# SAFEGUARDING ADULTS REVIEW

Adult L – April 2024

# ONE PAGE SUMMARY

**Background:** this discretionary Safeguarding Adults Review (SAR) was initiated following a referral from Adult Social Care following the death of Adult L. Adult L was found dead in a ditch near his home. There had been concerns about cognitive decline and wandering alone since his wife was placed in a care home.

**Findings:** Adult L and Adult M were a private couple who sought to live out their days without the intervention or interference of services. There are multiple notes in agency records that they wished to be left alone despite their increasing needs. Friends and neighbours were raising concerns about the couple and this continued when Adult L was living alone. There were a number of agencies actively working with Adult L around the time of his death and his needs appear to be well documented. In his last two weeks, Adult L did finally accept that he was not managing well and accepted the offer to find him a care placement, which was being arranged at the time of his death.

**Learning Points:**

1. There appeared to be a reliance on informal information sharing when a formal sharing, such as raising a Safeguarding Concern, may have been more appropriate.
2. In adopting a strengths-based approach, it may be that Adult L's limitations to care for himself were not fully appreciated or that his informal support arrangements were more substantial than they were.
3. There appeared to be a lot of activity by professionals but the evidence of this having a positive impact is limited. It may be that a coordinated multi-agency response, bringing together the professionals involved, or an escalation of the concerns about Adult L to more senior managers could have offered some alternative options for working with Adult L.
4. Capacity assessments are not clearly documented when references are made to Adult L lacking capacity.

**Reflective Thought for Workers:** Impact and Consequence – what is the likely impact of my decision/action on the person? Is this likely to affect anyone else in the family/household? If so, what am I doing to mitigate any negative impact? If that's outside my control, who else could be involved to assist in mitigating negative impact? Could a multi-agency meeting to share information and decide on actions together have more impact?

**Key Lesson for Organisations:** Supporting the Frontline - How are we supporting frontline workers who are working with complexity? Are we offering enough time to reflect on practice and enough constructive challenge (through peer or managerial supervision arrangements) to ensure we are doing all we can within our resources and have considered the possibilities of multi-agency options? Have we made it clear to our workers what options are available to them internally and via multi-agency work?

# BACKGROUND

Adult L, of a small village outside Bicester, died on 29th December 2022. His body was found in a culvert (a large pipe used to channel water), just 50 metres from his house. Adult L's cause of death was given after a post-mortem as hypothermia.

The inquest heard that Adult L, a man in his 80s, lived alone and was suffering from dementia (suspected for a number of months, formally diagnosed in September 2022). His condition had deteriorated since his wife (Adult M) went into a care home two to three months prior to his death.

Oxford Coroner's Court was told that concerns had been raised about Adult L's welfare to social services. His neighbour provided a written statement, which was read out at the inquest.

The neighbour said Adult L would often go out on walks to neighbouring villages. On a number of occasions, Adult L would be found on the lanes in the village looking confused. In 2021, the neighbour made contact with social services telling them that they thought they needed around the clock care.

He explained that he phoned Oxfordshire County Council's adult social care department on December 28 suggesting that Adult L be taken into a care home that day.

The neighbour raised the alarm the next morning when he saw Adult L's front door open and he was not at home.

The inquest heard that CCTV footage shows Adult L leaving his house shortly after midnight on December 29.

At the Coroner's Court, Oxfordshire County Council's Social Care Team explained that although concerns had been raised by neighbours and carers, a risk of leaving his house at night had not been brought to their attention.

The inquest heard that at the time of his death, Adult L had agreed to go into the care home with his wife (Adult M) but logistical arrangements were still being made.

# METHODOLOGY

This Safeguarding Adults Review (SAR) was conducted under the discretionary SAR framework.

The referral came from Oxfordshire County Council, who requested that the Board consider whether the case met the mandatory SAR criteria, and if not, whether there was value in a discretionary SAR to review the multi-agency work undertaken with Adult L.

After scoping information from agencies, the SAR Subgroup did not feel the criteria were met for a mandatory review but wished to address the concern that the multi-agency work could've been improved upon, so undertook this discretionary SAR.

Agencies were asked to review their records from the period 1st November 2020 to 29th December 2022.

Agencies were asked to review both Adult L and Adult M's record during that period to look at relevant information held about the consideration of Adult L's needs, particularly at the point Adult M was moved into a residential setting.

# SUMMARY OF INVOLVEMENTS

## Oxfordshire County Council

From the records of both Adult L and Adult M, there is a lot of activity on both records which sat with a single Social Worker. Both Adult L and Adult M were suspected of having undiagnosed dementia. For some time prior to the death, neighbours were voicing their concerns about the couple's ability to cope. It would appear that the Social Worker was stuck in what to do, Mr Adult L was fiercely independent and declined support and Adult M supported his decisions.

Both were often seen dressed inappropriately and there was evidence of self-neglect; there was little evidence of food, bills weren't paid, and both were assessed to lack capacity regarding finances. Often the couple would be seen out and notably Adult M would be dressed inappropriately for time of year. They were both commented on as being unkempt, as were there living conditions. Both had visibly lost weight and latterly agreed to having meals and care.

There were reports of bruising on Adult M but her cognition prevented her from stating the source of her injuries. In late ~~in~~ October 22 , Adult M admitted to a neighbour that Adult L had been violent towards her in the past. This concern was shared and it led to Adult M being moved to a care home.

Adult L appeared bereft and was voicing that he wanted Adult M home or that he wanted to live with her as they had been married for over 50 years. The Social worker wrote regular case notes that tell a story of his despair. There was a plan for a Best Interest Meeting and there was evidence building being undertaken but the meeting did not take place before Adult L agreed to me moved into care. The social care record indicates there were times it was difficult to get hold of the GP. There was an unclear picture of what a good enough care package should look like, which led to a number of adjustments.

# SUMMARY OF INVOLVEMENTS

**Thames Valley Police (TVP)**

Adult M was first known to TVP on in October 2010 when she reported a theft of her bag, which it transpired, had not occurred. The crime was cancelled. There was an incident later that same month where she was reported as driving dangerously and a referral was made to Adult Social Care.

There were a number of incidents reported in relation to the couple with concern for their welfare. Reports were made from neighbours, social care, and on one occasion directly from Adult M. On every occasion of attendance for welfare concerns, both parties were sighted and spoken to.

On Police attendance, it was clear they were living in poor conditions and struggling with their health. On each occasion vulnerability assessments were completed and Police shared these with Adult Social Care. It appears that the attending officers were also making direct contact with the allocated Social Worker.

When concerns were raised by neighbours at a community meeting, this was acted upon as opposed to just completing an intelligence submission.

The neighbourhood team were also aware of the couple.

**Primary Care**

Primary Care had an extensive involvement with both Adult M and Adult L. Both were regular visitors to the practice and Adult L continued to visit the surgery after Adult M was moved into a residential home.

The GP appears to have adopted a very wholistic approach to their interactions with Adult L (and Adult M). As well as discussing the presenting medical issue, the GP would use these opportunities to ask about their general wellbeing, how they were coping, were they being supported, etc.

There are many examples of other services being contacted by the GP when necessary, including when they had concerns about Adult L. There is also a noted escalation of the concerns about Adult L to the Clinical Commissioning Group (now the BOB ICB), who in turn contacted a senior within the Local Authority Safeguarding Service.

The GP concerns appear to have been primarily shared through professional connections, e.g. directly to the Social Worker, rather than through raising a formal safeguarding concern. The response from the Social Worker gave reassurance to the GP that a safeguarding referral was not needed. With hindsight, a safeguarding referral may have been an option worth exploring.

# SUMMARY OF INVOLVEMENTS

**Oxford Health**

Within Adult M's record, there are glimpses of Adult L and it is clear that in 2021, there were concerns that Adult L was experiencing cognitive issues. The understanding from Adult M's record is that the GP was aware of Adult L's needs and was able to make onward referral. Adult M's record would indicate that Adult L and Adult M were operating as a partnership. Within the date range of the review, the Community Mental Health Team (CMHT) first became involved with Adult L in April 2022 following an urgent referral from his GP for a memory assessment. Adult L missed 2 planned CT scans causing some delay with further assessments. He was then visited at home for a memory assessment with CMHT in July 2022 who were unable to complete the assessment as Adult L did not want to engage. Adult L was assessed to be at high risk of accidental harm due to his suspected dementia. He was discharged from CMHT at this point with social care needs highlighted as priority within the discharge plan sent back to the GP.

Oxford Health next have contact with Adult L in November 2022 when he attends Bicester first aid unit. Adult L attended with his neighbour on the 22nd November, the 3rd of December and the 4th December. These visits were for injuries understood to be sustained when Adult L had fallen either at home or out walking. He was unable to recall exactly what had happened. The visit on 4th of December was due to a left shin injury which was assessed to have been incurred 2 weeks prior. The leg was assessed as being infected. It was also noted at this time that antibiotics had been prescribed by the GP three weeks ago, but the neighbour had no knowledge and doubted whether they were being taken by Adult L. Care providers noticed significant deterioration in Adult L's health & wellbeing in the weeks following the fall on 19th November.

Hospital at Home (service provider, Principle Medical Ltd) were providing care to Adult L between 9th and 11th of December. The district nursing service took over provision of care from PML on 12th December & it was decided that Adult L was to be seen twice a week. During the initial visit for wound assessment the nurse noted many concerns around Adult L's safety and planned to report these to social care, his GP and complete a Ulysses report. The patient mortality report states that there wasn't a Ulysses completed for this incident but there is evidence the District Nurse Team contacted the Social Worker directly via email to share their concerns.

District nursing visits were completed to provide wound care on 15th, 22nd & 26th December. On the 26th Adult L advised the nurses that he did not want them to visit anymore. On the 27th the District Nurse emailed the GP to inform of Adult L's refusal to further District Nurse visits and flagged concerns for his safety requesting that the GP urgently chase social care with regards to facilitating 24-hour care for Adult L to maintain his safety. The District Nurse also flagged concerns around Adult L's medication, asking for an urgent prescription and advising that Adult L's neighbour had agreed to support Adult L with this by collecting medication from pharmacy and supporting him in taking them. Contact with the district nursing team was continuous during the short period they were providing care before Adult L went missing on the 28th December.

# REFLECTIONS

After a review of the information received, the following reflections are offered:

1. Agencies involved Adult L as much as they were able to and proactively engaged with his neighbour, who would often support Adult L when it came to attending appointments, arranging visits, etc.
2. There was a lot of activity within Oxfordshire County Council in regard to Adult L in the locality team and the Social Worker received and responded to numerous communications from Neighbour as well as from other agencies.
3. Missed Hospital appointments were followed up and rearranged, including his Neighbour so that he could provide support, and throughout community & mental health records there is evidence that the Neighbour was included in communications about Adult L's care.
4. While there is a lot of activity on records and Adult L was well known to social care and health services, there is limited evidence of a coordinated multi-agency response to Adult L's needs.
5. There is extensive information sharing throughout the records, however, some of this appears to have been done through professional connections when other routes would perhaps have resulted in a different response.
6. There appears to be very little recorded reflection or consideration on the impact that removing Adult M from the family home would have on Adult L or what work would need to be done to lessen any impact on Adult L.
7. There are inconsistencies about the status of the neighbour in records. Some say the neighbour had LPA, some that he is Adult L's carer, others that he is just a neighbour. There is also one note that puts the neighbour down as Adult L's son. This inconsistent understanding across agencies of the role of the neighbour may have given an impression Adult L had more informal support than he actually did.
8. There are extensive records of attempts to offer Adult L help, which he often declined or would not engage with shortly after accepting. It was unfortunately not until his last weeks of life that he came to appreciate he was not able to look after himself and did need the support being offered.

# CONCLUSION

Adult L and Adult M were a private couple who sought to live out their days without the intervention or interference of services. There are multiple notes in agency records that they wished to be left alone despite their increasing needs and did not want to be separated.

While Adult M's removal was in her best interests as the couple were unable to manage her needs, the impact of this separation does not appear to have been well considered, or if it was, was not well recorded in the information submitted to the review.

Friends, neighbours and professionals raised concerns about Adult L. A number of these concerns could, on reflection, have been considered as a safeguarding concern but were not recorded as such and did not get raised via the Safeguarding Concerns process. Instead, these were shared via telephone calls or emails. Having these raised formally as safeguarding concerns may have led to the Safeguarding Team having sight of the case and possibly being able to offer some support and advice for the Locality Team working with Adult L.

There were a number of agencies actively working with Adult L around the time of his death and his needs appear to be well documented. In his last two weeks, Adult L did finally accept that he was not managing well and accepted the offer to find him a care placement, which was being arranged at the time of his death.

# RECOMMENDATION & ACTIONS

There appears to be a reliance of contacting and sharing information with the Social Worker when, in hindsight, raising a concern directly to the Safeguarding Team may have allowed further exploration of whether Adult L's circumstances met the S42 safeguarding criteria.

1. **Agencies should ensure that concerns are shared via correct channels.**

There are indications that Adult L's needs and limitations were not considered as a whole when help/support was provided. For example, providing him (an elderly man with suspected dementia and concerns about self-neglecting behaviour) with medication that required being taken four times a day and no care or support in place to ensure this would happen.

2. **Agencies should ensure that assessments include reflections on how support or services offered fit into the broader picture of that person's life and support arrangements.**

While there were mentions of Adult L lacking capacity, formally recorded Mental Capacity assessments were not clear in all agency records.

3. **Agencies should ensure when they note a person as lacking capacity that there is a documented capacity assessment on file.**

The impact on Adult L of the removal of Adult M was not documented in agency records.

4. **Agencies should review their processes to ensure that when the removal of one person from the household, an impact assessment on the remaining household members is conducted.**

While discussions were had about Adult L in agency supervision/case discussion processes, there is limited evidence on how these discussions went and what actions were agreed as a result.

5. **Agencies should review their supervisory processes to ensure that during case discussions there is clear consideration given for internal escalation and multi-agency options/remedies and that this is documented. Actions from Supervision in regard to a specific case should be recorded on the person's file.**