Dudley Safeguarding People Partnership

Safeguarding Adults Review
Overview report
Adult B

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Introduction

Adult B was an 82 year old white British male who died as a result of injuries sustained following a fall from the second floor balcony of his flat which was in an Extra Care housing complex. Adult B jumped from the balcony and had locked a door behind him to prevent anyone dissuading him.

It is not clear whether Adult B intended to end his life, and it is unclear what his state of mind was at the time to this incident and whether it was a result of deterioration in his vascular dementia.

Adult B lived at home with his wife, who was also his informal carer. He had several health problems one of which was his diagnosis of vascular dementia.

Adult B's wife at various times acknowledged to professionals that his behaviour was too much for her to cope with. Several offers of respite were made by Adult Social Care, however Adult B appeared to be resistant for care to be provided by any outside agencies and he appears to have been reliant on his wife and family to provide him care and support.

Following an admission to respite care after a hospital admission, which had only been in place for a matter of hours, Adult B returned home this was agreed to by Adult B's wife without any other support being in place by Adult Social Care despite support being offered.

Adult Safeguarding Process

The Care Act 2014 places a statutory duty on Safeguarding Adults Boards to undertake Safeguarding Adult Reviews in circumstances where an adult has died or sustained serious abuse or neglect and there are concerns about how agencies worked together.

The fundamental purpose of a Safeguarding Adults Review is that it seeks to determine what could have been done differently that could have prevented harm or death taking place and to learn the lessons to prevent a similar incident happening in the future.

The decision to undertake this review was taken by Dudley Adult Safeguarding Board in March 2019.

This Review process began in September 2019, a panel meeting was completed in January 2020, however any subsequent meetings were cancelled due to the Covid-19 pandemic and the review was placed on hold.

Methodology

The Terms of Reference for this review were drawn up by the Dudley Safeguarding Adults Board, now Dudley Safeguarding People Partnership.

These required that all of the agencies involved commission an Independent Management Report (IMR) which critically reviewed the practice of their own individual agency and included a chronology of their involvement based on agency records.

The focus of the Safeguarding Adult Review is from January 2018 (referral to Dementia Service) until October 2018 (when Adult B died), but consideration of information shared which was deemed to be relevant to the Safeguarding Adult Review pre scoping period has been considered in this report.

The Review process is a systemic enquiry into the actions and decisions taken by the relevant agencies and review those decisions in the context of the real working conditions which existed at the time.

Research has shown that methodologies that engage practitioners in reviews are more likely to achieve learning and changes in practice, therefore the participation of frontline staff is extremely valuable, and improves the quality of the overall review and the commitment to taking the lessons back into practice.

Reports have been provided by the following agencies:

- Dudley Metropolitan Borough Council – Adult Social Care
- Dudley Metropolitan Borough Council – Dementia Gateway Services
- Dudley Group NHS Foundation Trust
- Dudley Clinical Commissioning Group – Primary Care (now Black Country and West Birmingham CCG, Dudley Place)
- Abbeygate Care Centre
- Dudley & Walsall Mental Health Partnership NHS Trust (now Black Country Healthcare NHS Foundation Trust – Dudley and Walsall Division)
- Belvidere Care Home
- Midland Heart (Housing Provider)

Family members have been contacted but felt that they were unable to participate in the review.

The Overview Report is devised from two sources of information: the IMR's and a panel meeting where assurances were given that the IMR authors had discussed the event with practitioners.

Background Information

Adult B and his wife had been married for over 50 years and had two children; a son and a daughter who visited regularly. Adult B was retired after working in a factory for more than 30 years and kept himself busy with daily routines which included doing household chores and going out; he enjoyed walking.

Adult B lived in a second floor flat within an Extra Care Housing [1]Scheme owned by Midland Heart Housing Association. The complex is a retirement village made up of purpose built blocks of self-contained homes, along with other facilities such as small shops, gardens and restaurants. They owned the lease on their flat and were not in receipt of any care from Midland Heart Housing Association.

Adult B had been registered with the same GP practice since 2011, he had a long term chronic health problem (Chronic Obstructive Pulmonary Disease - COPD) which was routinely monitored by his GP Practice. The first indication of any problems with deteriorating memory and aggressive behaviour were recorded in June 2014. The GP arranged an appointment with a memory clinic which included physical health screening to rule out any health problems. The assessment by the memory clinic (July 2014) did not record any memory issues and he was discharged from the service.

In August 2015 a further referral was made to the memory clinic following further examination of Adult B's mental state. At this point the tests undertaken suggested mild dementia. These results led to referrals for a psychiatric assessment and Gateway Dementia Services[2] in October 2015.

In November 2015 a further review at the Memory Clinic was considered by the practitioner to be inaccurate due to Adult B's wife being present and "confrontational" during the assessment. The couple stated that these confrontations were typical in their relationship. The assessment was rescheduled so that Adult B could be seen on his own but there was no evidence that this further review was completed.

By January 2016 Adult B's wife and their daughter discussed with the GP their concerns about Adult B's increasingly aggressive behaviour and that he was becoming more verbally aggressive towards his wife. But there was no evidence to suggest whether this was further explored by the practice or whether any extra support was offered. This potentially was a missed opportunity to support Adult B and his family.

In February 2016 the GP discussed with Adult B whether he should still be driving, although it was not until September 2016[3] that the GP contacted the family to ensure his dementia diagnosis had been recorded with the DVLA. At that appointment Adult B also admitted to verbal outbursts and there was no evidence of any physical health issues and follow up review was completed

[1] Extra Care Housing is a type of purpose built housing scheme to enable people over 55 who want to live independently but with the added benefit of care and support as and when it is needed.

[2] There are two Dementia Gateways in Dudley which provide advice and support to patients and families.

[3] It is a legal requirement for license holder to inform both the DVLA and insurance company when they receive a diagnosis of dementia. https://www.gov.uk/dementia-and-driving

two weeks later where the family reported that his behaviours appeared to have settled.

Confirmation of the diagnosis of a mild cognitive impairment was in May 2016, the indications are that Adult B's mental health continued to deteriorate; he had a road traffic accident in May 2016 where the Police were called due to his verbal aggression. Adult B's wife and their daughter reported to the GP they were struggling to cope with his aggressive episodes, and they disclosed an episode of him going missing from home.

A diagnosis of vascular dementia was made in April 2017 following a further review by the Dudley and Walsall Mental Health Trust. He was seen in the outpatient clinic every 2-4 months and discharged back to the care of his GP in August 2017. During this period Dudley and Walsall Mental Health Trust (DWMHT) advised that an anti-depressant be prescribed to settle his irritation and frustration. This was then prescribed within Primary Care from the recommendations of DWMHT.

Key Events within the scoping period

17/01/2018 – Adult B's daughter contacted Adult Social Care regarding her father's diagnosis of vascular dementia. Adult B's health was deteriorating; he had lost his confidence and did not like his wife leaving him alone. A referral was made to Dudley Carer's Network[4] for Adult B's wife and according to Adult Social Care records not clear what interventions were offered but that normal practice would include an offer a carers assessment.

24/01/2018 Referral was made to the Dementia Gateway, and Adult B was placed on the waiting list. At this time there was increase in referrals to the Dementia Gateway Service and there was a recognised delay of up to 20 weeks and the review was completed on the 14th June 2018. When a visit was undertaken to The Crystal Gateway and Adult B started day care provision on 18th June 2018.

21/05/2018 The GP made onward referrals to Mental Health Services for Older Adults as Adult B's condition had deteriorated since his discharge from services. On the review by mental health his antidepressant was increased but this was not completed by the GP until 11th June although this would not have had any impact on his death in the October. The referral stated that his mood swings and level of violence had increased, and his wife was struggling to cope.

But it is not clear whether any practitioner explored Domestic Abuse and there is no evidence of any DASH risk assessment or onward referrals for specialist

[4] Dudley Carers Network provides advice and information for adult carers in Dudley. The Network is a mailing list whose members receive a newsletter 3 times a year.

services. This was a missed opportunity to ensure that extra support was offered to his wife, to aid her understanding of the potential triggers of his aggression towards her and to provide an understanding of possible progression of his dementia. Respite was discussed with Adult B's wife, but she remained ambivalent as Adult B's demeanour could change from aggressive to charming in a short space of time. The GP also contacted requesting support from Adult Social Care by telephone for support for Adult B's wife.

14/06/2018 Adult B was introduced to Crystal Gateway (one of the Dudley Dementia Gateways) – where he would attend for respite to support his wife. His wife also disclosed to DWMHT staff (this was documented in a letter to the GP from the consultant) that she had discovered him on the balcony of their apartment about to jump and she had to pull him off the edge. It is not clear whether the DWMHT or the GP shared this information with any agencies, including the housing association or the dementia services or considered a safeguarding referral due to the potential risk and this could be seen as missed opportunity. However, Adult B's wife felt that the home environment stabilised due to the medication prescribed and the support provided by Crystal Gateway for Adult B.

08/08/2018 - Following admission to hospital a visit was undertaken by a hospital Social Worker to identify Adult B's care needs and to ascertain his discharge pathway and that a mental capacity assessment was completed for Adult B, which indicated that he had clear understanding of the discharge process. A conversation with Adult B's wife took place where she stated she could no longer cope with Adult B at home. Adult B's memory had declined, and he was not sleeping at night.

A Package of Care was offered however Adult B's wife declined because she didn't want people coming to their home, but also felt it would not meet Adult B's needs as he wanted somebody with him all the time. There was a missed opportunity to support Adult B and his wife, as there was a need to consider them as a couple, as well as individuals. A two week emergency placement was offered in a residential home which specialised in mental health diagnosis and physical or sensory disabilities which was accepted by the family.

09/08/2018 Due to Adult B's vascular dementia a Mental Capacity Assessment (MCA)[5] was undertaken by a Social Worker within the Hospital Social Work Team to determine whether he could make a clear decision about his discharge destination. From the assessment it was clear that he lacked

[5] A Mental Capacity Assessment is an assessment undertaken in accordance with the Mental Capacity Act 2005, it must be carried out whenever;

- There are doubts over the ability of any person (from the age of 16) to make a particular decision at a particular time; and
- There is a belief that the reason that the person may be unable to make their own decision is because of an impairment of, or a disturbance in the functioning of the mind or brain.

capacity to be able to decide, as he was unable retain or understand the information regarding his needs for support. This was a different conclusion from the day before which indicates that Adult B's capacity fluctuated.

It was agreed by a Multi-Disciplinary Team (MDT)[6] that a 24 hour placement was in his best interest. A Deprivation of Liberty (DOLS)[7] was not felt to be appropriate at that time. Although no further details of this meeting were recorded, and it is not clear who was present.

On 10th August 2018 Adult B was admitted into a residential setting, for a 2 week placement, and during this time there were no reports of any agitation or distress, but he was readmitted to hospital 6 days later with a suspected infection and did not return back to the residential home.

22/08/2018 – Adult B was seen by an Occupational Therapist at Russells Hall Hospital, it is documented that the case would require input from social care to facilitate a safe discharge as Adult B's daughter and wife had reported concerns in regard to his wife's ability to manage Adult B at home.

24/08/2018 – An Assistant Care Coordinator discussed discharge with Adult B who was adamant he wanted to return home and he consented for the practitioner to discuss with his family. Later the same day, the ward received a call from Adult B's GP who had received a call from Adult B's wife, she was very upset as she thought her husband was being discharged and she would not be able to cope. The ward informed the Assistant Care Coordinator was involved in the discharge, but that Adult B had capacity and wished to go home, but this capacity assessment was not recorded. This was seen as a missed opportunity considering at the previous review it was recorded that he had fluctuating capacity therefore reassessment should have been completed before a decision was made to for him to return home.

The GP also contacted the Access and Prevention Team on the same day (the first point of contact for new referrals to Adult Social Care) to inform them that Adult B's wife is not able to cope with Adult B going home but it is not clear whether this information was shared with the hospital team.

Despite the phone calls to the ward and to the Access and Prevention Team this information did not reach the social care hospital discharge team. Adult B was screened for a Pathway 3 bed[8] by the Assistant Care Coordinator. It is not clear if the practitioner was aware that an MCA assessment had been completed 13 days earlier that said he lacked capacity on making this

[6] MDT's are a health initiative to provide a holistic assessment of a patient's needs; they consult all relevant health and social care professionals and the patient and family members.
[7] The Deprivation of Liberty Safeguards (DoLS) is a legal framework set out in Schedules A1 and 1A of the Mental Capacity Act
[8] Pathway 3 is discharge to a nursing or care home facility with recovery and complex assessment provision.

decision, and that an MDT had agreed that a 24 hour placement was in his best interest. A further specific MCA assessment for accommodation should have been completed as at this time Adult B was suffering with confusion and possibly may not have had the capacity to make this decision and it is questionable whether he would be fit for discharge due delirium. Further advice was given by the Assistant Care Coordinator to the family that they could contact the Access Team for a Carers assessment and advised they could fund respite themselves if they wished. There was no evidence in the IMR that financial assessment was offered. Adult B's daughter agreed that she would contact the GP for any further assistance.

Adult B was subsequently discharged home on the 27th August without any package of care. Although there had been a disclosure that his wife was struggling to cope.

26/09/2018 - Adult B was seen by a physician's assistant at his GP after a fall and the decision to treat Adult B for a Urinary Tract infection (UTI), two days later he was admitted to hospital.

28/9/2018 - West Midlands Ambulance Service made a referral to Adult Social Care due to concerns that Adult B's wife was struggling to care for Adult B, he was having falls and had infections which were causing confusion. Adult B's wife was unable to sleep. Adult B was taken to Russell Hall hospital and a referral to the Hospital Access Team for a re-assessment to facilitate a safe discharge. During this admission a further referral was received from the GP who again raised concern with Adult Social Care that Adult B's wife was unable to care for Adult B.

03/10/2018 – Adult B was seen by the hospital Mental Health Team for review as part of the dementia assessment process. Adult B was observed to be settled and well-presented although staff reported he could become agitated at night. The 'Take the Time'[9] questionnaire and dementia care plan were implemented. The use of the Abbey Pain Scale[10] was emphasised to staff as Adult B may not have been able to communicate pain or discomfort. No further input was planned from the Mental Health Team, but the ward staff could contact if there were any further concerns. The records state that Level 2 observations were commenced, and daily observations recorded but there is no evidence of completion of an increased level of observation screening tool while admitted.

[9] The Take the Time tool is a series of questions about an individual, completed by their loved ones. It is used while in hospital for providing information about the individual to those providing their care.

[10] The Abbey Pain Scale tool is designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

04/10/2018 hospital records indicate that a social care practitioner was to liaise with the family to arrange an appropriate discharge plan.

Adult B was assessed by an Assistant Care Coordinator for a Pathway 3 temporary care home placement. Given his diagnosis of dementia and fluctuating agitation and confusion a mental capacity assessment should have been completed but there is no evidence in the hospital records or any reference to this on the Discharge Co-ordinators' database. Social Care records indicate that Adult B was "not fit for discharge" at that time.

A referral was sent to How to find a Care Home[11] on the 10th October 2018 and a suitable placement was identified at a specialist residential home for people with dementia and other mental health conditions and physical disabilities.

11/10/2018 On arrival at the second residential home Adult B had become distressed and agitated, he lashed out at a member of staff and was demanding to go home and could not be calmed down, they had attempted to settle Adult B, distracting him by unpacking his belongings and offering him something to eat. When this had not worked, they had tried leaving him to calm down when he became verbally aggressive towards other residents. It was at this point they contacted Adult B's wife who said she would attend to try and settle her husband. Adult B's wife attended in an attempt to pacify him but with no success. The Care Manager was concerned about Adult B's wife being able to cope if Adult B returned home. Adult Social Care were contacted and concerns regarding Adult B's wife taking Adult B home were discussed.

Adult B's wife had declined further support from Adult Social Care. An increased number of days at day care were offered but this was declined. A Social Care Assessment was offered for that evening with an urgent Package of Care if required, this was also declined. Adult Social Care services offered to support both Adult B with his care needs and Adult B's wife within her caring role, but all options were declined. The final outcome was that Adult B left the residential home with his wife, with agreement that a follow up phone call with Adult Social Care would take place the next day. There was no evidence to suggest that a Best Interest meeting or a safeguarding referral was considered.

12/10/2018 A follow up phone call was made to Adult B's wife by Adult Social Care, and again options of support including a Package of Care within the home was declined. Adult B's wife did say she would consider additional day care and was referred to the Dementia Advisor. Adult B's wife was provided with the Access Team telephone number should she require any further assistance.

[11] How to find a Care Home is a private organisation used by Dudley MBC as a broker to help people identify a suitable care home.

There was a missed opportunity as it is unclear what mental capacity assessments were completed by the Social Care Team, and consideration that at discharge from hospital it was stated that he was confused and therefore his capacity would be fluctuated. It is not clear from the reports whether practitioners considered the risk to Adult B's wife by allowing Adult B to return to his permanent residence.

15/10/2018 Adult Social Care made further contact with Adult B's wife to ascertain the current situation regarding the wellbeing of Adult B and how she was coping with his care. Adult B's wife stated she was quite frightened; her husband had not struck out, but she felt like she was walking on eggshells. It is not clear if any action or advice was taken by the practitioner at this point.

As there is clear evidence that the situation was escalating within the home and although there was no physical assault, the emotional impact of the abuse. This was a missed opportunity to complete a DASH (Domestic Abuse Stalking and Harassment) assessment or discuss support from Never too Late Domestic Abuse service as it does not appear that practitioners had considered domestic abuse being a factor nor whether there was any consideration that a Best Interest meeting under the MCA Act should have been held.

An offer was made for someone to go and visit Adult B's wife which she accepted. Adult B and his wife were visited by two Senior Social Workers, this allowed time for the Senior Social Workers to speak to each of them individually. The Social Worker with Adult B's wife identified that she was really struggling to cope with her husband at home, she expressed a wish for Adult B to go into a 24 hour placement as she feared for her safety, as Adult B had been both physically and verbally aggressive. This identifies that the risks have increased and should have been considered as the safety of the couple was clearly compromised at this point. Although the Social Worker with Adult B felt that he had capacity to decide on whether to go into respite or not, there is no evidence of a full MCA being completed at this time.

Adult B refused to leave his home and enter a respite establishment, so the alternative option was for Adult B's wife to go for a break with her daughter and the Social Worker would arrange for carers to come in to support Adult B to ensure he was washed, dressed, had taken his medication and he was eating.

A Social worker contacted the GP surgery and discussed the concerns. The GP confirmed he would liaise with the Community Mental Health Team (CMHT) and get back to her once Mental Health had either contacted the surgery or completed an assessment. There was a missed opportunity as the social worker could have discussed with AMHP (Approved Mental Health Professional) Hub

or whether any advice sought whether a guardianship was an option at this time.

The initial contact between the GP and the Community Mental Health Team (CMHT) was by telephone where a brief summary of recent events and the current risks, which included verbal and physical aggression towards carers was shared. A formal written referral was made by the GP 75 minutes later making the initial contact with CMHT.

The referral was marked as urgent, included details of medical history and highlighted concerns about possible suicide and Adult B threatening to kill his wife. This was based on the contact with Adult B's wife and Adult Social Care although the referral criteria required the GP to have assessed the patient themselves prior to referral, the GP practice stated that the risks appeared too high to wait for a GP visit and that an appropriate mental health assessment was required due to the risks highlighted by Adult Social Care.

The GP contacted the family and recorded that Adult B's wife appeared overwhelmed by the situation, an appointment at the surgery was made for the family to be seen the next day. As these conversations were held after 17:00 and would have been considered "out of hours" it is noted that the GP did not make any further referrals to social care or the Mental Health Street Triage team. This was a missed opportunity. It was during a conversation about these arrangements with members of the family that Adult B left the room in an agitated state and locked himself on the balcony and jumped off.

Summary

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 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.

Ideally this would have involved a degree of specialist residential care, even on a respite basis, but unfortunately this was not acceptable to Adult B but there was only one specific mental capacity assessment complete during the scoping period, so it is unclear whether he had capacity to understand the impact of his possible deterioration of his dementia on both him and his family.

There is clear evidence that Adult B's wife had disclosed to many agencies that she was clearly struggling to support her husband, but the support offered was often declined. Caring for someone with dementia and behaviours that

challenged had an impact and at no point did any agencies consider that Domestic Abuse was a factor.

The review has identified number areas of learning where practice could be improved and arguably could have led to a different outcome in this case.

1 Lack of face to face assessment by the GP

Adult B had not been seen in person at his GP practice since the 26th September 2018, assessments and medication were based on conversations with Adult B's wife and other agencies, but this did not have had a direct impact on his death. During this time Adult B was of course an in-patient on several occasions and also had an episode of residential care, so the issue is not that his medical needs were uniformly neglected, but that the agency with a central role in coordinating support to maintain him in the community was basing their assessments on third hand information.

Given Adult B had dementia his mental capacity needed to be assessed through face to face contact particularly in the light of the reported changes in his behaviour and the history of Adult B's wife tending to speak on behalf of her husband.

2 Discharge Planning

The second residential home 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 to ensure that they could meet his needs. Due to his confusion it is not clear whether he was really fit for discharge from the hospital. 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. Although Social Workers did offer various options which were declined by the family.

Unfortunately, the home in question has provided little contextual information about their admission process and the decision making regarding Adult B's admission into the home. His distress was predictable and plans to ameliorate this should have been in place the home did attempt various distraction techniques and did contact Social Care for support when the situation was escalating.

3 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 second residential home on the 15th October 2018. 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 written referral contained additional information about the risk of harm to both Adult B and his wife but was based on second-hand information rather than direct contact with Adult B. It is not clear whether all information was shared around the couple, such as that Adult B's wife was feeling frightened and not being able to cope following the discharge from the second home. The clinician believed that due to the escalation in Adult B's presentation they felt that it was essential that 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.

The Community Mental Health Team were following the agreed referral policy; referrals require an initial face to face consultation with a GP to rule out any underlying physical health implications or establish whether primary care can provide effective first line treatment. At the present time this service can only be accessed through the GP, however there are emergency routes which could have been used.

At times of crisis time may be of the essence, and it is important the users of the service are familiar with the correct referral process to avoid unnecessary delays and practitioners should be aware of the emergency routes which can be utilised if they feel there is a high risk of harm.

4 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 co coordinator and no formal capacity assessment paperwork was completed on these reviews. There was no evidence that the Assistant Care Coordinator had any case discussion on the discharge with a Senior Social Worker plus the concerns raised by primary care to the ward and to the access and prevention team was not communicated to Hospital Social Care Team.

5 Domestic Abuse

The Care Act (2014) defines a carer as someone who 'provides or intends to provide care for another adult'. Research suggests that the potential for violence within a carer's relationship increases when the carer is an intimate partner or close relative. The caring dynamic can also present difficulties when the individual being cared for becomes the perpetrator, due to dementia that can exacerbate aggression this has led to professionals not suspecting domestic abuse due to the perceived vulnerability of the perpetrator.

In these situations, the victim may feel a lot of guilt connected to any disclosure of the abuse[12].

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[13]and referral to the "Never too late Project" (Over 55) domestic abuse service could have been offered Practice Issues.

The needs of Adult B's wife

As a general issue, agencies may have misunderstood the level of support Adult B's wife received from there housing provider. All agencies have described Adult B's flat as sheltered or very sheltered housing accommodation. In fact, Midland Heart 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 and professionals had not considered that the further support could have been offered by Midland Heart to support the couple.

There is a common dynamic in situations where couples grow old together, where one person often becomes the carer of their partner. This is not always a smooth transition from one type of relationship to another, and alongside love and compassion there can also be sadness, resentment and fear of the future.

Adult B's wife was understandably ambivalent regarding her role in the care of her husband. On numerous occasions she said clearly that she was unable to cope with his aggression and agitated state. Furthermore that his behaviours towards her as his main carer could be considered as Domestic Abuse. However, her requests for support were inconsistent and she would request help only to decline it at a later date. As a result of this there had never been a carers assessment of Adult B's wife or DASH assessment completed to understand the risks.

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.

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[12] Safe Later Lives: Older people and domestic abuse October 2016

[13] Scott, M., Mckie, L., Morton, S., Seddon, E., and Wosoff, F. (2004) Olderwomen and domestic violence in Scotland…and for 39 years I got on with it, NHS Health Scotland, Edinburgh.)

Assessment of Adult B needs

Adult B was not seen face to face by a GP for the last 5 months of his life, but 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. Although the GP and Physician's Assistant continue to complete onward referrals and discussed concerns with the Social Care team relating to the disclosure from Adult B's wife of not being able to cope with supporting her husband.

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 co 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.

There is evidence within this review of Adult B's wife declining assessments on her husband's behalf. There was no evidence that she or any of other family had Lasting Power of Attorney for health and welfare. Given that he was known to have failing mental capacity based on previous assessments, this raises the question that he should have been contacted and offered the opportunity to be re-assessed in person and an advocacy support should have been offered.

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.

If day centre provision had been provided earlier Adult B may have been more accustomed to support from care staff and built relationships which allowed him time to develop trust in others before his condition deteriorated. This may have resulted in Adult B being more accepting of a package of care which would have supported both him and his wife with her caring role. Or whether returning to the previous residential placement would have been less distressing on his last discharge from the hospital.

While this point is speculative, the six month delay in providing day care at the Crystal Centre saw a significant deterioration in Adult B condition.

Mental Capacity Assessments

It has been noted by most of the agencies contributing to this review that Mental Capacity have policies and procedures and it is unclear whether these were not followed consistently. There were several occasions where a formal capacity assessment would have been appropriate rather than rely on the opinion of others.

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.

An additional feature noted in this case was the inexperience of some of the Social Care staff, who were newly qualified Social Workers employed as Assistant Care Coordinators.

Recommendations

Multi-Agency and System 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. MDT meeting effectiveness Multi Agency Case Decisions about the care and treatment of vulnerable patients require a face to face consultation and should not be based on reported information regardless of the source. **Can be tested out in future case through Multi Agency Case File Audits.**

2. The use of the Mental Capacity Act and Deprivation of Liberty (MCA) 2005 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. **Can be tested out in future cases**

through Single Agency or Multi Agency Case File Audits.

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. **Monitor any changes numbers of referrals for Care Act and Carers assessments.**

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. 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. 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. **Briefing "Professional Challenge and Professional Curiosity" Should be produced.**

5. The partnership should consider creating 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.

Individual agency recommendations

Adult Social Care

To ensure Social Care Practitioners are aware of the policies and procedures in assessing and completing Best Interest Meetings for people who have a cognitive impairment. As we are approaching the launch of the new successor programme it would be beneficial for this to be considered.

There needs to be case note guidance on recording mental capacity and the outcomes of the assessment which includes the justification of the outcome from the assessment detailing specific decision for the service user.

Ensure that case work completed by Assistant Care coordinators is reviewed by a Social Worker (S6 Care Act) and that regular supervision is in place including a clear pathway to escalating concerns quickly especially within the Hospital Discharge team and when required Senior manager e.g. Head of Service (HoS), where demands for safe and timely discharges are critical. Access to Safeguarding and Mental capacity leads to give expert advice and support with complex cases. When leads not available the on call HoS must be consulted.

To ensure that appropriate training to be provided to agency staff on DMBC policies and procedures and pathways for services are easily accessible on the DMBC Internal web pages. All social care professionals to ensure completed mandatory training in safeguarding, mental capacity and Domestic Abuse.

Dementia Gateway to develop a waiting list protocol to ensure cases are monitored before service users reach crisis and Courtesy call backs are completed within a 4 week period and to established review of the waiting list on a weekly basis, Assistant Team Manager and Team Manager independently "dip sample" waiting list and poses a peer challenge for the rationale of who is or isn't seen as a priority and intervenes accordingly.

To ensure that is clear pathway for social care professionals to discuss concerns with AMHP Hub.

Dudley and Walsall Mental Health Trust (now Black Country Healthcare NHS Foundation Trust – Dudley and Walsall Division)

Review services information available to external partners, to ensure clarity including relaunching the GP packs that were previously developed.

Promote a proactive response for staff where there may be potential for increased vulnerabilities or missed opportunities by refreshing safeguarding bulletins and attendance at team meetings.

To ensure there is a clear pathway in place to ensure that any changes in medication is relayed to primary care.

Memory assessment service to consider when assessing new patients that part of the review should be completed without family members present.

The Dudley Group NHS Foundation Trust

Staff require a better understanding of the Mental Capacity Act implementation of the act and how it can support staff in ensuring that staff are assured that patients are making capacious decisions.

All staff to recognise the importance of clear and detailed documentation in relation to care given and discussions with patients, relatives and other professionals including any changes in medication.

Staff to recognise when Increased Level of Observation Screening Tool is required.

Primary Care

GP practices to complete an assessment of mood/depression with patients who have dementia on their health reviews and that face to face reviews are completed at regular intervals.

To ensure that safeguarding referrals are completed when a person has cognitive impairment when a disclosure of possible risk to self.

To consider whether family members are at risk and identify early signs of domestic abuse and to offer support from IRIS or the never too late project. To promote education and training from CHADD about Older Adults and Domestic Abuse.

To ensure that Mental Capacity Act principles are utilised with consultations with patients who make lack the capacity to understand their care and treatment and clearly document these assessments in the patient's records.

To ensure that all practices are aware of the older persons mental health pathway and briefing to be completed on carers assessments.