Safeguarding Adult Review

Gillian

Independent Reviewer: Bridget Penhale

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Contents

1. Introduction

The purpose of a Safeguarding Adults Review (**SAR**) is to establish the learning from the circumstances of a case, by gaining an understanding of what happened and why it happened. The underlying causes and systems issues are important to determine, in order to gain a clearer sense of what improvements are needed within the safeguarding system.

SARs were established on a statutory basis under section 44 of the Care Act 2014. A SAR should always be considered if:

- An adult has died (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity or quality of life (whether because of physical or psychological effects); or the individual would have been likely to have died but for an intervention; and
- There is concern that partner agencies could have worked more effectively to protect the adult.

Safeguarding Adults Boards (**SABs**) may also commission a SAR in any other situation which involves an adult in its area with needs for care and support. If the SAR criteria are not met but the SAB feels that there are lessons to be learnt an alternative review may be undertaken.

This case was considered by the Hampshire Safeguarding Adults Board (HSAB) Learning and Review subgroup (LRS) against the agreed and established criteria to commission a mandatory SAR under section 44 (Care Act 2014). The decision to commission a SAR was confirmed by the Independent Chair of the SAB in January 2022. It was considered that the case had the potential to support valuable learning about how the system is currently working with unpaid carers, and the challenges for services working with complex family situations where there are multiple needs and a reluctance to engage with services.

In response to these decisions, it was determined that a focussed SAR should be undertaken, requiring 3 days of an Independent Reviewer's time. This SAR would take the form of a relatively short piece of work, to take up to 6 weeks. The main focus of the report would be on the findings section, and only a short piece, effectively a summary, would cover the case account.

2. Review Methodology

This SAR methodology involves the following key components:

- Use of the summary merged chronology and multi-agency scoping data provided.
- Liaison with the family alongside the SAR Co-ordinator, as appropriate (see below).
- Identification of Key Practice Episodes and emerging themes.
- Facilitation of one virtual practitioner workshop to inform our understanding of the reasons behind the systemic issues and strengths identified (held in March 2023).
- Facilitation of one Review Team meeting to draw conclusions about the key learning that has emerged and test out how common the issues are thought to be, to discuss findings and finalise questions for the board (in place of recommendations).
- Preparation of Draft report - submitted to the Learning and Review Subgroup for Quality Assurance and to check factual accuracy.
- SAR Report finalised and presented to the main HSAB board for ratification.

3. Family Involvement in the SAR process

There are three adults referred to in this review:

Gillian (elderly mother – may have had dementia; subject of this SAR)
Natasha (daughter with dementia and possibly other LD or MH issues)
Richard (son in his 60s/family carer, may also have had LD or MH issues)

In line with accepted and recommended practice for SARs, including Care Act guidance, contact was made with the son, Richard, inviting him to provide some input into or otherwise contribute to the SAR process. An email response was received from him declining involvement in the SAR. In view of the daughter Natasha’s circumstances, contact was made with the care provider manager supporting Natasha. The care provider manager confirmed that the capacity assessment that was undertaken early the previous year was still relevant in the current situation in relation to a lack of capacity by Natasha to take decisions relating to her situation or the circumstances that led to it. Natasha was stated to be unable to recall living at home with her mother and brother and appears to lack awareness that her mother had passed away. Given this situation, no further contact with Natasha in relation to the SAR was deemed appropriate.

Additional information gained from the care provider included that Natasha does have her own children, however contact with them is limited. Further, the children had advised the care provider that they had not had any (substantial) contact for a significant number of years prior to Gillian's death. Involvement of these individuals in the SAR process does not therefore appear to be either necessary or advisable.

Based on this information, it is apparent that the family have declined and/or been unable to provide input into the Review or to participate in the SAR process. Whilst this is regrettable, it is understood that it is not always possible to secure family involvement within Reviews.

However, a representative from a local charity providing Carer support attended the professionals' workshop held in March 2023. This was secured to provide objective views about caregiving, together with information that the charity is aware of from their contact with carers and related service provision in Hampshire.

4. Synopsis of the Case under Review

This case concerns three adults in a family, who all lived together, as in the information provided in the previous section. The family had been largely 'under the radar' in relation to services, although there were periodic visits by the primary care nurses or the GP. However, no significant concerns had been raised by the primary care team about the family's ability to cope and no care package or service provision was in place at the time of this incident.

Gillian (mother) lived at home with her daughter who has Alzheimer's dementia and her son who appeared to be their main carer. Gillian was understood by family members to be very controlling (description by her son Richard) and had always been the ‘boss’ of the family even before her husband had died. In September 2021, Gillian was admitted to hospital from home, having been found in a state of severe neglect by her neighbours. The son (Richard) had gone away on holiday. After contact by the daughter, Natasha, neighbours found Gillian in a bed which was heavily soiled with faeces and urine and the room was full of flies with sheets on the bed and no clean clothing visible. There was no food in the fridge. A safeguarding referral was made to Adult Health and Care (AHC) by the hospital. Unfortunately, Gillian died in hospital in early October 2021.

5. Case Summary, Key Chronology and Practice Episodes

Former Related Information and Background

In October 2017, Gillian spent some time in hospital following admission for reduced mobility, sepsis and reduced food and fluid intake. Following a period of treatment, on discharge Gillian was provided with a Reablement package at home for 8 days. No follow-up service(s) were provided by social care after this care package ended. A review was held at the end of this provision (dated 22 October 2017); the outcome was that no ongoing services were required.

Since that time there is no record relating to any subsequent contact with AHC until the safeguarding concern was raised in relation to Gillian after she was found at home by neighbours in a serious condition whilst her son Richard was away on holiday and was transferred to hospital. The subsequent safeguarding alert, and Gillian’s death in hospital, is the subject of this SAR.

Gillian’s daughter, Natasha, who is reported as having mental health related problems does not appear to have been known to AHC. The daughter was stated (by her son) to have moved into the household when Gillian could no longer care for herself.

Gillian’s son, Richard lived with his mother - and latterly his sister, Natasha. He was reported (by nephew, Natasha’s son when contacted by police as part of their investigation) as not being able to look after himself, so Gillian had previously looked after him, until she was no longer able to. There is no mention that Natasha provided care for her brother once she moved in – there appears to have been an assumption that Richard provided care for his mother and sister when Gillian's health deteriorated and that he was 'de facto' the main carer.

Key episode – September 2021

Richard went on holiday in mid Sept. 2021, but did not arrange any care or support for his mother and sister before he went away. Natasha called on neighbours 3 days later in the early hours of the morning – they visited the house and reported that they found Gillian in bed, immobile and in very poor condition ('covered in urine, faeces and flies') and further reported that there was no food in the fridge. In view of Gillian's condition, the South-Central Ambulance Service (SCAS) was called and both Gillian and Natasha were admitted to QA hospital. Gillian was examined and found to be severely dehydrated, with 'acute kidney injury' and she subsequently developed pneumonia. A Safeguarding Adult Concern form was completed within the Emergency Department outlining the circumstances (neglect and severe frailty) and was sent to the Portsmouth Hospital University NHS Trust safeguarding team for triage. The outcome of the triage was that the safeguarding alert/referral was sent to HCC for Adult Social Care (ASC) Safeguarding and MASH attention.

Gillian was transferred from the hospital Emergency Department (ED) to the Acute Medical Unit within QA Hospital and subsequently admitted to a general ward. She died in hospital on 1st October 2021, 10 days after her admission. The cause of death was reported as due to pneumonia and frailty of old age; no post-mortem was held. At the Coroner's Inquest held in September 2022 at Portsmouth Coroner's Court, the medical cause of death was given as:

1a Pneumonia

2a Frailty of Old Age.

The Coroner concluded that Gillian died of natural causes to which a lack of care had significantly contributed.

This SAR report was commissioned as a result of Gillian's death and subsequent initial investigations, together with a decision by the Learning and Review Sub-group relating to eligibility for a SAR to be undertaken.

Other Practice Episodes of Interest – contact with Services (post 2017)

There does not appear to have been any 'routine' contact with services other than primary health care, and no social care contact since 2017 when Gillian had received a period of Reablement services following discharge from hospital. The final review of this provision, in late October 2017, indicated that Gillian was independent in personal care (including dressing), was mobile with the assistance of a frame and was supported with meals and domestic tasks by her son and daughter, who lived with her. At that point, no ongoing service provision was identified as needed.

Contact with the local Health Centre in recent years appears to have been somewhat sporadic. Although Gillian was recorded as having Ischaemic heart disease, Atrial fibrillation, Chronic Obstructive Pulmonary Disease and cognitive decline and as being monitored for high blood pressure, her last recorded contact with the GP practice was in April 2021 when she was given the second Covid-19 vaccination at home.

The last recorded blood tests Gillian had received were undertaken in Feb. 2018. Although further blood tests were requested for monitoring purposes, these were never conducted. The last routine medical/disease review was held in August 2019 through a home visit with the (practice) nurse. The record stated that Gillian was independently mobile within the house but was effectively housebound; no concerns were reported by the son at that time. The GP completed a medication review from the medical records at around the same time (Aug. 2019).

Annual flu vaccinations were provided at home by a nurse in Dec. 2018, Sept. 2019 and Oct. 2020 – records did not report any concerns from these visits. A home visit by the nurse in Oct. 2019 for pain in Gillian's L arm (post 'flu jab?) reported that she was not otherwise unwell and there was no evidence of chest pain. No mention was made in these records of anyone else in the home, or of any concerns about Gillian or her situation.

In Jan. 2021 a frailty nurse undertook a home visit to administer the first Covid-19 vaccination to Gillian – no comments were entered into the record about any concerns.

The same nurse visited in April 2021 for the follow-up vaccination – again no concerns were reported in the record. This was the last recorded physical contact by the Health Centre, some five months before Gillian's admission to hospital and her subsequent death. Routine medications were however regularly issued for Gillian - the last being issued on 9th Sept 2021, prior to the son's departure on holiday.

There is little reported information in the GP record about Gillian's home circumstances, and no concerns were reported by health professionals about her situation. There is no information about a carer/caregiving in the home, or of any possible needs for care and support. No safeguarding concerns were ever raised by health centre staff.

There were 2 failed attempts to hold home visits to Gillian in Dec. 2018 (for the purposes of a 'flu vaccination) and in July 2019 for an annual review. Both visits were followed up by successful home visits (in Dec. 2018 and Aug. 2019).

There seems to have been something of a pattern of non-engagement with the health centre at specific points, although follow-up visits appear to have been successful. However, the neglect experienced by Gillian was stated (in the 111 records from Sept. 2021) to be likely to have existed for 'a sustained period'.

Following Gillian's admission to hospital in September 2021, staff in the hospital ED contacted Richard who confirmed that he was away on holiday, due to return on 1st October 2021 and that he had not arranged for any care for his mother of sister during his absence. The record states that no concern or remorse was expressed by him about his mother's condition on admission during this telephone call, but that he had previously stated that his sister was not safe to be left alone in the house. It appeared that there was an apparent lack of insight by the son into the severity of his mother's situation.

When interviewed by the Police, following his return from holiday, records state that Richard had said 'I thought they would be okay' when he was asked if he had had any concern about his sister looking after his mother whilst he was away. A decision was taken subsequently that no charges would be forthcoming for Richard – the stated police view was that he was ‘incapable’ but that his actions (or lack of actions) did not appear to have been with any malign intent or ‘wilful neglect’ towards his mother or sister.

In considering the remit for a SAR to be undertaken, the SAR sub-group identified two lines of enquiry considered to be of particular interest. These were how the Family Approach is operating in practice within Hampshire, and issues concerning identifying and working with family caregivers in relation to professional practice. These are dealt with in turn in the following sections.

6. Finding Themes

Theme One: The Family Approach

The Family Approach was developed at local/regional level to emphasise the need for (all) relevant professionals to work together in an effective way to achieve better outcomes for adults, children and their families within relevant authority areas. This was achieved through the development of a protocol and supporting documentation, which was agreed to be implemented across Hampshire, Portsmouth, Southampton and the Isle of Wight, and which is currently under review (2022-3). Although the Approach originated within services relating to children and their families, it was recognised as being wholly relevant within Adult Social Care and so is now in operation throughout agencies in the authorities. Consideration of the needs of whole families and all family members involved in situations is a fundamental premise within the protocol, as is recognition of the importance of allowing professionals to reflect on the needs of families (through such mechanisms as supervision) and to develop their professional curiosity in relation to the uniqueness of families and their situations. The crucial need for effective information sharing within and between agencies concerning families which are worked with more than one agency, or even jointly, together with strong levels of collaboration and co-ordinated partnership working also underpins the Approach. This is evidently a developmental process and one of the areas of interest within this SAR is the circumstances of families in which there are several individuals who have their own specific health and psycho-social needs due to health conditions and/or disability and how the Approach might relate to individuals (within the family system) in these situations.

Findings-Theme Two: Contextualising Caregiving and support for Family Caregivers

In this SAR, in addition, there are a set of concerns that relate to Carers and caregiving. For the purposes of this SAR, a carer is anyone, including children and/or adults who looks after a family member, partner or friend who needs help and support because of a disability, frailty, illness, a mental health problem or substance misuse and who cannot cope without this support. Care provided by this type of carer is unpaid and the range of care provided will vary depending on the other person's condition (NHS Commissioning, 2022)

Within a practice context it is evident that there are several carers who don't consider themselves to be carers; it has been estimated that it can take such individuals several years to acknowledge their situation as being care related and their role to be that of a carer (NHS website: Understanding Carers (http://www.nhs.uk/CarersDirect/understanding-carers/Pages/understanding- carers.aspx)).

From the perspective of individuals such as these, it seems that it appears difficult for them to see their caring role as separate or in any way different from the relationship that already exists with the person for whom they care, this can be the case irrespective of whether the principal relationship involved is as a partner, parent, child, sibling, or even a friend.

In the situation that developed in relation to Gillian, from the limited available information it seems that she was quite a dominant person who oversaw the running of the household and who informed her adult children who were living with her what they should be doing. As her health declined, so too did this role – but it is not clear that either of her children were capable of effectively assuming the role of running the household – or of providing care and support for Gillian when this became necessary. It is also possible that either Gillian was considered by primary care professionals solely from an individual perspective, or alternatively that some assumptions about caring were made due to the presence of the adult children (the siblings) in the household rather than any discussion held with the individuals involved or any explicit decision taken about this matter. Such assumptions could arise, however, either within family or externally; at times implicit assumptions are made or expectations held about familial situations and relationships which are not openly discussed or communicated or otherwise shared between those concerned.

As the primary health care contact is not recorded as identifying this situation during home visits, notably to administer COVID-19 vaccinations to Gillian in January and April 2021, with no recorded identification of other members of the household or of any care and support needs pertaining to Gillian, it seems possible that some assumption was made that one of the children was providing necessary support for their mother. Whether this was the result of any discussion or observation is not clear. However, given the lack of recording about other adults in the household in Gillian's case notes such an assumption might not have been the case and the situation is thus unclear. Nevertheless, if such assumption was made, this appears to be an area of learning, as this led to a situation in which the son left the house to take a holiday for several weeks without arrangements being made for his mother and sister. Further, on questioning by the Police, the son indicated that he thought that everything would be okay for them whilst he was away. Thus, no provisions, even for food, were made for either Gillian or Natasha in his absence. Ultimately, this led to Gillian's admission to hospital with severe dehydration, from which she developed health complications and from which she failed to recover and subsequently died.

Provision of support for carers by health and/or care professionals requires that recognition and identification of individuals in caregiving roles takes place. At the time of the professionals' workshop, attendees were informed that there is an NHS carer-related objective that 70% of carers should be in contact with a health professional (Principle 1 of the document NHS Commissioning for Carers, 2014). Further, at national level there is an overall target that registration of carers with a GP should attain 7%. However, at local level within Hampshire, GP surgeries were indicated to be achieving between 0.5-4% of such registrations, suggesting some room for improvement in this area.

Appropriate recognition and identification of caregivers also requires discussion and engagement with individuals to determine what sorts of support might be necessary and sufficient to assist them in their caring role(s). Once a carer has been identified, there can be suitable consideration of whether there are needs for any further support and assistance for them, including referrals relating to any care and support needs that they might have as a carer. In the situation that developed for Gillian, it seems that neither of Gillian's children identified themselves as either being carers or providing care. It may also be the case that none of the healthcare professionals involved asked if anyone else lived in the household, or indeed if anyone was providing care and/or support. In addition, and perhaps quite likely, neither of the children/siblings may have been capable (emotionally, psychologically or physically) of taking on the role of caregiving for their mother. This may in part be due to the individuals having their own difficulties and needs for support, which were also, it appears at that time, unmet.

This is where there is a link to the Family Approach and where there appears to be an important element of cross-over with situations involving family carers. If professionals do not recognise the distinctive needs of other family members and/or individuals within a household, or consider the whole familial system, then this may link with a failure to recognise that such individuals might be limited in their ability to provide care for another family member in the household due to their own circumstances, or indeed be in potential need of care and support services themselves. Effective use of the Approach would mean that professionals/practitioners attain a satisfactory understanding of the dynamics and roles of all individuals in the household. Adequate identification of a carer by professionals needs to include explicit conversations with the carer to obtain mutual understanding of their role, expectations and carer wishes. When necessary, this should include issues relating to whether the person wishes to be a carer or to continue in that role (rather than potential assumptions being made) – and this is an area of interest perhaps highlighted by the situation that appears to have arisen in this case.

7. Additional information and context obtained:

From the work undertaken to date in relation to the SAR, the following points arise for consideration. Due to the lack of representation from primary care at the professionals' workshop that was held, it was not possible to fully explore issues raised by the questions set out below. The relevant representative from the Integrated Care Board was able to comment in more general terms about what healthcare practice within primary care currently comprises. The following questions were posed to primary care colleagues in relation to current practice within existing contexts and ensuring the robustness of practice (including associated recording systems, for example). Responses to those questions are provided after each question.

1) **What type(s) of concern would be expected to be reported by a (frailty) nurse completing home visits?**

   For concerns in relation to safeguarding, individuals should be trained in accordance with the existing intercollegiate document. Generally, staff who are involved in undertaking home visits are skilled at identifying a range of different concerns which may relate to safeguarding issues. This could include evidence of alcohol or drug misuse, unknown people present in a home, poor nutrition or out of date food in the house, possible fire risk(s) or medication-related concerns, as well as apprehension about domestic abuse.

   Individuals are required to uphold professional standards set by their professional bodies and in line with associated registration requirements. If a professional has concerns relating to safeguarding or is unsure about the course of action to take, the advice is to consult the practice safeguarding lead or to have direct contact with either the Named GP for safeguarding adults and/or the relevant designated nurse within the ICB and to follow the multi-agency safeguarding policy. All practices should in any case have a safeguarding policy in place for staff to refer to. This includes detail of reporting mechanisms via direct contact with the relevant local authority. As a further example, in the South-East sector safeguarding supervision drop-in sessions are held to offer support to primary care, and individuals are encouraged to take complex cases for discussion, particularly where there are uncertainties.

2) **Would household composition be routinely recorded/reported on a health or care record? Would such notation or recording also include any specific care or support needs that those individuals might have?**

   In ideal terms, good practice would be to record household composition as part of initial assessments, and for there to be routine review and updating (if/as necessary), but it is acknowledged that this is very hard to achieve due to current service constraints (including speed of access targets and national shortage of GPs) and time available for consultations. Evidently if there is a potential safeguarding concern it would be important to prioritise recording of such information together with that relating to care and support needs. However, in general terms the lack of this type of recording and information within patient records represents a potential system weakness. Realistically, in the context of current circumstances (within the NHS), due to the national target of consultations being completed within 10 minutes, there are limitations in terms of the extent and depth of information that practitioners can gather, ascertain, synthesise and record for individual patients.

3) **Does location/residence of NOK get recorded on a health or care record, or is it just contact/phone details? Is it possible to know extent of the kinship link from these records?**

It would appear to be unusual that anything beyond a telephone number be recorded for individuals acting as NOK within a primary care record. Usually what would be recorded is a telephone number together with a name/relationship to the patient.

4) **How would the existence of an unpaid/or family carer be noted on a patient's record (either health or care)? Would this indicate the nature of the (non-caring) relationship between the carer and the cared for person?**

The name and contact details of a carer would be held on patient notes (if provided to the professional) but this information and that relating to the NOK would generally appear as an alert on the system. If an individual then changes their health practice, this information would not be automatically transferred, although it would be expected that that sort of detail would be provided to the new practice at the time of re-registration. In general, details about the exact care provided by a carer would not appear or be held in a patient's GP record, although it is possible that there might be some free text recorded at the time of individual consultations. This could well be difficult to find within a record, however.

The social prescribing service tends to record this type of information and a lot of social details appear on the local EMIS system for individuals. However, this is not likely to be consistent across patient records (as it depends what information is provided by patients), and this may not be searchable on the system.

5) **At what point (if any) might contact have been made by health professionals with AHC re: possible concern about the social circumstances of a household, including request for assessment and service provision, if needed?**

If a referral is related to a potential safeguarding concern this would be completed via an alert to the MASH service; more general concerns would likely be referred directly to AHC, or via the voluntary sector etc.; this would depend on the identified need and relevant level(s) of concern. However, this could also vary depending on the knowledge and experience of the clinician or staff member involved in the situation and raising the concern.

8. Questions for the Board

1) Although it appears clear that the Family Approach applies equally in situations where there are family members with their own/multiple needs, deteriorating health (physical and/or psychological) or increased dependency in terms of needs for care and support, **is there a current need for improvement in levels of identification of family members with such needs? Is such improvement necessary across all agencies that contribute to the SAB and safeguarding processes? How might the Board be assured that such individuals are appropriately identified through use of the Approach?**

2) **Does the Approach also include situations where family members do not identify themselves as carers?** This would also include circumstances when the individual may not have been explicitly or overtly ‘elected/selected’ as a carer. In addition, **does the Approach also need to contain detail about how professionals can effectively**

establish who else is present in the household (and the family context) as a precursor to the exploration of any necessary issues relating to caregiving?

3) Given relatively low numbers of carers registered with GPs (and identified as carers) in primary care across Hampshire, **how can identification of carers and levels of registration be improved?** As indicated, carer recognition is an essential first step in improving provision for carers (and carer identification is central to this). After such recognition, consideration can then be given to the need for any further referrals relating to specific care and support needs for carers. **Some attention could also be given to how best to enhance linkage of records (for example, between individual patient and caregiver).** Are such initiatives needed across (and between) health and care organisations in the county and might this be achieved via appropriate linkage of relevant organisational information systems?

4) In situations in which there may be an unwilling or reluctant carer – an individual who does not accept caregiving role – or doesn't recognise (or understand) an expectation that they will provide care for person in need in the same household, **how does or might a Carer's policy apply? How might it be best to identify and record these types of situations? How best might it be possible for different organisations to successfully intervene when such situations arise?**

Furthermore, **what might good look like concerning responding to issues in relation to Carers and the Family Approach – and including the potential cross-over between the two policies?** During the multi-agency practitioner workshop that was held relating to issues raised by Gillian's situation, there was acknowledgement across/between agency representatives that the situation that exists now in Hampshire concerning both policies is somewhat different than the situation that existed in 2021 when this unfortunate event took place. Additionally, it was indicated that these changes, that were (at least) in part instigated because of the COVID-19 pandemic, have led to improvements in practice, including the provision of relevant training and associated increased awareness about the relevant policies. Additionally, needs for collaboration and joint-working across care, health and human professions/services to enhance the well-being of those in need of care and support (carers included) and in line with the well-being principle of the Care Act 2014 are considered to now be better understood. However, the question of how good might be identified (and by whom) in relation to the application of these policies and the intersection with adult safeguarding is an interesting one that is pertinent for SAB consideration and subsequent potential action(s).

9. Glossary of terms used

Abbreviation	**Term**
AHC	Adult Health and Care
ED	Emergency Department
EMIS	Electronic Medical Information System
GP	General Practitioner
GP practice	General Practitioner health centre
HC	Hampshire Constabulary (police)
Hants CC	Hampshire County Council
HSAB	Hampshire Safeguarding Adults Board
HSAB-LRS	Hampshire Safeguarding Adults Board Learning and Review Sub-group
ICB	Integrated Care Board
MASH	Multi Agency Safeguarding Hub
NOK	Next-of-Kin
PHUT	Portsmouth Hospital University Trust
QAH	Queen Alexandra Hospital
SAB	Safeguarding Adults Board
SAR	SAR Safeguarding Adults Review
SCAS	South Central Ambulance Service

10. References

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