Dudley Safeguarding People Partnership

Adult B

Safeguarding Adult Review Practitioner Briefing December 2021

WHO SHOULD READ THE SAR?

Any practitioner and manager whose work brings them into contact with Adults and their families.
For further information on SAR's visit the Dudley safeguarding website

BACKGROUND INFORMATION

Adult B was a white British male in his early 80s he lived in an Extra Care housing complex with his wife, who was also his informal carer.
Adult B jumped from the balcony and had locked a door behind him to prevent anyone stopping him. He sadly died from the injuries sustained from the fall.

POINTS TO CONSIDER

It is not clear whether Adult B intended to end his life, or what was his state of mind was at the time of the incident and whether it was a result of deterioration in his mental health. He had several health problems which included a diagnosis of vascular dementia.

Adult B's tragic death was the unforeseen and it had not been seen as a potential risk by the social workers who had visited on the day he died, although his presentation and behaviours were escalating. The professionals involved had tried to respect his wishes and had offered support to his wife, and at times these needs were incompatible.

Professionals had reached the reasonable conclusion that his needs could not be solely met by his wife, and she had accepted, albeit reluctantly, that her husband needed a level of care which she could not provide alone.

OVERVIEW OF LEARNING

- **There was a lack of face to face assessment by the GP practice**

Adult B had not been seen in person at his GP surgery since the 26th September 2018, assessments and medication reviews and changes were based on conversations with Adult B's wife or other health agencies, but this did not have had a direct impact on his death. During the scope of the review, Adult B had been admitted into hospital on several occasions and also had placements in residential care. The review found that that his medical needs were not neglected, but that the agency with a central role in coordinating support to maintain him in the community were basing their assessments on third party information.

- **Discharge Planning**

The residential home Adult B was placed in was experienced in caring for dementia patients. As the placement was through "Find a Care Home" the assessment was completed by this service. The home should have completed a review of the assessment by "Find a Care Home" to ensure that they could meet his needs. Within hours of his admission into the residential home he was discharged in a distressed state into the reluctant care of his wife fearful for her own safety and her ability to care for her husband. At this time, he appeared to be confused, it is not clear whether he was really fit for discharge from the hospital.

- **Referral process to the Community Mental Health Team**

The GP made a telephone call to the Community Mental Health Team following the hurried decision by the family to remove Adult B from the residential home. Having raised concerns, the GP was asked to check some details regarding medication and make a written referral in accordance with the agreed procedures which was completed the same afternoon.

The clinician believed that due to the escalation in Adult B's presentation they felt that it was essential that a Mental Health Review was completed that evening. Although the GP agreed with the family to review Adult B the next day, within 90 minutes of the written referral having been received by the Community Mental Health Team Adult B had jumped from the balcony.

- **Social Care assessments on discharge from hospital**

On first admission to the hospital a social worker completed the assessment which indicated that Adult B did not have capacity to make decisions around his accommodation and MDT Best Interest Meeting was held but this does not appear to have been documented in any health or social care records in detail.
The subsequent two reviews in the hospital were completed by an Assistant Care Coordinator and no formal capacity assessment paperwork was completed on these reviews.

- **Domestic Abuse**

Professionals working with older people may miss signs of abuse due to their own assumptions and perceptions of domestic abuse and ageism. There are several missed opportunities by agencies which clearly document both physical and verbal aggression towards Adult B's wife. DASH Risk Assessment should have been carried out as evidence shows that older women are far less likely to identify their situation as abuse and referral to the "Never Too Late Project" (Over 55) domestic abuse service could have been offered.

- **The needs of Adult B's wife**

Agencies may have misunderstood the level of support Adult B's wife received from their housing provider. All agencies have described Adult B's flat as sheltered or very sheltered housing accommodation. In fact, the housing provider did not provide any package of care to the couple; they were independent leaseholders, and they had no record or expectation of meeting any additional needs the couple may have had.
Professionals need to be aware of the emotional pressure that carers can feel, alongside their loyalty and compassion for their partner and understandable desire to look after them.

- **Assessment of Adult B needs**

Adult B was not seen face to face by a GP for the last 5 months of his life, during this time he had several admissions into hospital where he was reviewed by hospital consultants and assessments were based on information provided by his wife and other family members as well as the consultant and discharge letters from the hospital.

The three episodes in hospital between May and September provided an opportunity to assess and treat Adult B's physical health problems but these were missed opportunities to assess his mental capacity to understand the impact of his dementia on him and his family.

Two of the assessments completed by the Hospital Social Care team were completed by Assistant Care Coordinators and there does not appear to be any oversight from a social worker. There is no evidence of any Mental Capacity Assessments or any consideration of the Best Interest Meeting which was held during his first admission into hospital and the fact that they family were struggling to care for him in his home.

- **Timing**

The timing and availability of resources at the right time can often be crucial in encouraging reluctant service users to accept help. It is possible that earlier intervention may have provided a different outcome for Adult B.

- **Mental Capacity Assessments**

This report highlights two main issues; firstly, there is a training and familiarity issue with the basis for Mental Capacity Assessments, (this is widespread across all agencies, but possibly more of an issue for Hospital Social Care staff). Secondly, where a Mental Capacity Assessment had been

undertaken, and the outcomes were not shared with partner agencies, who were sometimes unaware that one had been done and that there may concerns about Adult B's decision making.

RECOMMENDATIONS

1. An effective discharge planning and management process should be in place which adheres to the Care Act 2014 specifically Section 6 of the Act. All professionals involved in the case and all records of discussions to be retained in line with GDPR procedures and there is consideration of any risks or safeguarding concerns. Production of a "What a good MDT meeting looks like" needs to be developed.

2. The use of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards should be embedded in multi-agency practice i.e., multi-agency training provided, supported in practice guidance and recording polices and discussed in supervision. Which will ensure that professionals understand their responsibilities and are clear in what circumstances a Best Interest decision is required. Clear and accurate records of the meeting and decision must be documented and kept on the persons' records.

3. Carers Assessments Practitioners are aware of when it would be appropriate to offer a carers assessment and triggers that should prompt a review and should be offered in all cases where a partner is caring for a person with dementia. Practitioners understand the complexities involved supporting a carer who is resistant to help.

4. Domestic abuse and older people practitioners should have an understanding of the signs of coercive control and domestic abuse including how to recognise this in familial or caring relationships.

5. Specific training for professionals on the incidences of abuse within a caring relationship, and/or where dementia or other mental/physical disabilities are present where there is coercion and control, to enable improved confidence in engaging directly with the person and developing greater professional curiosity and more effective safeguarding of vulnerable adults.

6. Where appropriate professionals must ensure vulnerable individuals are provided with the opportunity to speak to alone to professional and consider a DASH Assessment as necessary. In addition, where required a professional must consider in consultation with their line manager if there is a need to override consent.

7. The partnership should consider using a pro-forma to ensure more effective exchange of information between agencies concerning vulnerable patients, which could include known threats to self-harm and possible domestic abuse should be referred as safeguarding incidents.

MORE INFORMATION

For further information and to access the full report visit our website:

http://safeguarding.dudley.gov.uk