Oldham
Safeguarding Adults Board

Oldham Partnership

Safeguarding Adults Review in the Case of Vince
Final Report

Period Reviewed: 30th January 2016 to Date of Death

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1. Introduction and background to Vince

This Safeguarding Adults Review (SAR) was commissioned by the Oldham Safeguarding Adults Board under guidance contained in the Care Act (2014).[1]

The review offers condolences to Vince's family on their sad loss and thanks them for the contributions to the SAR.

The SAR relates to Vince, an older man who died in hospital in January 2017. In the 12 months before his sad death, Vince experienced a deterioration in his physical and mental health.

According to Vince's family, he had been an active and sociable man throughout his life. Vince was of south Asian heritage and had lived in the UK for many years. He spoke English as a second language.

Using the criteria set out in the Equality and Diversity Act (2010), Vince met the criteria for the protected characteristics of race and religion and belief.[2]

Prior to the period under review, Vince's family had arranged for him to receive support at home via a private carer arrangement. The family had CCTV installed in Vince's home so that they could keep an eye on him, and be alert to any difficulties that he may be experiencing. This appears to have worked well until the carer decided to retire, which left the family having to seek an alternative arrangement. It was at this point that they contacted Adult Social Care (ASC) to seek support in meeting Vince's ongoing needs.

During the period under review, it was noted by practitioners that Vince was able to communicate his day to day needs and basic care needs to them in English. However practitioners observed that Vince's ability to communicate his needs diminished as he became more unwell, and as his mental health deteriorated. He also needed help and support in communicating more complex needs, and occasionally language line was used to assist in communicating with Vince.

As he aged Vince experienced some difficulty mobilising, and his treatment and care needs increased. He lived in close proximity to his son, who assisted with this. Vince's daughter lived in another part of the country during the period under review, however she assisted whenever she could with Vince's care and was in frequent touch with him and with agencies on his behalf.

At the commencement of the period under review Vince, was living in his own home and receiving support from his family, and from a range of services including General Practice, District Nursing Service and Home Care Services (commissioned by ASC from a private sector provider). Vince's family had frequent contact with agencies and advocated on Vince's behalf at this time.

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[1] http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

[2] https://www.gov.uk/government/organisations/department-of-health/about/equality-and-diversity

During the period under review Vince also received respite care in a local residential home, and received acute services in local hospitals.

2. Methodology and Conduct of the SAR

2.1 Overview of the Methodology

The SAR was commissioned in June 2018 (almost 18 months after Vince's sad death). The decision to conduct a SAR had been delayed due to discussions around whether the case met the criteria for the conduct of a SAR. (This was mainly due to delays in the safeguarding enquiry process).

A case conference was held to review the case in August 2017, at which it was decided that SAR referral should be made. A referral to the SAR panel was made in March 2018 and it was decided that the case met the criteria for the conduct of a SAR.

In June 2018 a SAR was commissioned by the Safeguarding Adults Board. The SAB appointed an independent reviewer, Maureen Noble, to lead the review. The Reviewer has extensive experience in the conduct of a range of serious case reviews and investigative processes and is the Independent Chair of a Safeguarding Adults Board in another borough of Greater Manchester. Maureen had no previous professional contact with the family or any practitioner or agency involved in the review.

It was agreed that a concise review would be undertaken using a blend of SCIE Learning Together and 'Welsh' model methodology, which incorporated using records and written reports, with a strong emphasis on learning from practitioners who were involved in providing care to Vince.

A panel was convened with panel members representing the following agencies:

Agency
Oldham Council
Oldham Clinical Commissioning Group (CCG)
Pennine Care Foundation Trust (PCFT)
Pennine Acute Hospital Trust (PAHT)
Greater Manchester Police (GMP)

The panel met on three occasions to oversee the review and agree the final report.

Agencies were asked to provide detailed chronologies and an analysis of their involvement, including any learning for the agency and observations regarding multi-agency learning.

A practitioner learning event was held which was attended by practitioners from District Nursing Services, Police, Adult Safeguarding (CCG) and Adult Social Care. A further practitioner learning event was held in October 2018, with a final discussion with practitioners being held in December 2018.

Visits were made to the Care Home that provided respite care to Vince, and to the General Practitioner with whom Vince was registered. Ongoing contact with the GP took place via the Practice Manager.

NB: Despite numerous attempts to engage the Home Care provider in the review, at the time of writing, there has been no engagement.

2.2 Involvement of Vince's Family in the Review

Family members contributed to the review by telephone interview (as they were unable to attend a local meeting). The final draft report was shared with family members, they did not make any comments on the final report.

Both Vince's daughter and son said that their primary concerns in relation to Vince's care were in relation to co-ordination and communication across agencies. They felt that the care that Vince received was generally of a good standard.

They felt that, at times during the period under review, agencies did not respond to their needs and that agencies were not proactive in communicating with each other. They felt that improved communication would have eased the pressure on them as a family, and would have helped them to provide optimum care and support to Vince.

Their key message to the review was that agencies should work more effectively together to care for people like Vince who have multiple, and sometimes complex, needs.

2.3 Key Lines of Enquiry/Questions to be answered by the Review

The panel agreed the following key lines of enquiry to be answered by the Review:

1. Were assessments and reviews of Vince's medical needs timely and appropriate? Were any multi-agency assessments undertaken?

2. Were actions resulting from assessments undertaken in a timely manner? Were any safeguarding issues identified in relation to Vince? If so, how were these identified and responded to?

3. Was Vince consulted in relation to his care? Were assessments of Vince's capacity undertaken? If so, by whom and what were the outcomes?

4. Were Vince's family consulted in relation to his care?

5. Were matters of diversity (race, culture, religion, gender) identified and addressed?

6. Was communication between practitioners/agencies of a good standard? How could communication be improved?

7. What, if any, modifiable practice has been identified by agencies and by the review?

2.4 Information Provided to the Review

The review received chronologies and learning summaries from the following agencies:

- Adult Social Care (Oldham)
- General Practitioner
- Greater Manchester Police
- Pennine Care Acute Trust
- Pennine Care Foundation Trust
- Care Home (one to one interview)

2.5 Parallel Processes

There have been no criminal investigations, single agency reviews or other investigative processes in relation to Vince's death.

The Coroner was informed of the circumstances of Vince's death, however it was decided that no inquest was required as Vince died of natural causes.

3. Key Events

The period under review began in January 2016. At this time Vince was living in his own home, and was receiving regular visits from health professionals and from a private home care agency, commissioned by Adult Social Care.

On 31st January 2016, Vince told a health professional who was visiting him at home that his son had hit him. A referral was made by the Emergency Duty Team to police. The referral was documented and submitted for review by supervision, and was subsequently allocated for a strategy meeting on 1st February.

The strategy meeting took place on 1st February and the case was closed on 3rd February as, when Vince was visited by a social worker, he denied making the allegation.

On 8th September the District Nurse raised a safeguarding alert, as she was concerned about the length of time that Vince had been left alone, and was unable to contact family members.

The following weekend Vince entered a local care home for respite care, as the family had a commitment in another part of the country.

Vince's daughter liaised closely with the care home and was specific about Vince's needs (particularly adherence to a specific diet) during his stay. Vince spent three days in the home, during which time he appeared to settle and showed no signs of unhappiness or distress.

On 29th September, Vince received a memory assessment and a diagnosis of Alzheimer's disease was made.

On 10th October, the District Nurse made a referral to the moving and handling team (she also raised the possibility of permanent care being needed, but noted that this would require a multi-disciplinary meeting). The moving and handling assessment did not take place until end November 2016.

On 21st November, Vince presented to A&E following referral from District Nurse who had concerns about a deterioration in Vince's condition, and about Vince being on his own for long periods of time. Vince was diagnosed with a urinary tract infection and was discharged to home with his son.

On 17th December, Vince entered the same local care home for respite care. The manager of the Care Home told the review that they noticed that Vince had deteriorated in terms of his physical and mental health and that, by this time, he had a number of pressure sores.

The plan was that Vince would return home following the agreed period of respite care, however, the discharge did not take place. Vince's daughter came to collect Vince as planned and was unhappy that the home were not prepared to release him to her care at that time.

On 28th December, whilst Vince was still residing in the care home, staff became more concerned about his health. An emergency ambulance was called and Vince was admitted to a local hospital. Vince was diagnosed with sepsis and remained in hospital until his sad death on 23rd January 2017.

4. Learning from the Review

4.1 Addressing the key lines of enquiry

4.1.1. KLOE 1: Were assessments and reviews of Vince's medical needs timely and appropriate? Were any multi-agency assessments undertaken? Were actions resulting from assessments undertaken in a timely manner?

Assessments and reviews of Vince's medical needs took place, although these were not always in line with expected policy and practice, and actions resulting from assessments did not always take place in a timely manner. Pennine Care has identified a number of issues in relation to completion of assessments and reviews which were not in line with Trust policy and these are addressed in their single agency action plan.

Vince was assessed by ASC as requiring moving and handling equipment to enable him to be cared for at home, however this assessment was delayed which ultimately had a 'knock on effect' on the provision of the equipment. The District Nurse made a referral for moving and handling equipment in October 2016, the equipment was not installed until the end of November 2016.

The delays in acquiring this equipment, the lack of communication between agencies and the lack of communication with the family at this time created unnecessary delays to Vince's care. The review makes a recommendation that immediate attention is required to ensure that delays in the system are rectified as a matter of priority and that essential equipment is provided at the time of need.

There appear to have been no multi-agency assessments undertaken at any time during the period under review.

The review has concluded that it would have been beneficial to convene a multi-agency discussion regarding Vince's treatment and care, and his pathway through services.

It would also have been good practice to have discussed an 'end of life' plan for Vince between professionals and with his family. There is no evidence that this took place. In this regard co-ordination of multi-agency involvement by ASC fell below the standard expected. It was noted by the review that the District Nurse was proactive in liaising with ASC and highlighting Vince's care needs and in making safeguarding alerts. This was good practice.

4.1.2. KLOE 2: Were any safeguarding issues identified in relation to Vince? If so, how were these identified and responded to?

On 31st January 2016, Vince made an allegation that his son had hit him. This was reported to ASC by a health professional who raised an adult safeguarding concern via EDT. This was picked up by police and a strategy meeting was held the following day. Two days later, when visited by a social worker, Vince denied that he had made the allegation and the case was closed and the matter was not progressed further.

4.1.3. KLOE 3: Was Vince consulted in relation to his care? Were assessments of Vince's capacity undertaken, if so by whom and what were the outcomes? Were Vince's family consulted in relation to his care?

The review saw evidence that professionals who had frequent contact with Vince in a number of settings (District Nurses, Care Home staff) spoke to Vince about his day to day care needs, and good practice was evident in using creativity and sensitivity to communicate effectively with Vince.

It is apparent that communication with Vince became more difficult as his dementia progressed**,** however in general, language was not a barrier in relation to day to day aspects of his care.

The review could see no evidence of any best interest meetings having taken place, nor do there appear to have been any formal decision specific assessments of Vince's capacity to make decisions based on guidance contained in the Mental Capacity Act (MCA).

There are a number of occasions on which the General Practitioner consulted with Vince's family about his care, rather than speaking to Vince himself about matters that concerned him. There is no indication that the GP sought consent from Vince to discuss matters with

his family on his behalf. There is no indication that the GP considered MCA in making decisions regarding consultation with Vince's family. On one occasion the GP withdrew Vince's medication at the request of a family member, this appears to have been without any consultation with Vince.

4.1.4. KLOE 4: Were matters of diversity identified and addressed?

The review could see no evidence that matters of equality and diversity were not adequately addressed.

Practitioners who had frequent contact with Vince reported that they were able to communicate with Vince at a basic level and, when required, the services of language line were used.

There appears to have been no formal assessment of whether Vince had any additional needs in relation to race, culture and other aspects of diversity. The review therefore makes a general recommendation about good practice in relation to meeting the requirements of the Equality and Diversity Act in all services.

4.1.5. KLOE 5: Was communication between practitioners/agencies of a good standard? How could communication be improved?

There is evidence of communication between practitioners and agencies in relation to Vince's day to day care needs, however there is a lack of consistency and continuity in planning and providing care to Vince, particularly in relation to multi-agency working.

Examples of good practice are evident i.e. communication from the District Nurse during the period August to December 2016. The Care Home also demonstrate good practice in communication with the District Nurse and with the General Practitioner.

The absence of information from the Home-care provider means that the review is unable to comment on the quality and frequency of communication between that agency and other professionals.

There is a notable absence of any multi-agency plan, multi-agency meetings and discussions. A lack of co-ordination by ASC resulted in agencies working in silos to provide care and support to Vince and his family. This was noted by Vince's family as being a key area for improvement.

4.1.6. KLOE 6: What, if any, modifiable practice has been identified by agencies and by the review?

The review has noted that a 'cluster' model of service co-ordination and delivery will facilitate stronger joint working arrangements in the future and recommends that the SAB use this case as an illustration of where benefits can be gained from joint working and integrated service delivery.

The review has identified a number of areas in which practice could be modified as follows:

4.1.7. The Voice of the Adult (Making Safeguarding Personal)

The findings from the review highlight the need to ensure that all practitioners and agencies are focused on seeking and listening to the voice of the adult and understanding their daily lived experience.

Practice could be strengthened in relation to obtaining consent (directly or through best interest meetings); using Mental Capacity Assessments; appropriately involving family and other advocates. A recommendation is made in this regard.

4.1.8. Multi Agency Communication and Joint Working

The review highlights a lack of consistency in multi-agency communication and joint working. Agencies and practitioners did communicate, however there was a lack of co-ordination (i.e. a lead professional/single point of contact) which resulted in silo working. Opportunities to use multi-agency meetings to share information and to plan and review care were not taken.

The complexities of Vince's circumstances may have been underestimated by single agencies. A more robust multi-agency approach would have enabled practitioners to see Vince's needs in a more holistic context.

The review makes a recommendation regarding multi-agency working and the use of locality based 'cluster' arrangements to strengthen multi-agency communication and joint working.

4.1.9. Working with Families

Vince's family wanted to be involved in his care and were in frequent contact with agencies, however, the review highlights that opportunities were missed to engage with them as carers and contact with them by ASC was sporadic and reactive.

The review highlights the importance of harnessing family commitment and involvement and supporting them in their roles as carers (through both formal carer assessment and the provision of information, guidance and support)).

The need for a clear and informed discussion with families in relation to matters of consent, best interest and capacity assessment is highlighted by the review.

End of life planning that involves families is good practice and should be in place.

4.2 Wider Learning

Wider learning was identified in the practitioner events which, although not included in the recommendations, will be useful to take forward to strengthen practice and the safeguarding system as a whole.

- Issues identified in relation to staff turnover (cluster based working should improve this).
- There was no health input to the strategy discussion held following the allegation in January 2016, only police and social care were involved. Health should be included in strategy meetings.
- Relationships between statutory and private providers (i.e. the Home Care agency) need to be clarified so that practitioners are clear about roles, responsibilities and governance.
- Developing support via training (e.g. cluster based supervision, champions in each agency; lead professionals; understanding and clearly defined role of social care) would be good practice.

5. Conclusions and Recommendations

Conclusion 1

The review found that the guidance contained in the Mental Capacity Act in relation to policy and practice, best interest decisions, mental capacity assessments, consent (and power of attorney) was not consistently applied in this case.

Recommendation 1

The SAB should receive assurance that all agencies have the necessary knowledge and understanding of the requirements of the Mental Capacity Act to discharge their statutory responsibilities.

Recommendation 2

The SAB should be assured that General Practitioners are offered, and are participating in, training to increase awareness and knowledge of Mental Capacity Act requirements.

Conclusion 2

Vince's family were proactive in providing care and support to Vince throughout the period under review. Opportunities were missed to harness family support and form constructive relationships with them.

Recommendation 3

The SAB should receive assurance that all agencies have clear policies and a proactive approach to working with families. This should include sharing information; care planning; appropriate levels of decision making (that are MCA compliant); pathways for end of life care.

Conclusion 3

Opportunities to involve Vince in self-determining his own care were missed and the GP devolved decisions to Vince's family without his consent.

Recommendation 4

The SAB should receive assurance that General Practitioners are fully conversant with the requirements of MCA in relation to matters of consent and are supported in delivering the principles of Making Safeguarding Personal.

Conclusion 4

On a number occasions staff experienced concerns about Vince's safety, however, the lack of multi-agency discussion and joint working meant that these safeguarding concerns were not escalated.

Recommendation 4

The SAB should be assured that all agencies know when and how to escalate safeguarding concerns. The SAB should also be assured that multi-agency discussions regarding safeguarding concerns are built into local care planning and delivery