Safeguarding Adult Review Overview Report in respect of

‘Carol’

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TABLE OF CONTENTS

1. Introduction

This Safeguarding Adult Review (SAR) focuses on the case of Carol, who was a 58-year-old lady at the time of her death. Carol died at the beginning of February 2019, after being admitted to Hospital at the end of January 2019, suffering with abdominal pains and diarrhoea. Carol had previously been a patient in hospital and was discharged two weeks previously and before that in 2018.

Prior to her death Carol lived in a property, with her husband and daughter, on the Cambridgeshire and Suffolk border. Whilst the address was actually in the Cambridgeshire area some of the services that Carol received were delivered by agencies in Suffolk.

Following Carol's death, the case was referred to the Cambridgeshire and Peterborough Safeguarding Adults Board (CPSAB) in April 2019, for consideration of SAR to be undertaken. The case was first discussed in September 2019, at which time it was agreed that it met the criteria for a SAR, but more information was required. The case then suffered a number of delays due to agency availability and pressures created by the Covid pandemic.

2. About the Author

The author is independent of this case and any of the agencies involved. He is the independent chair of the Cambridgeshire and Peterborough Safeguarding Adults Review sub-group.

The author is a retired senior police officer and senior investigating officer. He has since been involved in working with local authorities, the health and third sector and the Church of England in a safeguarding capacity.

He has authored Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.

3. Methodology and Terms of Reference

The purposes of a SAR[1] are: -

- To establish whether there are any lessons to be learned from the circumstances of the case, about the way local professionals and agencies work together to protect adults with care and support needs.

[1] Worcestershire Safeguarding Adults Review Protocol - http://www.worcestershire.gov.uk/downloads/file/7071/safeguarding_adults_review_protocol

- To review the case as a learning process to identify where systems, procedures and practices might be improved to contribute to more effective individual and inter-agency working and better outcomes for adults with care and support needs.
- To ensure any urgent issues that require immediate actions are dealt with as soon as they are identified.
- To prepare an overview report which brings together and analyses the findings from various reports from agencies to make recommendations for the future.

The CPSAB formed a panel to oversee this review and it was decided that it would be conducted by all agencies involved in the case providing a chronology. Further information on the case was achieved by an agency case discussion and interviews undertaken by the author.

The panel agreed that the timeframe to be considered would be 1st June 2018 to 1st February 2019. Agencies were also asked to consider any areas which were outside these dates and may have had an impact on the case. The panel identified a number of areas they wished the review to consider.

- Did Carol have mental capacity? What assessments were done, by whom, and for what decision?
- Did Carol have a learning disability and if so, to what extent did this impact on her life and the care she received? Was she able to understand the long-term implications of refusing care?
- Is there evidence to suggest that professionals considered if all issues affecting Carol were the result of her self-neglect, and if so, how did this impact on the planning and delivering of interventions?
- How effective was the cross boundary working between Suffolk and Cambridgeshire services?
- How were risk and protective factors identified, assessed and managed?
- What actions were taken by practitioners and agencies to ensure that concerns were shared appropriately, and within the available frameworks, to attempt to mitigate any risk?
- Are there any areas of good practice?

4. Family details and background

Carol lived in a small village in Cambridgeshire but very close to the borders with Suffolk, and services often fell between agencies from either County, depending on the service being delivered. Carol's GP practice was located in the Suffolk area. The house where Carol and her family lived was local authority social housing.

Carol lived with her husband and one of her daughters, she has one other daughter who lived away from the family home. Carol's husband worked every day and therefore had to leave the house on most days. Carol's daughter who lived at home has learning difficulties and she and Carol's husband found caring for Carol both challenging and stressful.

A family member provided support to the family. It is apparent that some years ago Carol started to struggle with her mental health, the family would say that she 'effectively gave up on life' and ceased to care for herself and the house. This pre-dated, but was exacerbated by, the death of both her parents, who both died around the same time four years ago. Carol struggled with the death of her parents, to whom she was very close and lived nearby.

The family state that Carol went into hospital on a number of occasions and within the scope of this review on two occasions. Each time the family would inform the hospital that they were unable to cope with Carol at home but feel that their concerns were not taken into account when Carol was being discharged. They feel that the support given when Carol was discharged from hospital was inadequate and there were obvious signs of Carol neglecting herself which were not followed up.

The family waited for some elements of support for a long time and by the time they were forthcoming it was too late. An example of this is the fitting of a stairlift, which drifted for a considerable time and during which Carol's husband had to manually move Carol up and down the stairs or she would remain bedbound.

The family feel that Carol's mental health problems were deep rooted, and this was never investigated to understand whether Carol was able to make good decisions about caring for herself. They also feel that the ability of Carol's husband and daughter being able to care for her was taken for granted and not ever assessed to establish if there was support they could access.

The family feel that the communication regarding the end of life care in hospital was poor and they did not feel that they had a voice in the decisions regarding the reduction of medication and support. In general terms the family would say, in their view, '*the system failed Carol*.'

5. Summary of Facts

In the early part of June 2018, Carol was a patient in Hospital, it is recorded that Carol had presented with general weakness and severe self-neglect. Carol had been admitted following being found by her GP in a neglectful state. Her medical history at this time was that she suffered from type 2 diabetes, dilated cardiomyopathy (disease of the heart muscle), Myotonia dystrophia (muscle loss) and Psoriasis.

Whilst in hospital there was information that Carol had neglected her health, had failed to keep health appointments and had not taken her medication. Family members informed the hospital that Carol's husband worked, her daughter (aged 40) had learning difficulties and they struggled to care for Carol.

Carol felt that she was able to cope at home. There is no record of any assessment of Carol's mental capacity, but the hospital recorded that she had suffered neglect and she lacked insight into the severity of it.

Whilst in hospital Carol was assessed by the psychiatric liaison service and they recorded that Carol was suffering from depression and her medication was altered to address this. The assessment suggested that Carol should have bereavement counselling as an outpatient as she was suffering having lost her parents two years previously. Carol disclosed that she was in receipt of a social care package, but it is not clear what this consisted of or that enquires were made to establish this.

It was recorded as early the 6th June 2018, that Carol was medically fit to be discharged but she was not actually discharged until 19th July 2018. During this period there was a referral made to the MASH, the hospital, on the basis that Carol would be at risk when discharged. This referral was closed as Carol's case was open to reablement team. There was a request that this referral was resubmitted as it was not received by the discharge planning team and it was required before discharge could take place.

During this spell in hospital it was recorded by the hospital (1st June 2018) that Carol's family were in dialogue with the Council regarding the fitting of a stair lift at the home address and that a social assessment had been completed and that once a day care at home was required.

On 14th June 2018, ASC undertook an assessment. This assessment covered Carol's needs on discharge and recognised that a stairlift was required at her home. The assessment recommended that Carol received a commissioned care package of 30 minutes a day, 7 days a week. It recognised that without this there was a risk of severe self-neglect reoccurring. The assessor recorded that they had no concerns regarding Carol's mental capacity.

In mid-July 2018, ASC recorded that there was a discussion with Carol and an offer made regarding an interim care bed. Carol is recorded as stating that she would prefer to remain in hospital as 'she had got used to it there'. It was apparent that once daily care was proving difficult to source and, on this basis, and on a hospital view that Carol's general condition had improved, it was suggested that she was discharged on Reablement (RBT) or Intermediate Care Team (ICT) pathways.

At the same time Carol's daughter expressed concerns to the hospital regarding her mother's impending discharge. She felt that the house was not suitable and stated that that it was infested with fleas. This was contrary to conversations with Carol's husband and sister who are recorded as stating that Carol's room had been cleaned and decorated.

On 19th July 2018, a consultant at the hospital recorded that Carol's condition and mental state had improved and whilst she had awaited once a day care and offered an interim bed she was at that time able to mobilise and therefore she was suitable for discharge without once a day care. The social worker and GP were to be liaised with.

The duty social worker spoke to Carol on the phone, she stated that ideally, she would like carers twice weekly to assist with bathing. It was established that at home there was a working shower and Carol's husband could assist to bath Carol on a Sunday. A referral was to be made to the Safer Homes Project.

When the ward staff nurse contacted the family regarding discharge, they spoke to a relative of Carol. They were told that the family were not able to care for Carol and that she would not care for herself. The hospital notes indicate that there was some reluctance to collect Carol, but eventually the family did attend and collect her.

From 5 days after the date of discharge until 13th August 2018, Carol received daily personal care visits from the ICT of between 10 minutes and 30 minutes duration. During this period there was a referral made to the Occupational Therapy Team (OT). The lack of stair lift was discussed with Carol and her husband and that the Local Authority were to provide this this once the funding was available.

At the beginning of September 2018, after a number of attempts, the OT made contact with Carol for an assessment. It was established that Carol was spending time in the husband's van, during the day, whilst he was working. It was recorded that they were still awaiting a stairlift but could not afford it. The assessment queried whether Carol had learning disabilities but there is no record of consideration of a mental capacity assessment (MCA). Around the same time there was a physiotherapy assessment. This recorded that the family were providing care and the husband was dragging Carol upstairs when necessary. Carol was said to be able to mobilise well with a frame.

On 10th October 2018, Carol attended the hospital emergency department but left prior to being assessed. Carol had been directed to the hospital by her GP following a conversation with the renal registrar about abnormal bloods and a catheter, which needed to be inserted. The hospital tried to contact Carol but were not successful. The GP was not informed of the non-attendance at the hospital. Around this time the family were informed that the application for a stairlift had been successful.

There are no records of contact with Carol and family in October, November and December 2018, except some limited contact by ASC concerning financial support for Carol.

On 28th December 2018, Carol's husband attended the GP's surgery and stated that Carol had, over the previous few days, not been eating properly, had not been taking her medication and was slurring her speech. This had occurred following a fall she had on Christmas Day. An ambulance attended the home address and conveyed Carol to hospital.

The ambulance crew recorded that Carol had been self-neglecting for a while, but this had deteriorated since November. Carol had not been visiting the toilet and therefore urinating and defecating on her bed, her mattress was sodden with urine. These concerns were raised by the ambulance staff with the hospital. Hospital staff liaised with their safeguarding team. The ambulance crew made a safeguarding referral to ASC. The reasons given for hospital admittance were recorded as self-neglect, hypercalcaemia[2] and urinary infection. Carol also had pressure sores and reported not leaving her bed since November 2018.

Carol's husband was spoken to on the phone and stated that in his opinion Carol had 'given up on life'. He stated that three weeks previously she had curled up in a ball and stopped doing anything. Carol was admitted to hospital.

At the beginning of January 2019, during an OT assessment session, Carol's husband was consulted and detailed Carol's history. This included his view that his wife's issues were related to her mental health. The OT assessment noted that there had been a decline since November linked to a decline in her mental health. It concluded that discharge was unsafe at this time and further assessment was required.

Carol was assessed by a consultant who recorded '*that in my view, on balance, that Carol could not demonstrate sufficiently that she understood or could weigh up the risks associated with going home without care'.* It was assessed that the risk of not putting in place a proper care package was considerable.

[2] Hypercalcaemia – high calcium levels

The hospital recorded that a referral for 4 times daily reablement had been submitted. This was due to commence on the evening of Carol's discharge on 8th January 2019. It is not clear that this support started as planned but contact was made the following day by the Suffolk Admission Prevention Service. When contact was made, Carol's husband reported that Carol had fallen on three occasions since her discharge. There appeared to be some confusion between Cambridgeshire and Suffolk services as to who was to provide support.

On 9th January 2019, Carol was assessed by the Cambridgeshire reablement team. This assessment is brief and states that Carol does not have any applicable health conditions or disabilities. The assessment identified that Carol was doubly incontinent and has become bedbound and she had restricted mobility. The assessment identified that family were dealing with Carol's medication and meals. It also identified that the husband and daughter work and were absent on a daily basis. The assessment stated that there was only one mobile phone in the household, which was in the possession of the husband during day, creating a potential fire and safety risk for Carol. It further stated that Carol would be able to evacuate in an emergency. Having identified this risk, there does not appear to be any further action or mitigation offered. The assessment reduced the care from four times daily to one visit in the mornings only. This reduction was at Carol's request. There is no record of a mental capacity assessment being undertaken regarding this decision made by Carol.

On 10th January 2019, Cambridgeshire ASC recorded as part of a reablement assessment that Carol had fallen on discharge, but this fall was deemed to be on purpose. She was checked and remained fit to be discharged. Since being discharged Carol was said to be declining personal continence care.

The RBT visited daily from 11th to 24th January 2019, to give personal care, the records show that on occasions this care was declined by Carol. Carol's husband is recorded as being frustrated regarding his wife being afforded the right level of support. On one day the RBT records show that Carol been incontinent but there were no concerns raised by the RBT regarding Carol's condition or the conditions of her surroundings. There is no record of any consideration of pressure ulcers, which had been a feature on Carol's previous admission to hospital.

On 14th January 2019, the GP contacted Carol's husband, it recorded that the RBT was only visiting once daily, it had previously recorded that this occurred 4 times daily. There were arrangements made for the district nurse to visit to change dressings but there was some confusion as to which Suffolk team should be dealing. It is apparent that the reduction in RBT visiting had not been communicated to the GP.

On 15th January 2019, the district nurse visited and changed Carol's dressings. An ASC social worker also visited and spoke with Carol, and then her husband on the phone. Carol's husband stated that he did not feel that his wife was being supported. The social worker stated that they would follow up on a physiotherapy assessment.

On 16th January 2019, Carol started to receive care from the Suffolk Community Matrons.

On 23rd January 2019, Carol was visited for the purposes of a physiotherapy assessment. The physiotherapist found that the bed was heavily soaked in urine and the mattress was covered with a tarpaulin. The conditions at the address were poor and unsanitary. The physiotherapist requested other staff to come to the address to assist her in moving and cleaning Carol. It was noted that Carol did not seem to understand the long-term implications of refusing care. To afford the necessary care three persons were required and they noted what was recorded as a small pressure area to Carol's left hip and an oval wound to the lower leg as well as some bruising. The reablement records were checked at the address and it was noted that Carol had been refusing care in the mornings.

An environmental assessment recorded that the house was generally very unclean and unkempt. Kitchen, floor and worktops very unclean, as was the commode. The physiotherapist recorded that a referral would be made to the Early Intervention Team. There was no record of a safeguarding referral being considered or submitted.

On the evening of the same day the Suffolk Admission Prevention Service contacted the Cambridgeshire Reablement Service by phone. They were informed that carers provided care once a day in the morning and they had no concerns regarding pressure areas, mobility or care. Although they admitted they had not met Carol personally.

The following day the Suffolk Admission Prevention Service visited Carol at home. Two members of staff were able to move and wash Carol, but she was unable to stand. They recorded that she had lost the ability to manage any aspects of her care, mobility and transfers since returning home. The home was considered to be a health and safety risk and the safeguarding issues needed to be addressed. It was also recorded that Carol did not appear to be eating or drinking.

The following day (25th January 2019) Carol was re-admitted to hospital. Admissions notes showed that Carol had suffered abdominal pains for three days, was not eating or drinking and was vomiting.

Carol had been conveyed to hospital by ambulance who made a safeguarding referral which stated that Carol was receiving support once a day, on their attendance that evening she had an incontinence pad which was full of diarrhoea. Carol's daughter had been present and was distraught and visibly upset.

The family were contacted and gave a history. There was considerable anger from the family as they felt that Carol's mental health had been ignored and that her early release from hospital and lack of support had been the reason for her readmission. A mental capacity assessment is recorded as showing that Carol lacked mental capacity due to her low consciousness level. Discussion with the family showed that they would wish her to regain her cognitive function to allow her to return home.

On 29th January 2019, a consultant discussed with the family that Carol had now developed a chest infection and her condition was deteriorating. On 1st February 2019, Carol died in hospital, the cause of death being hospital acquired pneumonia.

6. Analysis of involvement

Did Carol have mental capacity? What assessments were done, by whom, and for what decision?

From the beginning of June 2018 to 19th July 2018, Carol was a patient in Hospital. When an assessment was undertaken on 14th June 2018, the assessor stated that there were no concerns over Carol's mental capacity. Carol had been admitted to hospital with reported severe self-neglect and the assessment recognised that without a care package providing care on a daily basis, this self-neglect was likely to be repeated.

In September 2018, there was an OT assessment of Carol, in her home. Whilst there is no mention of a mental capacity assessment, the assessment did query whether Carol had a learning disability but there is no record of this being followed up.

In January 2019, after Carol had been admitted to hospital, for the second time, with health conditions exacerbated by her self-neglecting a consultant recorded that "*that in my view, on balance, that Carol could not demonstrate sufficiently that she understood or could weigh up the risks associated with going home without care'.* It was assessed that the risk of not putting in place a proper care package was considerable. It was clear at this point that professionals were questioning Carol's capacity to have the required understanding of the impact of not caring for herself would have on her increasingly poor health.

Carol maintained that she could care for herself although there are indications that she was reliant on the hospital care. On her first admission she stated that she was happy to stay there as she had become 'used to it'. On the second admission when she was being discharged she is said to have 'deliberately' fallen. This may have been an indication that she did not wish to leave.

Carol's immediate and more extended family were clear that they believed that Carol could not care for herself and they were not able to effectively care for her.

Although professionals felt that Carol had mental capacity, that capacity was being assessed at the time it was considered, as opposed to what this may look like when Carol was in her own home. When Carol was discharged from hospital on the second occasion the plan was for her to receive personal care four times daily. Almost immediately this care was reduced to once daily at Carol's request. Carol then on occasions declined the daily care completely. Although the risks of receiving no care package had previously been identified, these decisions to significantly reduce it were never reviewed or questioned in the terms of mental capacity.

The ability of a person to make a decision and then having the capacity to take action on that decision is often referred to as Decisional and Executive capacity. This area was explored in a recent article in Community Care by Dr Emma Cameron and James Codling, 'When mental capacity assessments must delve beneath what people say to what they do'[3]. This article makes the point that many of the decisions in supporting people are rarely just decisional, tending to require both decisional and performative considerations. Their research indicates that often observational real-world evidence from sources such as families is not considered when undertaking assessments. It is acknowledged that to build this picture more than one assessment would be required. In this case there was a wealth of evidence to suggest that Carol would not be able to care for herself, without considerable support, when discharged from hospital. Any reduction in this care should have initiated a further assessment of mental capacity.

The assessment of mental capacity in cases of self-neglect featured in a previous Cambridge and Peterborough SAR, the case of Arthur.[4] The following recommendation was made ' (The SAB) *Provides guidance on consideration of executive capacity in mental capacity assessments, especially where there are repeating patterns of presentation.'* Although this recommendation has been addressed by training, this SAR would indicate that a review of the embedding of that training would be good practice and timely.

Since this case and the case of Arthur, the Cambridgeshire and Peterborough Safeguarding Adults Board has introduced the Multi Agency Risk Management (MARM)[5] process. This process relates to persons who are deemed to have mental capacity and initiates multi agency risk planning and management.

[3] Community Cares, October 28th 2020, When mental capacity assessments must delve beneath what people say to what they do (accessed 21/12/20) - When mental capacity assessments must delve beneath what people say to what they do

[4] Cambridgeshire and Peterborough SAR case of 'Arthur', December 2018, Michael Preston Shoot (accessed 21/12/20)- Cambridgeshire and Peterborough SAR case of 'Arthur'

[5] Multi Agency Risk Assessment Process (accessed 21/12/20) - Multi Agency Risk Management (MARM)

A more detailed examination of Carol's mental capacity is likely to have shown that she lacked the insight to understand that the impact of her neglecting her own care was having a significant impact on her overall health. If this was not the case, the MARM process would now be initiated.

Did Carol have a learning disability and if so, to what extent did this impact on her life and the care she received? Was she able to understand the long-term implications of refusing care?

There was no diagnosed learning disability for Carol. In June 2018, a consultant psychiatrist saw Carol in hospital. He recorded that it would be worth Carol being seen and assessed by a learning disability nurse, but this did not occur. There was also a recommendation that Carol should receive bereavement counselling, again this did not take place.

In September 2018, during an assessment by the OT, it was also queried whether Carol had a learning disability but again this was not followed up. It was recognised on a number of occasions that Carol was struggling with her mental health and this was linked to the death of her parents. Although bereavement counselling as an outpatient was discussed it was never delivered or followed up.

Is there evidence to suggest that professionals considered all issues affecting Carol were the result of her self-neglect, and if so how did this impact on the planning and delivering of interventions?

There is no evidence to suggest that professionals considered all issues affecting Carol were a direct result of self-neglect. There is evidence that professionals failed to consider the case holistically and to explore what the root causes were for Carol failing to care for herself. The family presented the view that Carol had effectively given up on life but there was no effective review of Carol's mental health. Although bereavement counselling was considered it was not delivered.

How effective was the cross boundary working between Suffolk and Cambridgeshire services?

Carol and her family lived on the Cambridgeshire and Suffolk borders and due to this some of the services delivered to her were from each of the Counties. Most notably Carol's GP was in Suffolk and therefore did not have the close links that it might have had they been in the same County. It was recognised in the practitioner event that the GP practice has 50% of their patients resident in the Cambridgeshire area. They hold regular multi-disciplinary meetings to discuss cases and have representation form Suffolk ASC but there is currently no representation from Cambridgeshire ASC or CPFT.

On Carol's first admission it was recorded that she was medically fit to be discharged on 6th June 2018 but was not actually discharged until 19th July 2018. This delay was primarily due to the right level of care in the community not being available in the area that Carol lived.

In October 2018, the GP referred Carol to hospital following a conversation with the renal registrar regarding some abnormal bloods and the need for a catheter to be inserted. Carol absented from the hospital, who tried to contact her but failed to do so. There was then no follow up on this appointment with Carol or the GP. This DNA (did not attend) would not routinely appear on the GP DNA list as there was no safeguarding concern recorded on Carol's record.

Apart from the cross-County issues of services there was a lack of joined up working between agencies involved with Carol. There were three different reablement teams involved at various stages of Carol's care (Cambridge City, Cambridge South and Ely). The hospital social care team and reablement were both involved and there was confusion over 'ownership' of the case. After the first admission the discharge plan noted '*I believe it is important that all services keep clear consistent communication to ensure support and interventions are in place to sustain Carol's safety in the home.*' Whilst this comment was insightful it was not followed through. With the number of agencies involved and the complications over boundary issues this case needed a clear multi-agency plan and a professionals meeting to coordinate its delivery.

Information that was known to agencies, particularly the ongoing risk of self-neglect, did not follow Carol through the system and was not available or considered when making decisions.

On 28th December 2018, the ambulance service attended Carol's address and she was conveyed to hospital. They found Carol in a very poor condition. Her bed was sodden with urine and faeces. The ambulance crew made a safeguarding referral to ASC but this was closed on the basis that Carol was open to the reablement team. In the practitioner event it was established that the reablement team did not understand the critical nature of Carol's care when they agreed to reduce the 4 daily care visits to one in January at her request.

CPFT had previously been involved in providing care to Carol but at the beginning of January 2019, they passed the request for physiotherapy to Suffolk Community Services. This had an impact on the continuity of care being delivered to Carol. It was agreed at the practitioner event that it would have been preferable for CPFT to have remained involved, but this was not possible due to commissioning arrangements.

How were risk and protective factors identified, assessed and managed?

One area that lacked assessment and consideration was how able the family were to care for Carol. The family repeatedly voiced their concerns about their ability to give Carol the right level of care. There were also signals that agencies could have picked up on such as Carol's reticence to leave hospital and the family's reticence to collect her.

The Care Act states, that where it appears to a Local Authority that a carer may have needs for support (whether currently or in the future), the Authority must assess (a) whether the carer does have needs for support (or is likely to do so in the future), and (b) if the carer does, what those needs are (or are likely to be in the future).[6]

The recognition and requirement for carer assessments has been identified in other SARs both locally (Arthur) and nationally[7]. The need for an assessment in this case was stark and would have allowed for an informed view of how the family could be best supported.

There is no doubt that the family did their best to care for Carol but struggled. The daughter had her own health issues and learning difficulties. She is described by ambulance staff to be visibly upset when they attended in January 2019. Carol's husband worked on a daily basis and was not at home to allow him to care for Carol and therefore relied on care support.

Carol's husband struggled with written communications. There was no home landline and the mobile signal in the area was poor. The family only had one mobile phone, which the husband had during the day. This left Carol at home without any means of communication. This was recognised in the reablement assessment in January 2019, but stated that there was no risk to Carol as she stated that she would be able to evacuate the home in an emergency. This, given Carol's mobility difficulties was unlikely and more consideration should have been given to measures to mitigate this identified risk. A carer assessment would have identified some of the barriers the family had in communicating with agencies.

The reduction of daily care in January 2019 by the reablement team has already been discussed. The daily care was provided from 9th January to Carol's re-admission to hospital on 25th January 2019. On occasions Carol declined the care when visited. The district nurse also visited as did a social worker. The physiotherapist attended the address on 23rd January and recorded that Carol's bed and pad was soaked in urine and that the mattress was covered in a tarpaulin. Carol was cleaned, it took three

[6] Care Act 2014, section 10 (accessed 21/12/20) - Care Act 2014, section 10

[7] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection (2015) 17 (1), 3-18.

members of staff to move her. It was noted that she had a small pressure area to her left hip, a sore to her right side and an open oval wound on her leg. The case was handed to the Suffolk Community Team and a safeguarding referral was made to Cambridgeshire ASC. What is surprising is the level of deterioration in Carol's physical and environmental condition and that this was not recognised on the daily visits from reablement and other professionals.

During the practitioner event it was recognised that the reablement team in particular had been focused on the OT and physiotherapy and they had not recognised the ongoing risk and deterioration of Carol's condition. This phase of care in particular, lacked the necessary coordination and planning.

The requirement for a stairlift was identified as early as June 2018, before Carol was discharged from hospital. There was confusion over how this was going to be funded and the family would say that it was not clear to them at various stages who was leading on this or whose responsibility it was. The stairlift did not arrive until October 2018. During this period Carol's husband was having to manually manoeuvre Carol up and down the stairs on the rare occasions she left her bed.

In December 2018, Carol was admitted to hospital when her husband raised a concern that she had not been taking her medication. On admission this was confirmed by the level of medication in Carol's possession. This failure to properly self-medicate did not feature in discharge plan or any plans to mitigate this risk. The medication not being taken included medication for her depression. The reablement assessment of 9th January 2019, identified that Carol was taking medication but stated that reablement were not to get involved as Carol was independent. There should have been more consideration of Carol's medication management and how this was to be sustained, taking into account Carol's inability to care for herself.

What actions were taken by practitioners and agencies to ensure that concerns were shared appropriately, and within the available frameworks, to attempt to mitigate any risk?

Are there any areas of good practice?

A feature of this case was that there was silo working and agencies did not work well together to provide the care and support that Carol needed.

There could have been more communication and involvement with the Local Authority responsible for housing to ensure that there was a joined-up approach and in particular with regard to the provision of mobility aids and self-neglect.

The ambulance service made two safeguarding referrals following their attendance at the address in December 2018 and January 2019. On both occasions the referrals were detailed and on the first occasion suggested that there should be a mental health

assessment and a care package put in place. They also used the clutter scale to describe the environmental aspect of the address. The input of the ambulance service was thorough and followed good practice.

7. What are the learning points from this case?

Mental capacity – there needs to be a review of the learning to date and interagency understanding of mental capacity and its relationship to self-neglect. The learning from this case and the previous case of Arthur could be used to better understand and support the challenges faced by professionals when assessing mental capacity in these circumstances.

Carer assessments – There needs to be greater interagency awareness of the need to complete assessments of persons undertaking a caring role, to provide them and the person subject of the care the support they require. This should include understanding the ability of the carer to navigate the system of care and what is available to them.

There needs to be clear lines of communication between the hospital social care team and reablement team to ensure that assessments are effectively undertaken and known risks and concerns are included in the assessment and appropriately mitigated.

Where there are a number of agencies involved in delivering care to a person in the community there should be a coordinated care plan, an identified lead professional, underpinned by professional meetings where required.

There needs to be a review of community care services in Cambridgeshire, particularly in the rural border areas to ensure that services can be accessed, which in turn will prevent un-necessary extension to hospital admission.

Cambridgeshire ASC and CPFT should ensure that there is good communication with Suffolk GP practices that border Cambridgeshire and hold a significant Cambridgeshire patient list. This should include attendance at the relevant multi discipline meetings.

Where there are concerns that a patient is not taking prescribed medication there should be a review and medication administration should feature in care and discharge plans.

Agencies providing daily community care need to be aware of the impact of self-neglect and where necessary make appropriate safeguarding referrals.

Where a safeguarding referral is made it should not be closed on the basis that another agency is involved, without understanding that the care being provided will address the concern and that the other agency is aware of the concerns and the onus on them to address them.

Where there is a recognised need for services in the community, such as bereavement counselling to a person, this should be communicated to the relevant GP and measures put in place to ensure that it is delivered as intended.

There could have been more involvement with the Local Authority responsible for housing and in particular around the issues of self-neglect.

8. Recommendations

1. The Cambridgeshire and Peterborough Safeguarding Adults Board should be assured that the safeguarding partnership has delivered effective training to equip professionals to understand assessing mental capacity in the context of self-neglect and this training is embedded to ensure that the signs are identified and appropriate actions taken.

2. The Cambridgeshire and Peterborough Safeguarding Adults Board should be assured that professionals and carers are aware of the need to assess the role of persons performing a care role as required in the Care Act.

3. Cambridgeshire and Peterborough Adult Social Care should ensure that the communication between hospital social care teams and the Reablement Service is clear and that ownership and responsibility for cases is clearly understood.

4. The Cambridgeshire and Peterborough Safeguarding Adults Board should be assured that relevant Cambridgeshire agencies are linked into GP practices in bordering County areas who have a significant Cambridgeshire patient list.

5. The Cambridgeshire and Peterborough Safeguarding Adults Board should be assured that where there are a number of services delivering support to a person in the community, that there is coordinated plan, a lead professional and there are professional meetings where required.

6. The Cambridgeshire and Peterborough Safeguarding Adults Board should be assured by the commissioners of care for the community services that the service is available in the more remote and rural areas.