on the phone, to monitor the home situation and get back to the Safeguarding Service if concerns remained. There was no further contact between the agencies. |

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| 4.9 | In the meeting held with Person D's daughters to discuss the SAR they described their dad as having been a proud and smartly dressed man. It is not surprising that he was embarrassed and, on occasion, in denial about his incontinence and he is likely to have been distressed by his loss of dignity. It remains unclear whether Person D refused assistance because his son did not want carers in the house or whether this was his own choice. There are occasions when he is described in professional notes and from his daughters as someone who, "didn't like to make a fuss". |
| 4.10 | There were eleven occasions, identified in the IMR prepared by the Sheffield lead GP for safeguarding, where raising safeguarding concerns would have been good practice. A number of visits were made by district nurses who were unable to get into the house to provide health interventions, such as monitoring tissue viability and delivering catheter care for Person D. On one occasion a health care assistant and on another an OT was also unable to get in even though visits had been planned with Person D's son. Person D was unable to let people in as the door was locked internally and he had no access to a key. This posed preventable risks to Person D from fire and getting help if he injured himself and should have been identified as potential safeguarding matters. |
| 4.11 | Some staff did raise these issues with his son, particularly pointing out the potential fire risk[24], but he said that, in the event of fire, his dad could get out of the back door into the garden. This explanation was not challenged, though certainly in the last few months of his life Person D's mobility was poor. Person D's son also said he was worried his dad would be unsafe if he got out of the house. The CCG IMR author described it as a missed opportunity that no professional suggested a South Yorkshire's Fire and Rescue Service Safe and Well check, which might have identified some mitigating actions and/or technology within the home. |
| 4.12 | Person D's son was advised about a key safe when his dad was discharged from hospital in 2017 and on a subsequent occasion, but he said he did not want that, though no explanation was recorded about his reasons. There is also no record of any discussion with Person D about that or about having a pendant or similar body worn alarm device, the latter being particularly relevant as he had also had a number of falls. |
| 4.13 | On one occasion, 10th July 2017, the DN visited but was unable to gain access. His 10-year old grandson was with Person D and he said there was no key so he couldn't let the nurse in. In effect both the child, who had some identified special needs, and his frail grandparent were at risk. |
| 4.14 | Whilst there was some discussion with Person D's son about this, there is no evidence that there were any specific safeguarding concerns raised |

[24] The fatality rate from fires in 2018/19, was highest among older people: 7.8 people per million for those aged 65 to 79 years old and 17.3 for those aged 80 and over In dwelling fires, 46 per cent of fire-related fatalities were 65 years old and over in compared with 24 per cent of non-fatal casualties.

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| | in relation to Person D or the child being locked in the house. This was a potential deprivation of liberty for Person D and a child protection issue for his grandson and would have been an opportunity to raise formal safeguarding concerns that could have considered the difficulties being experienced by all family members. |
| 4.15 | There were two other agencies which had information about potential risks to Person D, but they were not directly involved with him. These were the children's school and Sheffield Children's Service MAST team[25]. MAST staff were aware of Person D in his son's home when they visited on 2 occasions in the months before Person D went to live there permanently. It is also recorded that Person D's son told them in 2016 that he was receiving a Carers Allowance benefit for caring for his dad. Although the information is not date-recorded, both school and MAST were aware of the children's and their mother's struggle having granddad live with them. However, neither agency appears to have raised any safeguarding concerns on the basis of this information. |
| 4.16 | In the Practitioners' Meeting there was some discussion about why more safeguarding concerns had not been raised. Barriers identified, particularly by district nurses (not just those involved in this review), included that when safeguarding concerns were sent to social services *"they don't receive any feedback from safeguarding other than to say they have received the alert. This can be very difficult for the staff who then feel a safeguarding alert wasn't necessary. Equally when the alert is not progressed they can also feel they shouldn't have completed one... (doing) this can cause barriers with a family".* |
| 4.17 | In feedback following the Practitioners' event, the OT reflected that the style of engagement following making a safeguarding alert/concern was "*not sufficiently 'conversational' and 'collaborative', (with professionals) not taking joint ownership of resolving the concerns*". She identified that locality working and greater access to joint working between social workers and OTs might improve this. |
| 4.18 | A number of staff, including safeguarding practitioners, raised the longstanding, and certainly not unique to Sheffield issue of timely information sharing and access to one (or a fully compatible) IT/data recording system between professional groups and between children and adults' services. |
| | **Key Concern 2: Person-centred support, direct conversation and exploration with the at risk person about their wishes and personal** |

[25] [25] MAST (Multi-Agency Support Team) is part Sheffield Council Children and Young People's Services offering families "support to build on their strengths and find solutions that work for the family to meet their needs with support from relevant professionals and the family's safe network."
www.sheffield.gov.uk/mast

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| | **care needs. Evidence of consideration of GP oversight and consideration of mental capacity. (ToR questions 3, 6, 7, 8, 9)**<br>• *When Person D declined support from the Short Term Intervention Team (STIT) following his admission to hospital in July 2017, did agencies ask appropriate questions, maintain contact and highlight any potential risks?*<br>• *Were Person D's personal care needs being attended to appropriately?*<br>• *How compliant with expected practice was the routine care by the GP and what difference would additional oversight from the GP have made in ensuring appropriate medical intervention and care provision were in place?*<br>• *Was Person D's mental capacity assessed in line with the Mental Capacity Act Guidance and did he have capacity to make important decisions including that he did not need outside agency care?*<br>• *Was appropriate and person-centred support offered to Person D and his family in relation to him being cared for at home? What support networks were in place? Did any agency ask for his views on his care needs and provision?* |
| 4.19 | When Person D was admitted from his own home to Northern General Hospital Emergency Department (ED) on 19th July 2017, it was apparent that he already had needs for care and support as he was thin and frail and unsteady on his feet. His condition, particularly dehydration, suggested he was not caring for himself/being cared for effectively, a view also expressed by one of his daughters who challenged the decision about where he was going to live on discharge from hospital. |
| 4.20 | His son told hospital staff that his dad stayed over with him and his family 3 nights a week. The information from MAST indicates that his son had been receiving a Carer's Allowance[26] as his dad's carer since 2014 but he had not had a social care Carer's Assessment and his dad wasn't receiving any social care services, though some had been put in place following his 2013 hospital stay for a severe depressive/psychotic episode following his wife's death, and he was receiving Attendance Allowance from 2014. |
| 4.21 | Whilst he was in hospital in 2017 Person D was quickly assessed for a range of support services with the expectation of a discharge to his own home. However, his son said he would have dad live at his house for a short time and Person D agreed. When one of Person D's daughters challenged this plan based on the unsuitability of her brother's house and |

[26] https://www.moneyadviceservice.org.uk/en/articles/benefits-and-tax-credits-you-can-claim-as-a-carer Carer allowance £66.15 and can earn up to £123.It is a taxable benefit. Person D was also receiving Attendance Allowance (unclear whether at the higher or lower rate–£87.60 or £58.70)

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| | his capacity to care for their dad due to his family and work commitments, the discharge was appropriately delayed. |
| 4.22 | An OT carried out an assessment and recorded that Person D gave 'valid consent' and he was deemed to have capacity to make a decision to go to his son's house for a short term stay and then make a decision about whether he returned to his own house. |
| 4.23 | A variety of aids were made available and there were discussions about referral for assessment for potential adaptations to his son's house. Some practical caring support and referral for day activities was offered to Person D, though this was not taken up. The plan appeared to be for a short term stay at his son's house but this quickly changed to a permanent arrangement. There seems to have been no wider family discussion about this decision. |
| 4.24 | There was no formal Carer's Assessment[27] of his son and daughter-in-law. The services that had been suggested were said not to be necessary by his son as he was not working and could provide all care. |
| 4.25 | In August 2017 there was no evidence that Person D lacked decision-making capacity, or that he and his son were not offered appropriate support services. It was recognised that his son's house was not ideal but plans were being discussed to make adaptations. Person D was involved in some discussions and his daughter's concerns about the discharge were considered. It is unclear whether there was any conversation with Person D's daughter-in-law about what she thought of these arrangements at that time. Person D's faecal incontinence is not recorded as a significant issue at the point of discharge. Yet it was known that he would not have access to a downstairs toilet or shower, though a commode was ordered. His bed and commode would be in a ground floor room next to the family sitting room and kitchen. It is unclear to what extent Person D understood the arrangements he was agreeing to, particularly as it transpired that he was reluctant to use the commode. The OT also identified that the commode was not easily accessible to him once his room became more cluttered with stuff that had to be cleared from the garage to give access to a faulty gas supply. |
| 4.26 | Following discharge from hospital on 2nd August 2017, Person D attended the GP surgery accompanied by his son and appropriate referrals for specialist health checks and blood tests were arranged. Community nurses began to visit, as he needed attention to an indwelling catheter. On 23rd of August Community/District nurses carried out a detailed needs and risk assessment and noted that Person D was incontinent of faeces; and using the standard Waterlow[28] assessment |

[27] www.carers.uk.org
Information for Carer's including what an assessment should cover: impact on the carer's life and wellbeing, including physical and emotional health. Issues of choice and control over their caring role, having a break and financial support.
[28] www.nice.org.uk

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| | tool identified a high risk of pressure ulcers. Community Nursing documentation states a Carer Needs Assessment was completed and concluded that the family wished to meet Person D's needs without external support. It is unclear whether there was any discussion with Person D's daughter-in-law before this conclusion was reached. |
| 4.27 | Whilst the detailed IMR provided by the GP lead for safeguarding on behalf of Sheffield Clinical Commissioning Group (CCG) noted that the proactive discharge review by the GP was 'exemplary' in relation to speed and detailed assessment of Person D's physical health needs, there was no documentation suggesting that he was involved in the discussions; nor were he and his son seen separately to explore any sensitive issues such as abuse (coercion/undue influence) or carer's stress. These were missed opportunities to explore Person D's feelings and also for his son to discuss in private the challenges of caring for his dad. |
| 4.28 | When Person D began to miss appointments for a range of health assessments/interventions in 2018, these were documented by agencies as "*did not attend*", but the CCG IMR author pointed out that they should have been referred to as, '*was not brought*', and the reasons for not being brought explored more proactively with his son who identified as his carer and received financial support in the form of a Carer's Allowance. |
| 4.29 | The GP states that, at a surgery appointment just after Person D's discharge from hospital, "*his memory seems better*." Given that he was identified on occasion by his son as 'confused', it would have been good practice, if only to establish a base line, to have used a formal assessment test and considered a Memory Clinic referral. Good practice would have also indicated referral for a falls assessment. There is also no reference to assessment of Person D's mental health though he had in the past been diagnosed with depression. |
| 4.30 | A referral was made for assessment by a dietician as there were concerns about his continuing very low weight, and advice was given about nutrition. On 20/2/18 a dietician visited Person D for the third time since he was discharged from hospital and recorded a weight gain of 2.1 kg since October 2017. She also recorded, but without any detail, that Person D received "*good support from family*." This indicated some progress in the first few months of Person D living with his son and family, though poor nutritional intake remained an issue, and Person D began to show indicators of type 2 diabetes in the later part of 2018. |
| 4.31 | During March 2018 Person D's daughter-in-law, raised concerns with the DN that her husband was struggling to provide his dad's personal care but he would not admit it. Whilst a safeguarding discussion took place |

Waterlow assessment tool for prevention and management of pressure ulcers

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| | with Person D's son, no further discussion is recorded with his daughter in law, when Person D and his son declined support after the OT's/DN's concerns led to a social worker carrying out a telephone based care needs assessment. |
| 4.32 | With hindsight it is not difficult to see that the family was under considerable pressure by March 2018. The relationship dynamic of a dignified old man suffering from embarrassment and described by professionals as in denial about his incontinence, and a son who had said on a number of occasions that he wouldn't/couldn't deal with his dad's intimate care needs, was not explored. It is recorded that on several occasions Person D's son said he would accept support for his dad but he then said he could manage, possibly because he was responding to his dad's wishes. This ambiguity in his son's response, together with some identified reluctance to his dad being seen by professionals when he wasn't present, could have been a missed opportunity to explore his motivation, particularly when he had shared information that he was in 'low mood' in continuing to care for his dad. |
| 4.33 | The impact of Person D's faecal incontinence and consequent unmet intimate personal care needs was not considered by any of the GPs (he saw several at the surgery) none of whom saw Person D in his home environment. |
| 4.34 | Whilst community nurses were concerned about Person D's living conditions, it took the visit by the OT, who had never met Person D before, to identify those concerns as indicators of potential neglect/abuse even if there was no deliberate intention. Detailed assessment of toileting and bathing needs and the risks of these personal/intimate care needs not being met, are central to the professional role of an OT. |
| 4.35 | The CCG IMR author notes that, when the safeguarding concern was raised by the district nurse in March 2018, the GP was involved by telephone to give advice about assessing Person D's capacity. The advice that no capacity assessment was needed as Person D did not have a dementia diagnosis, was felt to be understandable by the IMR author but she noted that Person D might have undiagnosed memory issues that could have impacted upon his capacity to fully understand the consequences of some of his risky behaviours. Again, face-to-face contact and a capacity assessment focusing on information retention and executive decision making might have led to a different approach to Person D's care arrangements. |
| 4.36 | The IMR author's opinion was that Person D was offered a routine/expected level of care by his GP. This included flu immunisations, annual reviews of his medication and chronic conditions. However, she noted that there was no documentation suggesting that Person D was directly involved in the discussions at these appointments and some were not face-to-face. |

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| 4.37 | She identified that good practice would have been a face-to-face review each year, when the GP would review any recent blood test and investigation results and any correspondence from secondary care, and address any concerns from other agencies involved and from family members. A truly holistic approach would have included comment on care needs, how they were being met and action taken to signpost to agencies which could provide support for any informal carers. In addition, given that there were some concerns about Person D's living conditions and faecal incontinence, a home visit to carry out a review might have provided better evidence to the GP about the deficits in the quality of care being received by Person D. |
| 4.38 | Whilst Person D lived on his own, following his wife's death, information from his daughters suggested that they saw him on a regular basis, as did his brother and niece, and at least one of his granddaughters. It is reported that his son was receiving a Carer's Allowance from 2016, (the details of this are unclear) and his daughters and niece all confirmed that he was very close to his son. However, wider family relationships with his son and daughter-in-law had been strained for some time, with particular concerns about money. Person D also attended meetings of his faith group, which may have provided him with a supportive network outside of the family. |
| 4.39 | When Person D went to live with his son and family his wider network relationships would appear to have reduced significantly, though one daughter did visit him each week, and he had a short break in August of 2018 at the house of another daughter, where he also met up with his brother. His niece said her dad felt telephone communication with his brother was 'controlled' once her uncle moved to his son's house. One daughter described her dad as speaking less when they did have contact with him. His standard response to questions was that he was alright and he didn't want a 'fuss'. |
| 4.40 | It is unclear whether Person D had much contact with his faith group after the move, though one sister did see two people at her brother's house on one occasion. Most of the staff, who had contact with Person D, whilst he was living at his son's house, were unaware of Person D's other family members or his faith group connections and there was no information recorded about friends or other support networks. |
| 4.41 | Whilst there is very little information about Person D's son and family and their potentially supportive networks, there is information that they did not have such networks. The potential support from the children's school and the MAST support workers was not seen positively |
| | **Key Concern 3: Identification of and involvement of family members and assessment of and support to family carers. (ToR questions 4 and 5)** |

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| | • *Were all family members able to contribute to the decision to care for Person D at home and was sufficient notice taken of the difference of opinion between family members about their ability to provide appropriate care*<br>• *Was a carer's assessment carried out and were the family signposted to other sources of support.* |
| 4.42 | In the meeting for this SAR with Person D's daughters, they described that they felt their brother was 'taking over' their dad during his hospital admission on July 2017 and on his discharge on 2nd August 2017. They gave examples of where they, and their dad's brother, experienced barriers being put up to prevent them from contacting Person D. They acknowledged that Person D loved and, in their opinion, 'spoilt' his only son, whose birth followed that of three daughters. |
| 4.43 | Person D's discharge from hospital was delayed whilst the concerns raised by his daughter were considered. There was discussion with Person D who confirmed he wanted to go to his son's home and also with his son to check out what supports would be in place for his dad. There is no information of a family meeting being suggested to try to resolve the differing opinions. There is no information that Person D's daughter-in-law was asked for her views. |
| 4.44 | Whilst there continued to be some contacts with his daughters whilst he was living at his son's house, there was also some tension and friction. Person D did stay at one daughter's house on occasion including in August 2018. The OT recorded that she was told that Person D did that regularly. This daughter described a 'non direct' request from her brother to have dad stay with her on another occasion, over the 2018 Christmas period, whilst the family went on holiday to Blackpool, but she was unhappy about her brother's attitude and not speaking to her directly and so did not agree to having dad stay. His eldest daughter visited her dad one day most weeks. Whilst not comfortable with the conditions he was living in, she felt she could at least help him to stay connected to other members of the family and keep an eye on him. |
| 4.45 | However, they and their dad's brother began to believe that their brother's motivation to have their dad live with him was to exercise control over his money. |
| 4.46 | In spite of their concerns, none of the daughters or their uncle made any referrals to any agency about their dad's care or their suspicions about their brother's financial motivation in wanting to care for his dad. It is therefore difficult to see this issue as having a material bearing on professional practice. |
| 4.47 | In their IMR Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) acknowledged that there is no recorded evidence of a formal carer's assessment being carried out, and the support needs of the |

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| | individual carers/family members were not fully explored. Some practical support was offered to the family to care for Person D, though most of this was not taken up. Consideration of the impact on Person D's children of their parent's caring role for their granddad could have been explored and risks to their wellbeing discussed particularly as their dad appears to have been the main carer for granddad and for them, who were children already identified as having special needs. |
| | **Key Concern 4: Speed of identification and response to Person D's deteriorating condition. (TOR question 11)** |
| | • At what point was Person D's deterioration apparent to agencies and were there missed opportunities to intervene at an earlier stage? |
| 4.48 | A number of missed opportunities, suggestions for different practice that might have led to better outcomes for Person D have been identified in response to the 3 Key Concerns already considered in this Report. Towards the later part of 2018 there were increasing incidences of non-attendance for health checks, including checks to his pacemaker, and staff experienced more frequent 'no access' visits, even when an appointment to see Person D at home had been agreed with his son. Person D developed a heel pressure ulcer, incontinence increased and pads were ordered, though DNs described him as 'in denial' about his incontinence. Person D told staff he was spending more time in bed, which is a high-risk factor for accelerating serious health deterioration. His diet was identified as nutritionally poor and in December 2018 he was diagnosed with borderline diabetes. |
| 4.49 | Person D's daughters and his brother were not seeing him as frequently and were suspicious as they believed they were being prevented from making contact with him. Person D's son's family were under stress: and the school was concerned about the children, particularly as both parents were struggling and had health problems. |
| 4.50 | Person D's son had not progressed any of the plans for adaptations assessed for in March 2018, which would have possibly made Person D and the rest of the family more comfortable in their shared living arrangements. Person D was also not being taken for some health appointments. Some wider family tensions increased. |
| 4.51 | 13/12/18: following a GP request for a blood test to be carried out, District Nurses visited Person D and also carried out a Waterlow risk assessment and reviewed the pressure ulcer prevention care plan. No pressure damage was evident and Person D was mobile but said he spent most of the time in bed. No specific areas of concern were identified. However, the blood test needed to be repeated due to an error at the blood testing laboratories. |

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| 4.52 | 18/12/18: a Health Care assistant visited to take further blood samples. The blood sample was taken successfully. No other documentation about Person D's condition was completed and no concerns were raised by the Health Care assistant. This was the last time any professional had any face to face contact with Person D, until 14 days later on 02/01/2019 when a district nurse visited Person D at the request of the GP. |
| 4.53 | 21/12/18: a GP phoned to discuss the blood results with Person D, who asked the GP to discuss the results with his son. |
| 4.54 | 28/12/18: Person D's son rang and told the GP that his dad ate lots of cakes and drank high calorie drinks. The GP explained that, given the diagnosis was 'borderline diabetes', this could be controlled with some minor changes to diet. There was no mention of Person D being unwell during this conversation. |
| 4.55 | The details of the District Nurse's visit to Person D on 2nd January 2020, just 4 days after (28th December) his son had returned the GP call of 21st December, can be found in sections 3.57 to 3.65 in this Report.<br>For ease of access the concerns expressed by the District Nurse to the Deputy Community Nurse on return to her office base on 2nd January are repeated here. The DN was shocked by the signs of visible neglect and uneasy about the content of the conversation she had with Person D's son and also an exchange she heard between him and his wife. |
| 4.56 | She described finding Person D groaning, weak, with severe oral thrush, a thick brown plaque on his teeth, very dehydrated and unable to swallow any medication, and morning tablets were seen to be still on his tongue. His son reported that Person D may also have had the start of pressure damage to buttocks. The environment was very cluttered and contained a plastic milk bottle with urine in it. Person D was unkempt, with greasy hair and dirty hands and nails. His son said it was a week since he washed after he had soiled himself and, when asked, he said dad had not passed much urine. |
| 4.57 | The observations made by the DN following her visit are noteworthy:<br>• The physical state of Person D which indicated neglect of personal hygiene, nutrition and hydration, and medication, which *were not just of recent origin*. His son's reluctance initially for her to visit Person D<br>• His son not seeking medical attention when he said his dad fell and hit his head 3 weeks earlier (there was a visible scar)<br>• His son not seeking medical attention even though he told her his dad was poorly all the previous week<br>• His son asking questions about what the blood sugar results (diabetes) would mean for his dad following a recent HBA1C (test for diabetes), whilst more serious illness was evident and urgent attention was needed |

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| | • His son giving conflicting information about Person D's mobility. The DN was unable to get Person D to stand as he was too weak and yet his son reported he had heard his dad mobilizing to the toilet earlier that morning. The DN believed that was "highly improbable." |
| 4.58 | Person D's deterioration between being seen by the Health Care Assistant on 18th December 2018 and the state he was found in on 2nd January 2019, appears to have been very rapid. Rapid deterioration is not unusual in people of Person D's age with his health conditions. It is, however, of concern that his son was not seeking medical help for his dad, even though he had contact with the GP on 28th December, just 5 days before the DN made her visit. It is unclear what impact Christmas may have had on the family responses to Person D, particularly given that they had been planning for a Christmas holiday break. |
| 4.59 | What is of concern from a safeguarding point of view is the description of the district nurse of Person D's dirty, unkempt state, with plaque coated teeth and the fact that his son admitted his dad had not eaten and had drunk little in the previous week. These are indicators of neglect, and of particular concern when his son did not appear to recognise the seriousness of his dad's condition. |
| 4.60 | The actions by the DN on 2nd January showed persistence in gaining access to Person D and were swift and appropriate in getting emergency support, as was the response from the Yorkshire Ambulance Service and subsequent Northern General Hospital services. |

| 5. | Conclusions and Recommendations[29] |
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| 5.1 | Person D was clearly a well-loved dad, brother and uncle. Once his wife died, the visibility of his health problems, not uncommon in a man of his age (83/4 when his wife died), exacerbated by his significant bereavement, became more apparent to his children and to outside agencies. |
| 5.2 | Evidence brought together during the course of the SAR process indicated that his son's family had their own longstanding difficulties with, parental ill health, and two children under 11 who had special needs. |
| 5.3 | Some family tensions amongst the 4 siblings appeared to be of long standing, and became more evident when Person D 'chose' to live with his son and his family after his discharge from hospital in August 2017. |
| 5.4 | Information held in agency records indicate that Person D's son was already identified/had identified himself as his dad's carer, having him to stay over at his house three nights a week before his dad moved in permanently. Whilst Person D's daughters and niece described conflict over where/how dad should be cared for, all agreed that Person D said he wanted to stay with his son. They had concerns about this decision, and didn't believe it was in their dad's best interests but wanted to stay in touch with their dad, who was upset when his children voiced their disagreements. The painful impact of their dad's death and the condition he was found in on 2nd January 2019, the day before he died was evident in their meeting to discuss the SAR. |
| 5.5 | Information held by a range of health and social care agencies prior to the day before Person D's death, did not indicate that he was being deliberately neglected, though some staff had concerns about his wellbeing. Following the discussions with his daughter during his hospital admission in July/August 2017 there appears to have been no occasions when any significant concerns were raised about his capacity to make decisions about who should care for him and where he should live. Some family members had concerns about the quality of his care and suspicions about his son's motivation to care for his dad, but none of these concerns were raised with agencies after his hospital discharge until his death nearly 18 months later. |
| 5.6 | The gift of hindsight that a SAR process can bring to viewing information and events through a wider lens can identify that there might have been occasions when different practice, might have led to better outcomes for Person D. More face to face contact with him in his living environment might have stimulated more curiosity about the quality of his life as well as the impact of his presence and increasing care needs on the wellbeing of his son's family. |

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| 5.7 | On the whole health and social care practice was compliant with professional practice and agency policies and procedures. There is no doubt that a good range of supports, both in terms of health tests and interventions, opportunities to improve his living environment, opportunities for care and social activities were offered to Person D. |
| 5.8 | If agencies had looked at Person D as in need of safeguarding rather than just support services it is possible that the face to face contact would have led to greater curiosity about his reasons for wanting to be with his son in less than ideal physical circumstances. |
| 5.9 | It is difficult to draw conclusions that this was a predictable and/or a preventable death. Given Person D's age (89 at death); his long standing health problems, and a previous history of self neglect, particularly in relation to nutrition, his death was statistically predictable. However, the very sad circumstances in which he died, which one can only surmise followed some days when he was in pain, may have been preventable. |
| 5.10 | The purpose of a SAR, as described very clearly in the Statutory Guidance is so "lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[30]. |
| 5. 11 | Whilst this SAR has identified some lessons that can be learnt and certainly has no intention of holding anyone 'to account', it is difficult not to have concerns about the potential for undue influence/coercion and control that might have been exercised over Person D, though it was not being flagged to practitioners by family members. The question that hangs in the air and the unease expressed by some practitioners, particularly those who had involvement with the family as a result of childcare concerns is: was this a case of an escalation of unintended neglect by a family, particularly a son who wanted to support his dad but wasn't able to carry out all the personal tasks made necessary by his dad's frailty, or were there other motives for inadequate care that resulted in a distressing and painful death, even if not a statistically unpredictable death. |
| 5.12 | Person D's son had his own stressors and the family had many difficulties. As a consequence Person D's son's inability to provide the physical and intimate personal care his dad needed, but was embarrassed by, was combined with refusing to accept, perhaps not to upset his dad, the help that was offered by services. |
| | **Recommendations and Considerations** |
| 1. | Sheffield Safeguarding Board (SASP) should commission training and/or briefing events for staff in organisations working with adults who are |

[30] Care and Support Statutory Guidance to Care Act 2014 published 24th March 2016 https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

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| | potentially at risk of abuse and neglect, including self-neglect, to consider the findings and learning from this SAR, particularly in relation to risks associated with carer/family support and where there are children in a shared household. The 2014 Care Act Statutory Guidance in relation to the relevance/irrelevance of intentionality of neglect should be made clear in any staff training. |
| 2. | All partner organisations should provide evidence to the SASP that they have a programme of staff training/development that includes practice-based workshops on use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards DoLS), including Deprivation of Liberty in a Domestic setting (DIDs). Workshops in relation to MCA should be regular, brief and 'case based' The distinction *and* connection between decision making and executive function capacity and rights under the Human Rights Act (ECHR) need to be included[31]. |
| 3.a | The procedures of all Sheffield's health and care agencies should be reviewed in relation to involvement of family members as potential carers. The procedures need to include advice that staff should ask questions about the views of all family members, particularly when the 'at risk' person is being discharged to the home of one family member and concerns are raised about its appropriateness by another family member. Staff should support family members to reach shared decisions, even when there are some disagreements. |
| 3.b | If it is felt necessary, following the review of procedures set out in 3 above, the Sheffield Adult Safeguarding Partnership (SASP) should request partners responsible for the Family Group Conference process in relation to children[i][32] and young people to consider the feasibility of developing a similar process for staff to access where there are disagreements about the care of a potentially vulnerable adult. |
| 4. | All family/friend carers should be offered a Carer's Assessment, which should include the opportunity for advice and support from the Sheffield Carer Centre or similar specialist organisation. This is particularly important where the vulnerable adult person is living with the carer and where there may be other potentially vulnerable people, including children living in the same home. |
| 5. | In the light of the finding in this SAR that some staff felt discouraged from raising safeguarding concerns through the current channels the SASP should receive assurance that all agencies with safeguarding responsibilities receive appropriate feedback on their concerns and are confident to challenge decisions that may leave the adult to continue to be at risk. |

[31] https://www.39essex.com/health-welfare-and-deprivation-of-liberty-report-february-2020/

[32] https://www.slideshare.net/ripfapresentations/family-group-conferencing-with-adults

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| 6 | The voice of the person with health and care needs should be heard above all others and private space and appropriate technical and environmental supports provided as well as independent advocacy made available to hear their voice. This is particularly important where there are questions of capacity and differing opinions amongst family/friend carers. It is important that all organisations, including GPs should give an opportunity to patients whose family are their carers to be seen separately to explore any sensitive issues such as abuse or carers' stress. |


Pictorial of family and agency relationships document

## Individual Agency Recommendations

### Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)

1. Building on the actions completed following the Adult M Domestic Homicide Review: STHFT safeguarding training will include a reminder to clinical staff to consider the suitability of family as carers and to acknowledge the support required by family carers.
2. Information will be circulated to all staff within the STHFT community care directorate, the Front Door Response Team, Transfer of Care Team and staff in the Emergency Department to encourage them to consider the suitability of family as carers when assessing care needs and planning the discharge of patients.
3. Information will be circulated to frontline to raise their awareness of the support that can be offered by the Sheffield Carer Centre and to encourage staff to signpost carers to this organisation. The Carer Centre information has already been made available to staff via the Safeguarding Adults Intranet site.
4. Greater awareness of the role of South Yorkshire Fire and Rescue (SYFR) in managing risks for dependent people in their own homes has been identified in previous reviews, particularly with regard to having a clear exit route from a property or access for emergency services in the event of a fire or other emergency. The information that was previously circulated needs to be re-issued to advise staff to consider the potential for SYFR's involvement and to make 'Safe and Well' referrals in a timely way.

### Yorkshire Ambulance Service YAS

On review of the available records from Yorkshire Ambulance Service care was provided in accordance with expectations of an isolated emergency ambulance attendance, therefore, there are no recommendations.

### Sheffield Adult Social Care Recommendations

1. That the relevance / irrelevance of intentionality of neglect is specifically detailed within our safeguarding training, alongside also ensuring it is specified within wider training programmes. I consider that this point should also be addressed in all social work staff team meetings.

2. Social care workers didn't contact JAD and his family to establish how his personal care needs associated with continence care were going to be met in the period following JAD's incontinence assessment. It is recommended that within supervision and reflective practice sessions managers need to reiterate the importance of re-evaluating our understanding of the person and their circumstances when we receive new information.

3. It is recommended that information is sent to all staff clearly articulating the need to make a referral to the carers' centre if a family member, relative, neighbour or friend provides or intends to provide care for another adult (Care Act 2014 Clause 10.3) where care is emotional, psychological or practice support. This is so that consideration is made of both carers support needs and the sustainability of their caring role. In this case the recorded information indicates that we did not discuss a carer's assessment with DD or ND. We

should have discussed it with them individually and referred them for a carer's assessment or documented if they declined an assessment. In addition, when an assessment is completed by the carers centre, it is important that adult social care workers ensure that any actions from the assessment are carried out.

4. A key recommendation from evaluating the work Adult Social Care did with JAD is that, alongside the occupational therapist visiting the family, the quality of work with JAD and his family could have been improved if the social worker had visited JAD to build a rapport with him. Within Adult Social Care our focus has changed. I am mindful that a visit by a social worker may have changed JAD's mind regarding engaging with formal support.

**Sheffield Clinical Commissioning Group**

1. Sheffield CCG will encourage GP practice staff to document who a patient is accompanied to appointments by.

2. Sheffield CCG will encourage GP practice staff to give opportunity to patients whose family are their carers to been seen separately to explore any sensitive issues such as abuse or carers stress.

3. Sheffield CCG to remind GP practice staff of the need to document a patient's involvement in decisions regarding management of their health care and assess their capacity if they are struggling. Clinicians should consider formal assessment and referral for patients with possible new diagnosis of dementia.

4. Sheffield CCG to encourage GP practice staff to adapt their Did Not Attend policy to consider the impact of not accessing health care appointments on the health of adults who may lack capacity.

5. Sheffield CCG to raise awareness of the Safe and Well checks offered by South Yorkshire Fire and Rescue Service.

6. Sheffield CCG to encourage GPs to consider how they respond to the information from other agencies documenting in the GP electronic records (SystemOne and EMIS).

7. Sheffield CCG will request guidance on the content of the "annual review" from NHS England and circulate this.