WAKEFIELD & DISTRICT safeguarding adults board

Safeguarding Adult Review in respect of Jackie

Author on behalf of Older Mind Matters Ltd:
Dr Susan M Benbow, MB, ChB, MSc, FRCPsych, PhD, GMC 2382872
Director of Older Mind Matters Ltd, Visiting Professor, University of Chester,
Psychiatrist and Systemic Psychotherapist
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FOREWORD

This Safeguarding Adults Review looks closely into the later life and subsequent death of 'Jackie'. Jackie was 62 years old when she died. As you read this review, you will learn that she lived with a serious mental illness in a complex family situation. Domestic abuse was a feature of Jackie's life which added to this complexity.

I would like to thank the agencies who contributed to this review with their time, written evidence and willingness to seek answers to key questions. I wish to thank Dr Susan Benbow for her work on this review; I know that there have been external personal factors as this review progressed which has not made her work on this case straightforward.

I would also like to thank Jackie's friend who had been supporting Jackie for contributing to the review, enabling us to understand more of what everyday life was like for Jackie, adding value and detail to the final review.

The Wakefield and District Safeguarding Adults Board will use the findings from this review to ensure continuous learning where relevant.

Diane Hampshire

WDSAB independent chair

1. Introduction

1.1 Wakefield and District Safeguarding Adults Board (SAB) initiated this Safeguarding Adult Review (SAR) in November 2022. It followed an incident when a woman aged 62 died at her home in autumn 2022. Her ex/husband had called 999 to inform them that she was not breathing, cold, and had not moved for 2 days, but later said he found her on the floor that day. Police and ambulance attended and Jackie was found deceased. The cause of death was initially unknown but deemed non-suspicious, and was eventually determined as 1a cardiomegaly, 2 alcohol intoxication in association with olanzapine[1] use.

1.2 The aim of a Safeguarding Adult Review is to promote learning and improvement action in order to prevent future incidents involving death or serious harm. The Care Act 2014[2] states the following:

(1) An[3] SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An[2] SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

1.3 In this case an adult with care and support needs was likely to have been experiencing domestic abuse from her husband; neglect/ acts of omission may have been present related to a recent hospital discharge; and there were concerns about how services worked together to keep her safe. This Report provides an overview of the deliberations and recommendations of the SAR Panel, Independent Chair/ Author, drawing overall

[1] Olanzapine is an antipsychotic drug used to treat major mental illnesses including bipolar disorder.
[2] See http://www.legislation.gov.uk/ukpga/2014/23/section/44
[3] "An" is grammatically incorrect but is retained here, in line with the original as quoted.

conclusions and recommendations from the information and analysis contained in Individual Management Reviews (IMRs) and other information supplied.

1.4 The Review seeks to capture as much learning as possible for the agencies involved.

2. Circumstances that led to a Safeguarding Adult Review being undertaken

2.1 On a date in September 2022 a woman aged 62, Jackie, the focus of this review, was found dead at home when a Yorkshire Ambulance Service crew responded to a 999 call from her ex/husband and attended a house in the Wakefield area.

2.2 Jackie lived in the Wakefield area with her ex/husband. She had previously lived in Leeds and had three sons.

2.3 She died 25 days after hospital discharge and following the previous two hospital discharges temporary care packages had been put in place.

2.4 Jackie had been diagnosed with bipolar disorder in 2018 following an admission to hospital in the context of a 'manic episode'. She was discharged from mental health services in June 2019 as her mental health was deemed stable at that time.

2.5 In 2021/2022, Jackie had several reported falls/ incidents at home resulting in injury, including an ankle fracture in March 2021, a shoulder injury in April 2021, a swollen ankle in August 2022, and abdominal pain following another fall/series of falls in August 2022. This could potentially indicate that she was experiencing increasing difficulties with mobility.

2.6 Jackie described herself as dyslexic, although services suggested that she may have had a level of illiteracy and/or learning difficulty, rather than dyslexia.

2.7 Information gathered during initial fact finding suggested that her ex/husband experienced significant alcohol misuse, but there was no information to suggest that this was the case for Jackie.

2.8 The discretionary Safeguarding Adult Review was initiated in November 2022.

2.9 The timescale for the review was agreed as covering the period from January 2018 (shortly before Jackie's move from Leeds to Wakefield) to the date of her death in September 2022.

2.10 The following agencies were known to have been involved with Jackie's care and support:

An extended access primary care service: evening and weekend clinics

A local GP practice

Mid-Yorkshire Teaching Trust

South-West Yorkshire Partnership NHS Foundation Trust

Turning Lives Around Sustain Wakefield

Wakefield Council Adult Social Care

Wakefield District Housing

West Yorkshire Police

Yorkshire Ambulance Service

2.11 The detailed process of the Safeguarding Adult Review is set out in section 4: Process of the Safeguarding Adult Review.

2.12 *Independent Chair/ Author*

The Author of this report is by professional background a psychiatrist (retired from psychiatric practice) and systemic psychotherapist specialising in work with older adults. She has broad clinical and multi-agency experience in the North West and West Midlands. She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past. She has no connections or ties of a personal or professional nature with the family, with Wakefield Council, or with any other agency participating in this review.

3. Terms of reference

The key lines of enquiry agreed and circulated to the agencies for them to address in their reports were:

3.1 *Accessing Jackie's voice:*

(a) When, and in what way, were Jackie's wishes and feelings ascertained and considered?

(b) How was Jackie supported to make decisions for herself?

(c) Were there concerns about Jackie's decision-making capacity?

3.2 Domestic abuse:

Was there evidence of ongoing domestic abuse between the couple, were any disclosures made, and was any response appropriate?

3.3 Possible self-neglect:

Was there evidence of Jackie lacking self-care or lacking care of the home environment to the extent that it endangered safety and wellbeing?

3.4 Possible neglect/ acts of omission by agencies in respect of Jackie's care in August 2022:

Was information shared appropriately and appropriate actions in line with existing agency policies and best practice taken in respect of

(a) Jackie's contact with an out-of-hours GP on 6 August 2022 and

(b) Jackie's hospital discharge on 15 August 2022?

Considering communication between all agencies, was information shared appropriately in line with existing policies/best practice, and were there any barriers to information sharing?

3.5 Safeguarding:

Was safeguarding considered at any stage, were there grounds to raise a safeguarding concern at any stage, and might this have led to a change in practice?

3.6 Systemic issues:

Did any systemic issues impact on Jackie's care/ service delivery, including, for example, agency resource/ capacity issues, austerity, the COVID pandemic, pressures relating to hospital discharges?

3.7 Learning:

What learning will your organisation take from this review and how will any changes be implemented?

3.8 Good practice:

What good practice was evident in this case

4. Process/ Methodology of the Safeguarding Adult Review

4.1 The review process started with the decision of a Safeguarding Adults Review Initial Panel meeting on 15 November 2022 that the criteria had been met to undertake a discretionary Safeguarding Adult Review. The meeting concluded the following:

- Jackie was an adult with care and support needs who lived in Wakefield.
- It appears likely that Jackie was experiencing domestic abuse from her ex/husband.
- It also may be the case that neglect/act of omission was present with respect to the hospital discharge and poor communication/coordination between agencies.
- Jackie does not appear to have been experiencing self-neglect to the extent that it endangered her safety and wellbeing. The Panel's rationale for this decision was that the most recent Yorkshire Ambulance Service referral made no mention of poor house conditions. Furthermore, Jackie was accepting of support and agreed to a social care assessment – it appears that the main barrier to her receiving support may have been her ex/husband.
- It is not possible to conclude on the link between Jackie's death and the abuse/neglect, but it would not be proportionate for Panel to postpone its decision-making.
- It is possible to conclude that there was no direct link between Jackie's death and the domestic abuse she experienced, which is why a Domestic Homicide Review referral was not made.
- There are concerns about how services worked together to keep Jackie safe.

4.2 Following this the process of commissioning an Independent Chair/ Reviewer was commenced and an appointment made in early 2023.

4.3 Terms of reference were drafted, revised and endorsed at a Planning meeting on 17 April 2023.

4.4 The members of the **Safeguarding Adult Planning group/ Panel** were identified and are set out overleaf in Table 1:

4.5 Following the April meeting, agency representatives were asked to provide the Reviewer with a report using a template provided to them. The report included a chronology, detailing their involvement with Jackie and analysing their involvement in line with the key lines of enquiry in the terms of reference. The date for return of agency reports was agreed as 7 July 2023.

4.6 Table 2 sets out details of the Individual Management Reports.

Table 1: Members of the Safeguarding Adult Planning group/ Panel

Susan Benbow (Chair)	Independent Safeguarding Adult Review Author
Sarah Clarkson	Business Manager, Wakefield and District Safeguarding Adults Board
Karen Charlton	Designated Professional for Safeguarding Adults, West Yorkshire Integrated Care Board/Wakefield District Health & Care Partnership
Marie Gibb	Head of Safeguarding, Mid Yorkshire Teaching NHS Trust
Deborah Longmore	Named Nurse Adult Safeguarding, Mid Yorkshire Teaching NHS Trust
Theresa Kirk	Service Manager, Intermediate Care & Support, Wakefield Council
Anne Howgate	Service Manager, Mental Health, Wakefield Council
Sally Fawcett	Strategic Safer Communities Manager, Wakefield Council
Kristy Wright	Detective Inspector, West Yorkshire Police
Emma Cox	Associate Director of Nursing, Quality and Professions, South West Yorkshire Partnership NHS Foundation Trust
Gary Lumb	Community Safety Manager, Wakefield District Housing

Table 2: Details of Agencies and Individual Management Reports

Agency	**Agency role in relation to LB**	**Referred to as**	**Author**	**Endorsing Manager**
Extended access primary care service	Evening and weekend clinics	Extended access service	Quality Governance Lead	Chief Operating Officer
South West Yorkshire Partnership NHS Foundation Trust	Mental health services	The Partnership Trust	Specialist Advisor Safeguarding Adults	Associate Director of Nursing Quality and Professions
The Mid Yorkshire Teaching NHS Trust	A range of services across 3 hospital sites and in the	Mid Yorkshire	Named Nurse Adult Safeguarding	Head of Safeguarding

	community, including Emergency Department services			
Turning Lives Around, SUSTAIN Wakefield	Wakefield Council's Housing Sustainment Pathway, providing housing-related support to people at risk of homelessness to enable them to keep and maintain their housing.	Sustain	Pathway Manager	Services Coordinator (Senior Manager)
Wakefield Council – Adult Social Care	Social care	Adult Social Care	Service Manager	Service Director - Adult Social Care
Wakefield District Housing	Owned and managed Jackie's property	Housing	Community Safety Manager	Service Director (Housing)
West Yorkshire Integrated Care Board (on behalf of GP)	Primary care services	Primary care	Named Nurse Safeguarding Primary Care	Director of Nursing and Quality
West Yorkshire Police	Policing.	Police	Serious Case Review Officer	Detective Chief Superintendent
Yorkshire Ambulance Service	Emergency ambulance and patient transport service. Also NHS111 (medical help and advice for urgent need not constituting an emergency.)	Ambulance service	Named Nurse for Safeguarding	Head of Safeguarding

4.5 The review aimed to involve/ meet with **friends and family** should they agree, and the process of identifying people to approach started following the April meeting. The aim was to consult relatives on how names would be presented in the report and, towards the end of the review, provide an opportunity to complete a brief impact statement.

Family members said that they did not want to be involved in the review, but that they thought more could have been done to keep Jackie safe, and they expressed concerns about the circumstances of her death. The family did not feel that they would get any benefit or value out of participating in the review. One of Jackie's friends, who had been supporting her over a number of years, shared her knowledge of Jackie with the Reviewer.

4.6 The Panel met on the following dates:

17 April 2023

23 Oct 2023

4.7 The initial aim was to complete the review within 6 months of agreeing terms of reference.

4.8 The final draft would then be presented to the Panel for further comments. The family had expressed a wish not to be involved in the review process.

4.9 A final draft report would then be presented to the Safeguarding Adult Board for agreement and publication on the Board website (including agreement on the extent of any anonymisation); alongside a bitesize summary. The published report would be shared with the Community Safety Partnership.

4.10 An action planning meeting would subsequently be held to progress agreed multi-agency and individual agency actions, including arrangements for oversight and monitoring.

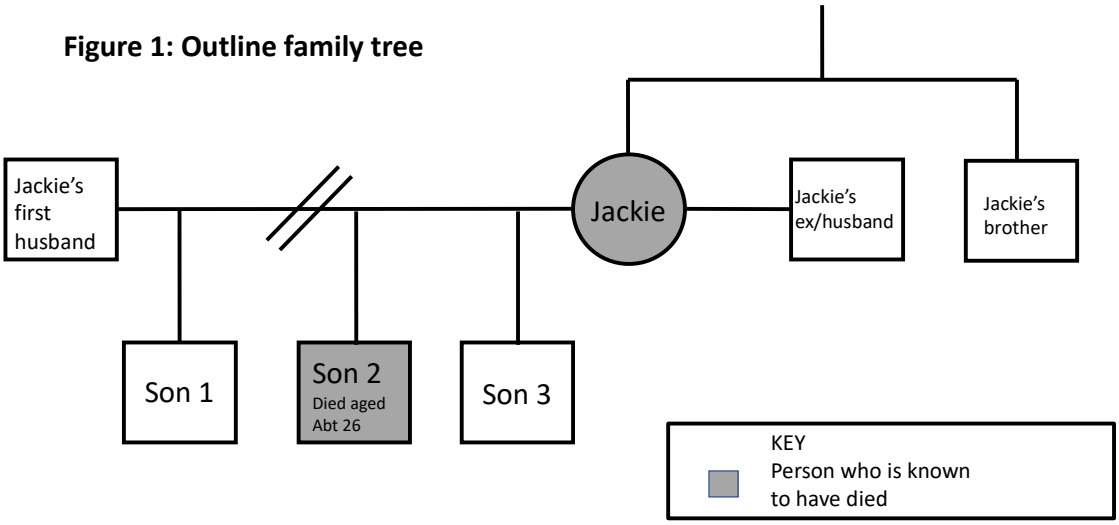
4.11 Confidentiality was maintained throughout the review and for that reason pseudonyms are used in the report. The pseudonym Jackie was suggested by her friend. A pseudonym is also used for a close friend who supported Jackie. Her second husband is referred to as her ex/husband, as they were separated for some time, but he was living with her again at the time of her death and the nature of their relationship was unclear.

4.13 It was agreed that any disclosures to the media or other parties would require the agreement of the Wakefield and District Safeguarding Adults Board Business Manager.

5. The Facts

5.1 Jackie's Background

Figure 1: Outline family tree



The information on which this section is based is drawn from a number of the reports prepared as part of this Safeguarding Adults Review and from a conversation with a close friend. For that reason, please read it with the awareness that it is likely to emphasise the difficulties in Jackie's life rather than her strengths and does not give a balanced picture of her. Information from Jackie's friend is included as told to the Chair. Overall, we have limited information about Jackie as a person and her background.

Jackie was someone who enjoyed chatting, a good joke and having a laugh. She was well-liked, enjoyed life and loved her grandchildren. She also had good friends, and a small dog that she dearly loved. Carol[4] used to be her neighbour and knew her for at least 7 or 8 years before she died. She understands that Jackie got on well with her mother but not with her step-father.

It appears that Jackie was married prior to her relationship with her ex/husband and had three sons from that first marriage: they are referred to in this report as Son 1, Son 2 and Son 3 (see Figure 1 above). Carol said that Jackie had dyslexia, which had affected her education, and she struggled with reading, writing and dealing with forms and information. When she was young, her friend believes that Jackie had a child-minding business. At one time she thinks Jackie might have been addicted to pain-killers. Jackie was a smoker and later in life had breathing problems and was prone to respiratory infections.

[4] The name 'Carol' is a pseudonym.

Jackie is referred to in records relating to a child protection case conference in Leeds in January 1991 in respect of Son 2, with concern for the other two sons, and that record refers to a previous address in the British Forces and also to an armed forces charity, suggesting that one or both parents were in the forces. Her friend thinks that it was Jackie's first husband who was in the forces and that at one time they lived in Germany. She understands that Jackie had a difficult time with her first husband, as he ''wasn't very nice''. We have no further information about this and understand that the papers relating to the case conference have been destroyed. Nothing is known about Jackie's first marriage.

By autumn 2002 we know that Jackie was married to her ex/husband and still living in Leeds. She called Police to report a domestic abuse incident when it appears that her ex/husband was regarded as the perpetrator and was removed from the home by Jackie's brother. Later that year their youngest son, Son 3, told a friend's family that he had run away from home and reported physical abuse from his mother and step-father. In spring 2003 the family was still living in Leeds. There is reference to the ex/husband working away from home and, on one occasion, he was arrested (but not convicted) in connection with assault on his youngest stepson (Son 3). In December of that year Jackie was thought to be experiencing a 'mental ill-health episode'.

In 2005 the family was still in Leeds and Son 2 reported that his step-father had punched his mother – Jackie's ex/husband was charged with assault and later convicted. There were other reports around the mid 2000s suggesting that the ex/husband was physically abusive towards Jackie at that time, and it appears that Son 2 died in around 2008 of natural causes, possibly related to drug misuse.

Information is limited; there must be questions about the episodes in 2003 and 2004 (and later) when Jackie was said to be involved in family violence: were they related to mental ill-health, or might they have involved coercion, control or possibly retaliatory abuse/ violent resistance (for more information about possible factors see 6.2 Domestic abuse in the Analysis section)? Drawing together what information we have, it appears that Jackie was living in a stressful domestic context over some considerable time with complex family relationships involving verbal and physical violence between family members. Jackie's friend believed that Jackie's ex/husband was an alcoholic and referred to financial problems: at one time she referred to facing eviction because of bills not being paid. Carol, her friend, understands that Jackie's ex/husband didn't pay the rent and the result was that they nearly got evicted. Alongside this Jackie appears to have had episodes of mental ill-health.

In 2018 Jackie moved to live on her own in a one-bedroom bungalow, referring in connection with rehousing to having recently split up with her partner but, by the time of her death, her ex/husband appeared to be living with her again. Carol described Jackie's ex/husband as a 'control freak' particularly where money was concerned. She believed that the ex/husband was an alcoholic and took advantage of Jackie's dyslexia, which had

resulted in her not being able to read or write. Carol also believed that the ex/husband 'wormed his way in' after Jackie moved into a bungalow and that Jackie had difficulty living independently. She felt that no-one liked Jackie's ex/husband and, as a result, family and friends stayed away when he was around: she herself didn't feel comfortable around him.

Carol only learned about Jackie's death from a local shop, as she used to keep away when Jackie's ex/husband was around.

5.2 Outline summary chronology

5.2.1 Events prior to January 2018 (the start of the review period)

There is evidence of reports to Police of domestic abuse between Jackie and her ex/husband dating back to 2002. There are reports that Child 3 was physically abused by his mother and step-father, and that Child 2 was physically abused by his mother. The context for these events is unclear (and further discussed in the Analysis section.) There are references to Jackie drinking/ being intoxicated but these references are at times that she was described as 'behaving erratically' or similar, raising the possibility of episodes being related to mental ill-health (eg on 29 December 2003 Police were called and noted she 'appeared to be having a mental ill health episode': she was taken to hospital.)

5.2.2 Scoping period starts: Concerns about mental health January 2018 to June 2019

In March 2018 Jackie was living in Leeds with her then husband (referred to in this report as her ex/husband). Her ex/husband expressed concerns about Jackie's mental health ('depression and anxiety') to the GP surgery but, when Jackie was seen by a GP, she said that her ex/husband was an alcoholic, disclosed an overdose two days previously, and referred to financial difficulties. She was subsequently seen by mental health liaison. She was seen regularly by a GP over the next few months, accessed some counselling sessions, and appeared to be improving in mood, until she received a letter informing her of forthcoming eviction when she phoned the surgery in distress and talked about concern that she might take another overdose if not supported.

In April 2018 Jackie applied for rehousing in Wakefield and stated in her application:

'I have recently split up from my partner and have nowhere to live. I am currently lodging short term with my friend (referred to in this report as Carol). I am unable to read or write so will need communicating with over the phone.'

In June 2018 (and in July 2018) she was noted to be staying with Carol, but this was said to follow an argument with her husband.

In late August 2018 she was offered a one-bedroom property, expressed an interest in it, and a pre-tenancy assessment was carried out by Housing. During the assessment, Jackie

referred to having dyslexia and struggling with reading, writing, and dealing with forms and information. She referred to Carol helping her with paying bills and budgeting, and said that she did not have a bank account of her own so her Employment and Support Allowance was paid into her friend's bank account.

Jackie's sole tenancy in the Wakefield area started on 1 September 2018 and an Estate Officer visited her in her new home on 10 September 2018, and recorded that matters were satisfactory with no concerns.

On 20 September 2018 Police, adult social care and mental health services became involved: she was 'showing obvious signs of mental health issues'. She was placed on a Section 136[5], and then detained under Section 2[6] of the Mental Health Act and admitted to an in-patient bed. Bruising on Jackie's arm was recorded when she was admitted and the plan was to ask her about it when she was well enough but there is nothing to confirm that this happened, although a body map was completed at the time. The notes indicate that there was to be consideration of a safeguarding referral when she had capacity to consent. Staff noted that she was verbally and physically aggressive at this time and she was initially in a Psychiatric Intensive Care Unit. That same day Housing received a nuisance complaint from a neighbour which stated that Jackie was regularly shouting, swearing at herself and slamming the communal gate. Later the neighbour informed Housing that Jackie was now in Hospital 1. It was reported that Jackie had lost her keys and that the property was not secure.

An Estate Officer rang Jackie's contact number on 24 September to discuss the situation and her friend answered, explaining that Jackie used her number 'because she is easily confused' and her friend supports her. Her friend confirmed that Jackie had been admitted to Hospital 1 and that she (the friend) had a key to the property but that Jackie had lost her other key. The Estate Officer confirmed with Hospital 1 that Jackie was in their care.

The next day, 25 September 2018, Housing was involved in changing the locks on her property due to the lost key and concerns that it was not secure.

Her friend (Carol) remained in contact with Jackie and was noted on 3 Oct 2018 to be her appointee: it was also noted that Jackie did not have her own bank account. On 5 October 2018 during the multi-disciplinary team meeting there was reference to Jackie wanting to open a separate bank account from that of her ex/husband and she described him as 'nasty'. Jackie was then noted as saying that her ex/husband was 'taking her money' on 7 October 2018, but there is no evidence that these concerns were explored or followed up at the time, or that financial abuse was considered and/ or a safeguarding referral

[5] Section 136 of the Mental Health Act (1983) authorises a police officer to take a person who 'appears … to be suffering from mental disorder and to be in immediate need of care or control' to a place of safety: for more information see https://www.legislation.gov.uk/ukpga/1983/20/section/136

[6] Section 2 of the Mental Health Act (1983) authorises admission for assessment – for details see https://www.legislation.gov.uk/ukpga/1983/20/section/2

considered. The mental health diagnosis was recorded as bipolar affective disorder – mania.

On 28 September Jackie went home on Section 17 leave[7]. The ward subsequently received a call from Housing after they had been contacted by her neighbour, who reported that Jackie was outside her own property, struggling to get in, and being vocal. The ward asked Jackie to return immediately and she told them that she had contacted the police. The police then contacted the ward and informed them that they were with Jackie and would return her to the ward. Jackie was informed on her return that unescorted section 17 leave had been rescinded.

The Section 2 was rescinded on 15 October 2018 and Jackie remained on the ward as an informal patient waiting for community support to be put in place. She agreed to a home visit with an Occupational Therapist. A Housing joiner met Jackie and her support worker from Hospital 1 at the property to hand over new keys to the property. Her ex/husband was found to be in the home and the Occupational Therapist felt that the condition of the property was unsuitable and it needed cleaning. There are references to neighbours telling Jackie that her ex/husband had entered/ left her home, and also to Jackie saying that he did not have access since the locks had been changed. She was discharged on 8 November 2018.

Over the following weeks it appears that she took her medications as prescribed and was furnishing her home, but was concerned about finances. On 16 November 2018 a Housing officer visited Jackie at the property to enquire about her welfare. She reported that she was now well supported and no further assistance was required. She was followed up after discharge by the Enhanced Mental Health Team and from January 2019 by Sustain. Sustain advised her to be wary of contact with her ex/husband who was calling round, and noted that her friend, Carol, continued to support her. On 3 Jan 2019 Jackie was visited by the Housing Cashwise team to discuss household financial management and outstanding claims for welfare benefits. She told them that she struggled with correspondence since being discharged from hospital, so the Cashwise officer gave assistance with letters Jackie shared, as well her TV licence, and her claim for Personal Independence Payment[8]. On 10 January 2019 the Cashwise team carried out a follow up visit to further progress Jackie's Personal Independence Payment claim and gather supporting information for the claim. Jackie asked the officer to contact Carol to explain the purpose of the visit as her friend was helping her with budgeting and household payments. The call was not answered, so a voicemail message was left.

[7] Section 17 of the Mental Health Act 1983 allows patients who are detained under the Mental Health Act to be given 'leave of absence' from the hospital in which they are detained for a specified or indefinite period subject to specified conditions. See https://www.legislation.gov.uk/ukpga/1983/20/section/17/enacted for more information.

[8] Personal Independence Payment aims to help with extra living costs for those who have a long-term physical or mental health condition or disability and difficulty doing certain everyday tasks or getting around because of that condition/ disability.

By 28 February the Enhanced Mental Health Team noted she was managing well, paying bills and had the furniture she needed, but the Sustain support worker was concerned about her ex/husband being at the property and passed these concerns on to the Mental Health Team. When the Team visited Jackie on 25 March 2019, a neighbour told them that her ex/husband appeared to be living with her: it was unclear whether she wanted him there or whether there was coercion/ compliance rather than consent. In April 2019 the Sustain support worker noted concerns about Jackie's memory and the possibility of financial abuse, and in May 2019 they noted concerns about self-neglect. On 30 May 2019 the Sustain worker completed a safeguarding form which logged an internal concern, in line with internal safeguarding policy and procedures.

In June 2019 it was agreed that Jackie's mental health had been stable for some time, that she was looking after her property, and therefore the Enhanced Mental Health Team would discharge her back to the care of her GP. A Sustain worker was visiting weekly at that time.

5.2.3 June 2019 to March 2021: Period of relative stability

Sustain supported Jackie to attend a hospital appointment in August to have moles checked (but Jackie later cancelled an appointment for mole removal saying it was not necessary).

In early September there are references to possible Age UK support when Sustain support ended, but an Age UK assessor informed Sustain on 18 September 2019 that they could not provide a suitable service for her and suggested the Housing Live Well team.

Regular support from Sustain continued after this. There is reference (October/ November 2019) to her ex/husband being admitted to hospital as an emergency after suffering seizures and to Jackie contacting the GP surgery with back pain on 6 December. The Sustain support worker was concerned that Jackie's anxiety seemed to be worse at that time and she was described as 'agitated and rocking', but the GP thought this possibly pain-related. Her ex/husband called 111 and there was a disjointed and difficult conversation when the phone was passed between Jackie and her ex/husband. The call handler arranged for a nurse to call Jackie back and the call-back closed with Jackie saying she was going to her doctor's.

On 12 December the Sustain support worker recorded that Jackie's ex/husband was living at Jackie's property after losing his own property, and that Jackie was worried about how this might impact on her tenancy, but by 4 February 2020 she asked the support worker to inform Housing that her ex/husband had moved back in.

March-June 2020 First national COVID lockdown - England

On 1 April 2020 there was a discontinued 999 call to Police, who called Jackie back and closed the log on the basis of an accidental dial. Later that month (17 April 2020) her ex/husband informed the support worker that he thought they both had COVID and on 28

April the support worker spoke with Jackie about support ending. Jackie wanted support to continue until the Personal Independence Payment tribunal but support was ended due to Jackie not having any housing needs and re-opened when Jackie was given a tribunal date (27 May 2019) and she was supported on the conference call. The support worker was informed that Jackie was awarded Personal Independence Payment back-dated to November 2018, but Jackie received a letter on 17 June saying she was not entitled to payments and the matter was unresolved until Jackie received a formal award letter on 5 October 2020.

5 Nov – 2 Dec 2020 Second national COVID lockdown England

Jan-March 2021 Third national COVID lockdown England

5.2.4 March 2021 to date of death: Period of concerns about physical ill-health

On 10 March 2021 Jackie called 111 and said she was on the floor unable to get up and had 'gone over on her ankle'. She was taken to the Emergency Department and found to have a fractured ankle. She was admitted overnight. Various follow up appointments followed and she had community nursing support and integrated care team support at home.

On 28 April 2021 Jackie's ex/husband called Police and requested an ambulance as Jackie had fallen and he could not pick her up. The ambulance service soon after contacted Police and said there appeared to be a domestic abuse incident, but, when Police attended, they found no evidence of a domestic abuse incident. Jackie had told the clinician from the 999-control room that her ex/husband would not help her and would not let her use the phone. When Police re-contacted the ambulance service Jackie could be heard saying that she had been on the floor all night and her ex/husband was heard saying 'no, it's only been an hour'. The attending ambulance crew submitted a social care referral. Jackie was discharged home on 10 May 2021 with support from the Integrated Care Team. The discharge letter gave a diagnosis of urine infection with constipation and fall onto right shoulder. She was later (19 May 2021) seen by a GP at home with a painful hand possibly related to the fall.

On 6 August 2022 Jackie called GP Care: she had fallen and had a swollen ankle and pain under her bust. A nurse practitioner called her back, and Jackie was given a surgery appointment but did not attend.

On 13 August 2022 Jackie called 111 and again the call was difficult with conflicting information from her ex/husband and from Jackie. Jackie confirmed that she had fallen and had cut her chin. A clinician called her back and she said she kept falling, had 'a pain under my bust and my chin is bleeding and I am scared now'. An ambulance attended. Her ex/husband was described as 'disgruntled' and Jackie agreed to a social care assessment. She was transferred to hospital with a working diagnosis of lower respiratory tract infection and discharged on 15 August 2022 without hospital social work team involvement

or knowledge. The same day adult social care received a referral from the ambulance service indicating Jackie was not managing at home.

On 9 September 2022 Jackie's ex/husband called 999 and told the call handler that Jackie was not breathing and he could not find a pulse. He was given instructions on providing cardiopulmonary resuscitation but replied 'she's dead…' going on to say 'she hasn't moved in 2 days… she is cold, and not breathing and no heartbeat.' He told the attending ambulance crew that Jackie was alcohol-dependent and often slept on the floor. The crew recorded that Jackie was obviously deceased. They identified almost 50 empty whisky bottles in the property – her ex/husband said they were all Jackie's. A neighbour spoke with the ambulance crew during attendance and said that the ex/husband was alcohol dependent, had a history of being 'nasty' and had locked Jackie out of the home on her return from hospital. Her ex/husband gave a different account and told crew he did not drink but was later seen smoking and drinking whisky. He was intermittently aggressive with crew. Police were informed of suspicious circumstances and asked to attend.

After Jackie's death, on 10 September 2022, an anonymous caller informed Housing that Jackie had died and expressed concerns about the poor condition of the property and about the welfare of a dog at the property. They also told Housing that Jackie's ex/husband was staying there. He subsequently proved residence at the address for the previous 12 months as part of the tenancy succession process and became the sole tenant.

6. Analysis

The key lines of enquiry fall into eight thematic areas:

6.1 Accessing Jackie's voice
6.2 Domestic abuse
6.3 Possible self-neglect
6.4 Possible neglect/ acts of omission by agencies in respect of Jackie's care in August 2022
6.5 Safeguarding
6.6 Systemic issues
6.7 Learning
6.8 Good practice

These are addressed in turn below. 6.9 looks at additional areas of relevance.

6.1 Accessing Jackie's voice

(a) When, and in what way, were Jackie's wishes and feelings ascertained and considered? and
(b) How was Jackie supported to make decisions for herself?

Agencies found evidence that Jackie's wishes and feelings were addressed during their contacts with her, that decision making was shared, and that Jackie exercised choice, although adult social care noted that she had hearing problems, struggled on the phone and sometimes was helped by another person: reports note the other person was sometimes her friend, sometimes a support worker, and sometimes her ex/husband. The Ambulance service report notes that Jackie retained information, used it in relation to the context, and sometimes (appropriately) requested support.

When her ex/husband was present during agency contacts it may have been more difficult for Jackie to express her wishes and/ or her expressed wishes may have been influenced by his presence. The Integrated Care Board report notes that health records did not note who the accompanying support worker was or which agency they were from, and recommends that the names and relationships of those persons accompanying an adult patient should be recorded (as would be the practice with child patients).

In addition, whilst Jackie's wishes were considered and appropriate responses followed, her ex/husband shared negative thoughts of her with the ambulance service in August 2022. He appeared resentful of her and appeared to be minimising her need for help and suggesting that she was lying. On 13 August 2022 Jackie told ambulance staff that she had no help from mental health services 'as (her ex/husband) told them they were not needed'.

(c) Were there concerns about Jackie's decision-making capacity?

There were concerns about Jackie's capacity to make decisions on 20 September 2018. Members of the public had called the police after finding her wandering the streets during the night, knocking on doors and threatening to kill people. Police attended and found Jackie at home, responding to unseen stimuli, playing an imaginary trumpet and singing songs repeatedly. According to Partnership Trust records 'it was reported that Jackie was lacking capacity to make the decision whether to attend A&E and remain there.' She was detained under Section 136[9] of the Mental Health Act, taken to the Section 136 suite, and, after further assessment, detained on Section 2[10] of the Mental Health Act. She was admitted to an inpatient ward. Concerns about her decisional capacity were noted during this episode of mental ill-health but the Mental Capacity Act (2005)[11] was not applicable on this occasion as she was detained under the Mental Health Act (1983)[12].

[9] Section 136 of the Mental Health Act (1983) authorises a police officer to take a person who 'appears … to be suffering from mental disorder and to be in immediate need of care or control' to a place of safety: for more information see https://www.legislation.gov.uk/ukpga/1983/20/section/136

[10] Section 2 of the Mental Health Act (1983) authorises admission for assessment – for details see https://www.legislation.gov.uk/ukpga/1983/20/section/2

[11] For more information about the Mental Capacity Act (2005) see this link: https://www.legislation.gov.uk/ukpga/2005/9/contents

[12] The Mental Health Act (1983) and the Mental Capacity Act (2005) both provide a legal means by which people can be deprived of their liberty and admitted to hospital on a formal basis when they lack capacity to consent to their admission and treatment. The Mental Health Act 'trumps' the Mental Capacity Act when

On 3 October 2018 the Partnership Trust notes that Jackie was visited by her friend who brought her £300. Jackie said that her friend was her appointee[13], as she did not have her own bank account; she trusted her friend with her finances. There was no record of any concerns or capacity assessments in relation to finance management, and no record that staff asked for documentation[14] regarding the appointeeship. This was a **missed opportunity** to enquire further and show professional curiosity. On 5 October 2018 Jackie referred to wanting to open her own bank account separate from her ex/husband (and described him as 'nasty'). On 7 October 2018 she referred to her ex/husband taking her money. This was a **missed opportunity** to consider possible economic/ financial abuse (see 6.2 below).

Conclusions regarding accessing Jackie's voice:

- Agencies endeavoured to address Jackie's wishes and feelings during their contacts with her and to support her to exercise choices.
- Concerns about her decision-making capacity (other than in respect of finances) occurred during times that she was regarded as mentally unwell and in need of treatment

6.2 Domestic abuse

Was there evidence of ongoing domestic abuse between the couple, were any disclosures made, and was any response appropriate?

There are several incidents of domestic abuse that pre-date the scoping period. Some involved incidents between her ex/husband and Jackie. Others involved Jackie's sons. Some incidents involved the ex/husband and Jackie and one of their sons. It is unclear which incidents occurred in the context of Jackie's mental ill-health, or whether coercion, control, or possibly retaliatory abuse/ violent resistance might have been involved.

We know of the following incidents between 2002 and 2008:

- 03 November 2002 a non-crime domestic abuse incident was logged by the Police and Jackie's ex/husband was warned under the Protection from Harassment Act to stay away from a specified address. We understand that this was routine procedure at the time in cases of domestic harassment.
- 08 December 2002 Son 3 told a friend's mother that he had been physically abused by his mother and step-father. This was recorded as an assault crime report but after further enquiries there was no further police action.

someone meets Mental Health Act criteria by reason of mental disorder. There is discussion of this in a paper by Dawson (2008) see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2443558/

[13] For further information about appointeeship see https://www.gov.uk/become-appointee-for-someone-claiming-benefits

[14] If the Department of Work and Pensions agrees with an application for appointeeship, they issue a form formally confirming that the appointee can act on behalf of the person claiming benefits.

- 26 April 2003 Jackie's ex/husband contacted Police saying that his wife had attacked him and Jackie was arrested but released from custody without charge.
- 27 April 2003 Police attended after a 999 call to the effect that Jackie had assaulted her ex/husband and Son 2. She was arrested and charged with assault. It is unclear in the legacy record how this progressed and she was not convicted.
- 11 June 2003 Police attended a 999 call from Son 2 but it appeared that he had a verbal argument with his mother and it was recorded as a non-crime domestic incident.
- 29 December 2003 Jackie's ex/husband made a 999 call to Police which was recorded as a non-crime domestic abuse incident and on attendance it appeared that Jackie was experiencing an episode of mental ill-health so an ambulance was requested.
- 19 March 2004 Son 3 made a 999 call concerning his mother drinking, having taken tablets and behaving 'erratically'. This was recorded as a non-crime domestic abuse report. An ambulance attended and Jackie was taken to a local hospital.
- 19 March 2004 A friend of Son 2 called 999 saying that Jackie was attacking Son 2. Police attended and no criminal offences were disclosed. It was logged as a non-crime domestic abuse report. The Domestic Abuse Unit risk assessed the incident as a Level B incident (it predated the use of the Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment known as the DASH[15], and a risk assessment called the SPECSS was then in use: this took into account five risk indicators - Separation, Pregnancy, Escalation, Cultural awareness, Stalking and Sexual Assault - and assessed incidents as needing an A, B, or C response.)[16]
- 7 April 2004 Son 2 called 999 reporting that his mother was 'lashing out at people'. Police attended and no criminal offences were identified. It was risk-assessed as a Level C incident and logged as a non-crime domestic abuse report.
- 23 January 2005 Son 2 called 999 and reported that her ex/husband had punched Jackie in the mouth. Police attended and arrested her ex/husband, who was charged with assault and convicted in February 2005, receiving a 24 month Community Rehabilitation Order.
- 30 April 2005 A member of the public reported a disturbance from a specified address. Jackie was arrested to prevent a breach of the peace and later released without charge. It was risk-assessed as a Level A incident but the implications of this are unclear, as risk assessment has changed since that time. Information from an unknown source was recorded to the effect that her ex/husband 'often beats (Jackie) and caused (sic) her to have physical injuries' but it is not known whether any action resulted following this information.

[15] For more information about the DASH see https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

[16] The report was passed to the Domestic Abuse unit where police staff Domestic Abuse coordinators reviewed the initial attending officer's risk assessment and conducted a second assessment on a Form 170A. On the basis of this they would assess the incident as requiring an A, B or C response. This was known as the Killingbeck Model. The process then indicated the appropriate response to the incident by the coordinator.

- 5 October 2008 Jackie's ex/husband called 999 saying that he and Jackie were having a domestic argument and were going to kill each other. Jackie was arrested to prevent a breach of the peace and this was not recorded as a domestic incident so did not go to risk assessment.

It is important in connection with this historical information to consider two important issues:

1. Fact - the only judicially established domestic abuse was when her ex/husband was convicted of assault on Jackie in 2005 after punching her.

2. Context - we have limited information about the context of the incidents noted above.

Downs and colleagues[17] looked at strategies that women use to protect themselves in situations of domestic abuse and noted that:

> *'Many arrests of women in domestic violence situations likely involved women's use of self-defence and are therefore inappropriate.'* (p. 42)

Swan and colleagues[18] also noted that women's violence usually occurs in the context of domestic abuse by male partners, and that women's physical violence is more likely than men's violence to be motivated by fear and self-defence. Terms used for this include retaliatory abuse and violent resistance. Thus, in situations where women are violent towards partners it is important to consider who is the primary aggressor since violent resistance is one of the ways in which women resist men's violence[19]. In connection with this it is important to be aware that Hester[20] found that women were three times more likely than men to be arrested when they were identified as the perpetrator.

If women intervene in abuse between their partner and a child, they risk themselves becoming a target for abuse from their partner.

Curiously, after autumn 2008 there were no further contacts with Police or the ambulance service until 2018 and, during that time, Jackie was resident in Leeds, moving to Wakefield in 2018. The incidents that involved Police during the scoping period did not appear to involve domestic abuse with one possible exception. On 28 April 2021 Police were contacted by her ex/husband saying that Jackie had fallen. The call was passed to the ambulance service who then got back to the Police saying that it appeared to be a

[17] See Downs WR, Rindels B, Atkinson C. Women's Use of Physical and Nonphysical Self-Defense Strategies During Incidents of Partner Violence. Violence Against Women. 2007;13(1):28-45.
[18] See Swan S, Gambone L, Caldwell J, Sullivan T, Snow D. A review of research on women's use of violence with male intimate partners. Violence Vict. 2008;23(3):301-14.
[19] Rajah V, Osborn M. Understanding Women's Resistance to Intimate Partner Violence: A Scoping Review. Trauma, Violence, & Abuse 2022;*23*(5):1373-1387.
[20] See Hester M. Portrayal of Women as Intimate Partner Domestic Violence Perpetrators. Violence Against Women. 2012;18(9):1067-82.

domestic abuse incident. An officer attended the address but found no evidence of a domestic incident and an ambulance was asked to attend. A further complication is that her ex/husband asserted at the time that his wife was 'bipolar' and in a manic phase: Jackie may therefore have been experiencing an episode of mental ill-health. It is unclear what led the ambulance service to be concerned that this was a domestic incident.

Within the scoping period, when Jackie was admitted to mental health care on 20 September 2018, multiple bruises were noted on her arm. A body map was completed, and the plan was to ask about them when she was well enough, but there is nothing to confirm that this happened. This was a **missed opportunity** to enquire further into possible domestic abuse. At the time Jackie was assessed as lacking capacity to consent to care and treatment and the notes indicate that there was to be consideration of a safeguarding referral when she had capacity to consent. The notes suggest that she was likely to lack capacity to consent to a safeguarding referral at the time, but a referral could have been made in her best interests so this was a **missed opportunity** for a safeguarding referral.

There are also disclosures of emotional abuse and possible coercion/ controlling behaviour before and during the review period:

- 22 September 2014 a neighbour contacted adult social care and said that Jackie was experiencing emotional abuse from her ex/husband and that he was controlling.
- 23 March 2015 Jackie attended the Emergency Department and said her ex/husband had been emotionally abusive and controlling over a number of years. She had also found out she was not on the tenancy agreement. She was seen by the Mental Health Liaison Team and shared similar information with them. She was signposted to local domestic abuse services. Again, this may have been a **missed opportunity** as professionals could directly refer into domestic abuse services. Direct referral is often more effective than sign-posting to facilitate engagement.
- 05 January 2019 Sustain noted that Jackie disclosed that her ex/husband put her down a lot and was controlling. She was not at that time in a relationship with him.
- 28 April 2021 In conversation with a clinician from the 999-control room Jackie said of her ex/husband: 'he won't help me' and 'he won't let me use the phone'
- 13 August 2022 her ex/husband told a 111-call handler: '*don't listen to Jackie, she talks nonsense, she is a hypochondriac and has high blood pressure… she is grossly overweight and will not help herself… she says she has passed out but she didn't'.* Later when ambulance crew arrived her ex/husband told them*: 'there is nothing wrong with her'.*
- 13 August 2022 Jackie told ambulance staff that she had no help from mental health services '*as (her ex/husband) told them they were not needed'*. This may have been an indication of control and of him isolating Jackie but at the time staff did not identify definitive indicators of domestic abuse, although they did make a social care referral.

Ambulance clinicians were aware that her ex/husband's attitude towards Jackie was negative. It appeared that he resented providing her with care, was dismissive of her, minimised her reasons for asking for help, and called her a liar on more than one occasion. These observations raise questions about care-giver abuse.

In addition, questions may also be raised by the fact that Jackie told the Sustain support worker on 12 December 2019 that 'she wasn't confident about telling (her ex/husband)' about him going to present himself at the Housing Department as homeless – why not? Was it because she was afraid of how he might react?

Questions are raised by agency reports about **possible financial/ economic abuse** at several points:

- On 23 March 2015 Jackie told Emergency Department staff that she had found out she was not on the tenancy agreement of their home.
- On 03 October 2018 Jackie was visited in hospital by her friend who brought her money. Jackie said that the friend was her appointee, as she did not have her own bank account, and that she trusted the friend with her finances. There is no record of any concerns or capacity assessments in relation to finance management, or that staff asked for documentation regarding the appointeeship. This was a **missed opportunity** to enquire further and show professional curiosity.
- On 07 October 2018 Jackie was noted to be loud and argumentative on the ward, wanting to contact her barrister as her ex/husband was 'taking her money'. There is no record that this was considered to be possible abuse or followed up in any way. This was a **missed opportunity** to follow up possible financial and economic abuse.
- 22 October 2018 On a home visit with an Occupational Therapist it was noted that Jackie's ex-partner was in the home: this was not explored either at the time or later. The context was that the locks had been changed on 25 September and the keys had been kept at Housing premises for safe keeping. The keys were not handed over until 22 October: this could have been another **missed opportunity**.
- 27 October 2018 After some home leave, Jackie said that a neighbour had told her that they had seen her ex/husband leaving the property but she said that the locks had been changed so he would not be able to gain access. This contradictory information wasn't followed up which suggests a lack of professional curiosity.
- 05 January 2019 Jackie told a Sustain worker about previous financial abuse from her ex/husband.
- On 28 February 2019 the Enhanced Mental Health Team visited Jackie and noted that she was using a cash machine but on 06 June 2019 Jackie stated she was unable to use cash machines due to difficulties with reading. This discrepancy is curious and could have led to further enquiry in a spirit of professional curiosity.
- 04 June 2019 the Enhanced Mental Health Team carried out a home visit and saw Jackie in the presence of her ex/husband. It was noted that benefits were in place and Jackie had numerous agreed budget plans, but some plans were being

overpaid taking a good portion of Jackie's monies, also that Jackie and her ex/husband were frequently using a local food bank. This might also have triggered further enquiry/ professional curiosity.

- The ambulance service individual management review records the following on 9 Sept 2022:
  '*During YAS attendance, the neighbour … approached crew and advised that (Jackie's ex/husband) is alcohol dependant and has a history of being 'nasty' and had previously locked (Jackie) out of the home on her return from hospital. When questioned about this, (the ex/husband) gave differing recollections of events and told crew he did not drink but was later seen sat smoking a cigarette and drinking whiskey.*'

During the in-patient mental health admission in autumn 2018 Jackie talked about having left her husband. She told a member of staff that he had phoned her and she had hung up. Yet he was in her home when a home visit with an Occupational Therapist took place on 22 October 2018 (after the locks had been changed by Housing). She also said at a multi-disciplinary team meeting on 1 Nov 2018 that he had reportedly entered her home and that, if he did it again, she would call the police. Later, in February 2019, a Sustain worker noted that her ex/husband was calling at the property and bringing her food and snacks for the dog. It appeared that he was assisting with practical tasks, but the worker advised Jackie to be wary of contact with him. He appeared to be at the property increasingly, and in April 2019 the worker noted that '(Jackie) appear(ed) to be relying on (her ex/husband) a lot to do things for her'. At that time the main concern was in relation to previous financial abuse and, on 30 May 2019, when a Sustain worker completed a Safeguarding Notification Form, they recorded 'concerns surrounding losing her tenancy due to ex-partner staying at the property due to previous financial abuse' (alongside concerns relating to self-neglect). By 12 December 2019 the Sustain worker noted that her ex/husband was now living at Jackie's property after losing his own property.

Conclusions regarding domestic abuse:

- Historically her ex/husband had subjected Jackie to physical domestic abuse but the only possible incident of physical abuse presented to professionals during the review period was on 20 September 2018 when bruising was noted at the time of a mental health hospital admission. Unfortunately, this was a missed opportunity and not followed up.
- There were disclosures of emotional abuse and coercive/ controlling behaviour before and during the review period.
- There was evidence of financial/ economic abuse during the review period and there were several missed opportunities to follow this up and enquire into the situation further.
- There was a missed opportunity to make a safeguarding referral during the hospital admission in September 2018.

6.3 Possible self-neglect

Was there evidence of Jackie lacking self-care or lacking care of the home environment to the extent that it endangered safety and wellbeing?

A Sustain support worker raised a safeguarding concern on 30 May 2019 in connection with possible self-neglect (see also 6.5 Safeguarding):

- *'Safeguarding concerns were raised in relation to (Jackie's) infected toenails, changes in moles and leaving the gas cooker on in the property. (There was) no other evidence of (Jackie) lacking self-care'*

An internal Safeguarding Notification Form was completed and the support worker encouraged Jackie to see her GP; arranged a home visit by a mental health worker; and planned to monitor the situation and report any further concerns to social care/ mental health or police as appropriate. The plan was reviewed and signed off by a manager and was in line with organisational protocols.

On three occasions ambulance service clinicians recorded concerns about the home environment. These were:

- 28 April 2021 '*the home environment is a little unkept and a little dirty and there are trip hazards. Jackie is struggling with worsening mobility and is finding it increasingly difficult to do her own daily care needs such as washing and dressing and making meals. Jackie's husband has been helping with these requirement(s) but is now struggling as Jackie's mobility is very poor and Jackie is becoming increasingly confused recently. Jackie's husband has asked for help and support from social services and Jackie also agrees.'*
- 13 August 2022 *'Lives in bungalow with husband and dog, large mobility scooter blocking only entrance to home which poses a fire risk, has ramp into home'.*
- 09 September 2022 the property was noted to be 'littered' with whisky bottles '*approx. 50 1 litre bottles in total'*.

The only other concerns noted were in the Partnership Trust report which notes that:

- September 2018 when the Housing Officer contacted the ward to inform staff that the locks had been changed, they said that: *'neighbours had informed them that the house was in a poor state, that there was excrement on the kitchen floor. There was a discussion about having the house cleaned before discharge'.*
- October 2018 the Occupational Therapist undertook a home assessment and the home was *'described as untidy, the kitchen had rubbish strewn about, dog food and utensils on the floor.'*

These two concerns were noted at a time that Jackie was receiving treatment for mental illness, and the home was cleaned prior to her discharge home, after which no additional concerns were noted about its condition.

A Sustain support worker saw all rooms of the property during support and found that the home environment was kept to an acceptable standard. Prompts were given to hoover and clean the property, but its condition would not have endangered safety or wellbeing.

Taking all the information together, there does not appear to have been evidence of Jackie lacking self-care. It appears instead that she recognised her need for support in some aspects of her daily life, appropriately requested it, and was engaging with that support. Those agencies in contact with her did not feel that lack of self-care was of a degree to trigger a response under multi-agency self-neglect guidance[21].

Conclusions regarding self-neglect:

- Although there was some concern about self-neglect in relation to Jackie this was not of a nature or degree to trigger a multi-agency response under applicable guidance and Jackie was engaging with support.
- Although there were some concerns about the state of Jackie's home environment, this was not of a nature or degree to trigger a multi-agency response and there was no evidence that it endangered safety and wellbeing.

6.4 Possible neglect/ acts of omission by agencies in respect of Jackie's care in August 2022

Was information shared appropriately and appropriate actions in line with existing agency policies and best practice taken in respect of
(a) Jackie's contact with an out-of-hours GP on 6 August 2022

In relation to the consultation on 06 August 2022, the Extended Access Service report notes that during a one-off consultation, often over the telephone, it may not be easy to identify potential safeguarding concerns, and that they will in future be reinforcing the need for staff to consider safeguarding and to discuss any concerns when a patient does not attend a face-to-face appointment.

In relation to the same consultation, the Integrated Care Board report notes that Extended Access Service is delivered by a separate service, and that, although both services share the same health record and practitioners from both care providers can see entries made by each other, practitioners from each provider will only see entries by the other if they are '*directed to view'*. Jackie's registered GP was not '*directed to view'* the entry from 06

[21] See Wakefield guidance regarding Self-neglect at: https://trixcms.trixonline.co.uk/api/assets/wynyy-wakefield/93597f81-0687-44a9-96e5-1cab3f2751f9/wakefield-multi-agency-self-neglect-guidance.pdf

August, and, as a result, Jackie's GP would not be aware of the consultation until Jackie attended a consultation and the GP reviewed previous entries.

Although the consultation on 06 August took place in line with usual practice there was a **missed opportunity** to share information between the Extended Access Service and Jackie's GP.

> *Was information shared appropriately and appropriate actions in line with existing agency policies and best practice taken in respect of*
> *(b) Jackie's hospital discharge on 15 August 2022?*

In relation to the hospital discharge on 15 August 2022, Mid-Yorkshire Trust notes that a discharge planning clinical note was commenced by a social worker in response to an ambulance service referral. Ambulance service clinicians had attended Jackie on 13 August and Jackie *'asked YAS clinicians for more support at home and consented to a social care assessment being completed, which was appropriately done and submitted.'* The referral had been received by social care and indicated that Jackie was not managing at home and to complete a 'transfer of care' if/ when appropriate for discharge planning. The report notes that it 'appears' that no transfer of care referral was made on discharge, and suggests a possible reason: Jackie's needs at that time might not have been such as to trigger a transfer of care form. The result was that Jackie was discharged without a referral from the ward to the hospital social work team. The ambulance clinicians had been in the home and had been in a position to have direct experience and observation of the conditions/ circumstances. In addition, Jackie had asked for more support at home and it would have been appropriate to be professionally curious about this.

The discharge planning clinical note is a separate document sitting outside the continuation of the clinical document where all care and treatment is documented, and there is no documented evidence in the clinical notes that the communication was received/ reviewed by the clinical team prior to discharge.

This was a **missed opportunity** to enquire into Jackie's home circumstances in a professionally curious manner.

The Adult Social Care report notes that, if the ward had submitted a referral to Adult Social Care, as requested, prior to discharge, Adult Social Care would have contacted Jackie and a Care Act assessment would have started. If the Hospital Social Work team had been made aware that Jackie had been discharged without their involvement, they would have made social care aware and appropriate activity to contact her would have followed.

In this case Hospital staff followed agreed process: an Ambulance Service referral, submitted at the time a person is conveyed to hospital, is closed if the ward discharges the person without submitting an 'assessment notification'. This agreed process is based on the assumption that the ward has the most up-to-date information and that the ward has deemed that the individual can be safely discharged without involving social care: the

person concerned may have no social care needs at the time they are discharged, or may not consent to a social care referral. Yet ambulance personnel may have direct experience of interpersonal conflict in the home and broader knowledge of home circumstances. We are told that the process has now changed, and, if an Ambulance Service referral has been received and the person is discharged without an assessment notification to the Hospital Social Work team, the Ambulance Service referral is assigned to social care for follow up.

> *Considering communication between all agencies, was information shared appropriately in line with existing policies/best practice, and were there any barriers to information sharing?*

Possible barriers to information sharing identified during the review include the following:

- Communications between out-of-hours primary care and the registered GP rely on the registered GP being 'directed to view' a record.
- The assumption that a person's social care needs assessed by a ward team will more accurately reflect their social care needs post-discharge when they will be in a different environment and may be in a situation of interpersonal conflict, compared with an assessment made by practitioners with direct experience of that environment. The process has, however, now changed.
- Being clear about the identity and role of persons who may accompany an adult to appointments/ consultations.

Organisational abuse can be described as follows:

> *Organisational abuse – including neglect and poor care practice within an institution or specific care setting like a hospital or care home, e.g. this may range from isolated incidents to continuing ill-treatment.*[22]

and the NHS Leadership Academy states that organisational abuse:

> *can take the form of an organisation failing to respond to address incidents of poor practice brought to its attention.*[23]

The missed opportunity for the Extended Access service to share information with the GP raises questions about how practitioners decide when to direct GPs to view. The independent management review notes that the Extended Access service practitioner said that, in similar circumstances in future, they would message the patient's practice to let them know that a patient did not attend a face-to-face consultation, but this raises the

[22] See NHS England guide to Safeguarding Adults at: https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

[23] See page 6 of NHS Leadership Academy (2019) document Safeguarding Adults and Young People Policy at: https://www.leadershipacademy.nhs.uk/wp-content/uploads/2019/07/Safeguarding-policy-and-procedure-2019.pdf

question of whether that decision should be a matter for an individual practitioner or whether the service should have guidance on this to assist practitioners.

The change in practice in relation to hospital discharge described above shows that the organisation involved in Jackie's hospital discharge is addressing what might be regarded as an incident of poor practice.

Conclusions regarding possible neglect/ acts of omission by agencies

- There is no evidence of organisational abuse in respect of Jackie's contact with an out-of-hours GP service on 6 August 2022
- There is no evidence of organisational abuse in respect of Jackie's hospital discharge on 15 August 2022
- Information was shared in line with policies and practice at the time
- The review has identified areas where information sharing might be improved.

6.5 Safeguarding:

Was safeguarding considered at any stage, were there grounds to raise a safeguarding concern at any stage, and might this have led to a change in practice?

The only organisation to identify and raise a safeguarding concern was Sustain. Internal safeguarding concerns were raised in relation to Jackie's infected toenails, the potential neglect of changes in moles, and leaving the gas cooker on in the property. The plan was to monitor the situation and take appropriate action if indicated. This was in line with organisational processes and protocols. The concern was raised in 2019.

The Care Act 2014 makes clear that financial abuse is included under Section 42 enquiry[24] when adults have care and support needs and are unable to protect themselves against that abuse, stating that:

"Abuse" includes financial abuse; and for that purpose "financial abuse" includes (a) having money or other property stolen, (b) being defrauded, (c) being put under pressure in relation to money or other property, and (d) having money or other property misused.

During the hospital admission in 2018 there were missed opportunities to follow up on Jackie's statements that suggested possible financial/ economic abuse (for more information see 6.2 domestic abuse).

Conclusions regarding grounds to raise a safeguarding concern:

- There were grounds to raise a safeguarding concern regarding possible financial/ economic abuse during Jackie's hospital admission in 2018 and this might to have led to different management.

[24] For further information see https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

- There was a missed opportunity to follow up and show professional curiosity in relation to possible physical abuse during that same admission.

6.6 Systemic issues

Did any systemic issues impact on Jackie's care/ service delivery, including, for example, agency resource/ capacity issues, austerity, the COVID pandemic, pressures relating to hospital discharges?

Sustain identified a possible issue with missing case notes. It is thought that telephone support during COVID lockdowns may not have been accurately recorded.

There were changes in how health care was delivered during periods of lockdown and post-lockdown but it does not appear that that these changes impacted on Jackie's care, nor was there any evidence of resource/ staffing issues impacting on her care.

Conclusions in relation to possible systemic issues:

- There was no evidence of systemic issues impacting on Jackie's care or service delivery to her.

6.7 Learning

What learning will your organisation take from this review and how will any changes be implemented?

The learning detailed below is taken from agency independent management reviews.

Extended Access Primary Care Service

- Extended Access GP Service management team has reflected that, during a one-off consultation, often over the telephone, it may not be easy to pick up on potential safeguarding concerns. As a result of this the need for staff to consider safeguarding and discuss any concerns when a patient does not attend a face-to-face appointment will be reinforced as per organisational safeguarding policies.
- Extended Access GP Service will now be including a specific safeguarding section in regular team updates and have a safeguarding link on the service app which provides instant access to all the relevant policies and information.

South West Yorkshire Partnership NHS Foundation Trust

- The Trust identified that no formal mental capacity assessments were conducted in relation to management of finances.

The Mid Yorkshire Teaching NHS Trust

The Trust identified learning in relation to hospital discharges:

- At the time of commencement of the review the Discharge matron discussed the incident with the Hospital social work team manager and requested that physical contact is made with the ward or discharge coordinator should an ambulance service alert need following up. This information also needs inputting on to clinical notes in conjunction with the discharge documentation to prevent key information being missed.
- The acute admissions unit does not have a discharge coordinator and relies on clinical teams to facilitate the discharge planning process. The Trust identified a possible disconnect here.

Turning Lives Around, SUSTAIN Wakefield

- Identified a need to ensure accurate case note recording and that professional calls are accurately documented and followed up.

Wakefield Council – Adult Social Care

- There was possibly an opportunity to consider care and support needs during Jackie's last hospital admission and the referral from the ambulance service, but unfortunately she was discharged without the Hospital Social Work team involvement.

Wakefield District Housing

No lessons identified.

West Yorkshire Integrated Care Board

No lessons identified.

West Yorkshire Police

No lessons identified – noted that the police response to calls for service in relation to mentally disordered people has been subject to national review and a new strategy is in process of being implemented.

Yorkshire Ambulance Service

No lessons identified: the Ambulance Service report that initiatives already in place should address the lessons identified in this Safeguarding Adult Review, namely:

- In 2022 Domestic Abuse was included within the Level 2 and 3 Safeguarding Training. Level 2 training is undertaken by call handlers in both 111/999 control rooms and Level 3 safeguarding is being rolled out across all front line clinical staff.

- Yorkshire Ambulance Service has introduced a new role: Specialist Domestic Abuse Practitioner (SDAP). This person came into post in September 2023. The aim of the role is to promote and improve the Trust's response to domestic abuse, by increasing knowledge and resources available to staff when dealing with patients' experiencing domestic abuse.
- Since October 2023, the Trust has a dedicated Domestic Abuse Intranet Page with information about domestic abuse, resources, practical guides, and a service directory.
- The Trust has developed its own e-learning domestic abuse package which looks at identifying indicators of domestic abuse and undertaking triggered enquiry.
- The Specialist Domestic Abuse Practitioner will monitor numbers of staff engaging in training.
- The Trust's safeguarding team are recommending that the training should me mandated to all staff.
- The Specialist Domestic Abuse Practitioner is working with the project officer within 111 to review and update their domestic abuse training. And deliver it as part of 111 staff induction.

6.8 Good practice

What good practice was evident in this case?

The independent management reports identified aspects of good practice and not all are set out here. This section sets out good practice that stood out for the Independent Reviewer as being beyond what might be expected to take place as routine.

Sustain delivered support consistently over a period of approximately two years, liaising proactively with other agencies as necessary, and support was extended when Jackie requested support with her appeal related to Personal Independence Payment.

Mid Yorkshire notes that a trial is underway for a social worker link between Acute Admissions Unit and the Emergency Department. The trial will support discharge planning. The link worker will attend board rounds[25] and there is a direct telephone number for referrals: the transfer of care form will no longer be required.

The West Yorkshire Integrated Care Board noted that the GP practice concerned with Jackie has in post a Safeguarding Administrative Officer who undertakes and supports safeguarding administrative practices. This has been identified as a proactive innovation and showcased as an example of good practice.

[25] A board round is a process intended to improve communication among the multi-disciplinary team, enhancing team working and providing a more coordinated approach to discharge planning. It is a summary discussion of the patient journey, where all team members assemble to briefly review the progress of patients. Board rounds are expected to provide efficient goal setting and result in improved care for patients as well as improved pathways to discharge.

6.9 Additional areas of relevance

Jackie was aged over 60, known to have mental health problems and dyslexia (with the result that she was unable to read or write). She also had physical health challenges including respiratory problems and falls with resultant injury. All of these factors may be relevant to what happened to her.

The Mental Health Foundation's document Fundamental Facts about Mental Health[26] points out that the relationship between domestic abuse and mental health problems is bidirectional, i.e., that women who are experiencing domestic abuse are more likely to have mental health problems, and women with mental health problems are more likely to experience domestic abuse (compared with women in the general population).

It seems likely from our limited knowledge of her background that Jackie lived in a stressful domestic context involving verbal and physical violence between family members over some considerable time. At times she was seen by others as an instigator of abuse but it is possible that these were incidents of unrecognised retaliatory violence/ violent resistance (see discussion under 6.2 Domestic abuse).

Her mental health problems and physical health challenges rendered her more vulnerable to coercion and control and to economic/ financial abuse, as did her need for care and support. Her health problems may have changed the power dynamic between her and her ex/husband. She accepted help from him after being discharged to live independently, and his input appears to have increased over time. Gradually he moved into her property (after losing his own home) although she said that they were not in a relationship. The definition of domestic abuse in the Domestic Abuse Act (2021) does not require two people to be in an intimate relationship: Jackie and her ex/husband were living together and had previously been in an intimate relationship which meets the criterion of being "personally connected"[27]. Her mental and physical health problems may well have impacted on her ability to be independent and to exercise choice. There is evidence to suggest that her ex/husband resented caring for her and was negative about her: this may have resulted in her being subject to abuse from someone who was functioning as her carer. That also raises the question of whether her ex/husband should have been offered a carer's assessment.

[26] See https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf p. 51
[27] See the Domestic Abuse Act (2021) https://www.legislation.gov.uk/ukpga/2021/17/part/1

7. Conclusions and recommendations

7.1 Conclusions

1. Accessing Jackie's voice: Although agencies endeavoured to hear and respect Jackie's wishes and feelings, when her ex/husband expressed negative feelings about her and about caring for her, these negative comments were not challenged or further enquired into. In a caring context it is important to hear and address the experiences of both partners.

2. Domestic abuse: There were several missed opportunities in relation to possible domestic abuse, most notably in connection with financial/ economic abuse, when further professionally curious enquiry would have been appropriate or a safeguarding concern could have been raised.

3. Ambulance service call-handlers' conversations with Jackie's ex/husband are suggestive of care-giver abuse.

4. Possible self-neglect: There is no evidence of self-neglect that endangered safety or well-being.

5. Possible neglect/ acts of omission by agencies: There is no evidence of neglect/ acts of omission by agencies.

6. No safeguarding concerns were raised apart from an internal safeguarding concern raised by Sustain and dealt with appropriately in line with their procedures.

7. Communication: There were several occasions where communication could have been better; particularly between the Extended Hours Primary Care service and Jackie's GP practice and in relation to Jackie's final hospital discharge.

7.2 Recommendations

7.2.1 Recommendations from the Individual Management Reports

Adult Social Care

Yorkshire Ambulance Service referrals are being sent to Social Care Direct for community follow up if the adult has been discharged from hospital without social care involvement.

Extended Access Primary Care service

To implement a safeguarding section in the team update to ensure that all staff members who work for Extended Access Primary Care service are provided with information relevant to safeguarding children and adults within the GP Care setting, including update, lessons learned from incidents, and safeguarding training available across the Integrated Care Board.

To prepare a case study about this patient review so that lessons learned can be shared with the Extended Access Primary Care service team, highlighting the importance of communicating with practices.

South West Yorkshire Partnership Foundation Trust

No new recommendations.

Mid Yorkshire Teaching NHS Trust

No new recommendations.

Turning Lives Around, SUSTAIN Wakefield

No new recommendations.

Wakefield District Housing

No new recommendations.

West Yorkshire Integrated Care Board

GP practices to use professional curiosity to establish and record the names and relationships of individuals attending appointments with a patient.

West Yorkshire Police

No new recommendations.

Yorkshire Ambulance Service

No new recommendations.

7.2.2 New single-agency recommendation

Extended Access Primary Care service

The extended access service to develop guidance for practitioners on when a GP practice should be directed to view details of an extended access contact.

The aim of this recommendation is to assist practitioners in making decisions about when to direct GPs to view details of an extended access contact.

7.2.3 *Multi-agency recommendations*

Domestic abuse:
Training on domestic abuse for all agencies should include coercive control, the offence of Controlling or Coercive Behaviour in an Intimate or Family Relationship[28], abuse by family care-givers, abuse of care-recipients, and the interface with an individual's care and support needs which may render them more vulnerable to some forms of abuse.[29]

This recommendation aims to ensure that both coercive control and abuse in caring contexts are not missed but are recognised and addressed by health and social care practitioners as forms of domestic abuse.

All agencies to provide relevant frontline staff with DASH training.

This recommendation aims to assist practitioners in identifying financial/ economic abuse and coercive controlling behaviour.

When individuals make disclosures suggestive of emotional abuse and/or coercive/ controlling behaviour and/or financial/ economic abuse these disclosures should be followed up even when someone is regarded as mentally unwell.

People with mental health problems are at increased risk of domestic abuse (including economic/ financial abuse) so it is important that any suggestion of domestic abuse is followed up.

Professional Curiosity:

Training on the skills and importance of professional curiosity and the exploration of this within clinical or professional case management supervision should be provided by agencies. This would allow for a more comprehensive understanding of an individual's circumstances and prevent 'opportunities missed' to fully explore potential safeguarding risks.

Communication:

When people attend health and social care appointments with another person it is good practice to record details of who that accompanying person is (name and relationship) and, if they are a practitioner, to record details of which agency they work for.

This will assist in liaison between agencies and may help in identifying influences on individuals

[28] See https://www.legislation.gov.uk/ukpga/2015/9/section/76
[29] It worth noting that even when victims are not identifying as being in a 'relationship', domestic abuse can still occur and should be explored (see page 34 for further details on this.)

Appendix 1: Glossary of abbreviations

A&E	Accident and Emergency Department
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment tool
GP	General Practitioner
IMR	Individual Management Review
NHS	National Health Service
NHS111	A service to call when medical help is needed urgently but the situation is not life-threatening.
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review

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