Cambridgeshire and Peterborough Safeguarding Adult's Board

Safeguarding Adult Review 'Esther'

Date: December 2022

Contents

1. Introduction

Esther was a white female aged 51 years in 2020. She was described by some of those professionals who had worked with her as having a good sense of humour, although she could be found on occasions to be low in her mood and disengaged. It was felt that this might have been as a result of her disability and the related loss of independence. She was described as having a good understanding of her various medications and being able to ask for help and request support when she felt she needed it. The impression given by those professionals was of a likeable woman who overnight had lost the ability to take care of herself, and understandably had struggled with this dramatic change to her lifestyle.

Until November 2016, she had been living a somewhat chaotic lifestyle owing to her drug and alcohol use and resulting homelessness. She had been an independent person but following a spinal abscess resulting in spinal cord injury, Esther became paraplegic. As a consequence, she was non-weight-bearing, spending the majority of her time in bed or her wheelchair, which she was able to self-propel. She required the use of a full body hoist and two care providers to support with all moving and handling manoeuvres, including the support of one care provider for formal repositioning. Esther had a long history of alcohol and drug misuse and a historic diagnosis of a personality disorder. She had also been a victim of domestic violence in the past.

At the time of her death she had been living with Joe for approximately three years. The nature of the relationship between Esther and Joe was unclear. He was described as her partner, ex-partner and carer interchangeably. On 18th May 2020 Esther was taken by ambulance from her home to hospital, where she was admitted with a suspected broken arm. Whilst in the ambulance, Esther disclosed that her partner Joe had assaulted her. Unfortunately, she died in hospital on 28th May 2020, from what is thought to have been pneumonia. The cause of death remained undetermined at the time this report was being written.

Esther had suffered a history of domestic abuse, and initially this case was considered by a domestic homicide review (DHR) panel. However, it was believed that the difficulties surrounding Esther were wider than domestic abuse, and that a safeguarding adult review (SAR) was a more appropriate review.

2. Methodology

Relevant agencies were required to complete a "key events" chronology, which once completed, were combined into a single composite chronology.

The chronology was used as the basis for a virtual facilitated workshop with representatives from the relevant agencies. Those present at this meeting were asked to consider the information within their own agency's chronology and to participate in an in-depth case discussion regarding the safeguarding issues surrounding Esther before she died. The aim of this discussion was to extract learning and good practice relating to Esther in order to improve practice across the adult safeguarding workforce.

Chronology

The following agencies were required to complete a chronology on an agreed template:
Independent Domestic Violence Advocate (IDVA) service
Cambridgeshire Constabulary

Cambridgeshire Adult Social Care
Clinical Commissioning Group/ Continuing Health Care
Cambridge University Hospital: Addenbrookes Hospital
East of England Ambulance Service
Cambridgeshire and Peterborough Foundation Trust (CPFT)
General Practitioner
Change Grow Live (CGL)
Trust Home Care Agency
Local Authority housing department

3. Scope of the review

5th November 2016, the date that Esther was admitted to hospital with reduced mobility and back pain to 28th May 2020, the date of her death.

4. Contact with family members

As with all safeguarding adult reviews, it is important to gain the views of the families of the subjects of these reviews. Attempts were made to make contact with both Esther's son and daughter, both of whom were adults themselves. An initial contact was made with Esther's son and at the time he felt unable to talk about his mother but agreed for the author to make contact with him again. Sadly, he passed away in 2021 before further successful contact could be made. Despite a number of attempts, contact was not able to be made with Esther's daughter.

5. Summary of Agency Involvement

2016

Esther was admitted to Addenbrookes hospital on 5th November 2016 by ambulance reporting reduced mobility, back pain and numbness in her legs. Esther's heroin use was noted when she was admitted, and she was assessed and supported during her admission to access methadone. An epidural abscess was diagnosed the same day and Esther was informed that the chance of recovery of the function of her legs was remote. The operation took place on the same date that Esther was admitted and following the operation, unfortunately, Esther was left with complete motor and sensory loss in both legs.

On 9th November, four days after being admitted, non-hospital syringes and needles were found in Esther's personal items. When asked, Esther suggested that her 'partner' Joe had brought them into hospital during visits. On 12th November, Joe visited Esther and his behaviour caused concern, and a decision was made to search both Joe and Esther's belongings but nothing of concern was found. It was accepted by the author's group that whilst the decision to search Joe had been made at the time, it is not an action which would be considered now. The hospital would not have the power to search a visitor but may ask for consent to search a patients belongings if it was felt to be necessary. The hospital records included both the concerns for Esther's safety in relation to the syringes and her own views: she denied being aware of the presence of the syringes or what they contained. A safeguarding referral was completed and sent to the multi-agency safeguarding hub (MASH). It appears from records that an internal safeguarding plan was put in place within the hospital as on 14th November hospital records state that Esther was to be closely supervised when her boyfriend (Joe) visited. This close supervision of Esther involved having a member of hospital

staff sitting with her when Joe visited – this was due to concerns that Joe was providing drugs to Esther in the hospital.

On 18th November 2016 it became apparent that Esther's phones had gone missing and it was observed that Esther's physical state appeared to deteriorate after Joe had visited. It was suspected from her presentation that she had been using illicit drugs whilst in the hospital, although when asked Esther denied this. A safeguarding plan is recorded in the hospital notes to observe Esther when Joe was visiting and ask him to leave and search Esther's room if there are any concerns for Esther's safety. Esther's views in relation to her ongoing care needs are documented: she requested a soft food diet similar to that which she had been consuming at home and asked for Joe to be added to her records as next of kin.

On 22nd November Esther was assessed by a physiotherapist to determine what rehabilitation support might be necessary to support her to use a wheelchair and 'achieve functional goals'. Esther's views were again recorded: she expressed that she 'did not see the point' of rehabilitation if she would not walk again and was described as 'quite frustrated'.

On 28th November it was recorded by Addenbrookes hospital that Joe had taken Esther's bank card, that she consented to this and had the capacity to do so.

Concerns remained relating to Esther's drug taking and she was asked on 7th December to undertake a drugs test but she did not give her consent, although she did engage in a 'long discussion' relating to her drug use. A decision was made by the hospital at this point not to permit Joe onto the ward to visit Esther due to the concerns for her safety and that of staff.

On 22nd December 2016 Joe attempted to visit Esther but was stopped by hospital staff. He asked that a bag be given to Esther. A decision to search the bag was made and a syringe was found amongst the contents of the bag. Esther was informed of this action and her views were recorded: she was described as 'upset and angry' having asked where her belongings were. Joe later telephoned the hospital to ask if the bag had been passed to Esther and became 'very upset' and threatening when he was told that the bag had been searched and that Esther had not received the contents. The hospital contacted the Police for advice who logged a report and suggested the hospital dispose of the syringe.

2017

On 9th January 2017 'suspicious' items were found amongst Esther's possession after a male visitor has brought in some of Esther's belongings on behalf of Joe. These items were thought to be drug paraphernalia, but Esther did not present as having taken any illicit drugs. A full search of Esther's room was undertaken with her consent the following day. Hospital records also indicate a discussion with Esther relating to her engagement in physical and occupational therapy and supporting her to avoiding discharge into a nursing home, in alignment with Esther's wishes.

On 25th January 2017, Joe again attempted to send what were thought to be illicit drugs into the hospital to Esther amongst some of her possessions. These were disposed of and Cambridgeshire Constabulary were informed.

The following day, 26th January 2017, Cambridgeshire Constabulary communicated to Addenbrookes hospital that the drugs that Joe attempted to send in to Esther on this most recent occasion were of sufficient quantity to enable them to pursue a prosecution. A decision

was made within the hospital to ban all visitors to Esther for her own safety and that of the staff. Esther was informed of this and her views and observations of her behaviour in response were well documented: she is described within the records as: ''visibly disappointed however acted nonchalant and blasé'.

On 9th February Esther received physical therapy in the hospital to support her independent living skills. Esther's response to this session is well recorded.

On 28th February 2017 Esther was observed 'making an exchange' with a male. A full search of Esther revealed a loaded syringe with a used needle. Cambridgeshire Constabulary were informed and one to one nursing was implemented for Esther for her own safety and that of hospital staff. A review by the liaison psychiatry team on 01st March 2017 considered Esther to be 'not physically dependant' but 'psychologically dependant on illegal drugs'. The review stated that Esther's repeated denial of the presence of drugs in hospital, hindered the hospital staff's ability to treat or offer support to Esther. There was also recognition of Esther's views relating to how her care and support needs might be met on discharge from hospital, she had expressed that she did not want a nursing placement.

On 1st March 2017 a discussion was held with Esther to complete a Continuing Health Care checklist about her ongoing care but she became verbally abusive towards staff. Between 24th of March and 26th April 2017 there are multiple discussions with Esther regarding her discharge from hospital, potential placements and ongoing care needs. Esther's views are well recorded: again she expressed a firm desire to retain her independence and secure her own accommodation. On 4th May 2017 an interim placement for Esther was confirmed and there are discussions recorded within the chronology regarding the additional support needed to meet Esther's needs: carers, a wheelchair, hoist, daily visits by District Nurses.

On 17th May 2017 it is recorded that Esther's discharge had been delayed due to a lack of availability of District Nurses. Two days later, 19th May 2017, Esther's discharge was planned for 22nd May 2017. Records suggest Esther was kept well informed and was then discharged from Addenbrookes on 22nd May.

On the 25th May 2017 carers from the care agency visited Esther and raised concerns regarding a man who had climbed through a window to enter the property and was described as being 'extremely angry' and causing the carers to feel intimidated. The care agency withdrew the care package with immediate effect due to concerns for the carers safety. A new package of support from a different care agency could not be sourced by Continuing Health Care (CHC) until 31st May 2017. Cambridgeshire and Peterborough Foundation Trust (CPFT) records show that the District Nurse who attended on 27th May 2017 recorded that whilst there was not a care package in place, Esther had a 'friend giving personal care'.

On 31st May 2017, carers raised concerns with the Continuing Healthcare team regarding Esther's vulnerability and her dependence on her 'friend' who had been helping her whilst she had not had support from a care agency. They asked if Esther could be supported to be more independent because Esther has expressed that she suspected this male was taking money from her but did not feel able to take any action because she was reliant on him for support. On 4th June 2017, carers from the new care agency contacted the MASH to raise possible safeguarding concerns. When carers had attended the previous day, they had seen bruising to her upper body. These bruises varied in colour but they had not asked Esther what had

caused them. Esther had also cancelled several calls recently. The concerns were referred back to the Discharge planning team at Addenbrookes Hospital who contacted Esther but she was described as 'not very forthcoming'. It was confirmed with her that she was alone at the time of the call and she is recorded to have said that the bruising noted by the carers was 'not linked to anything violent'. She was offered further support from a Social Worker but declined this.

On 2nd August 2017 a phone call between the Physiotherapist and a Social Worker further discussing Esther's vulnerability and her 'friends who may be taking advantage' took place. On 9th August it is recorded that the Physiotherapists had made the decision to complete visits to Esther in pairs 'due to home circumstances'. Recording of another visit on 5th September 2017 by the Physio team suggests that Esther's partner, Joe, was 'acting aggressively towards her regarding money'. The Physio advised Esther to contact her key worker if she did not feel safe and the Physio contacted the key worker who agreed that they were 'aware of the situation' and therefore no referral was made to the multi-agency safeguarding hub. This was a missed opportunity to explore the relationship between Joe and Esther from her point of view. Little is understood about this relationship as it does not appear from any agency's records that any professionals sought Esther's views or asked her how she felt. It is clear from the records that Esther was dependant on Joe for a number of things, not least of all drugs and that she became increasingly unhappy I this relationship through the time period of this review.

On 11th September 2017 the visiting District Nurse recorded concerns for Esther relating to self-neglect and theft of money. After seeking advice from the CPFT Safeguarding Lead, a Multi-Agency Safeguarding Hub (MASH) referral is recorded to have been made but because consent from Esther had not been sought from Esther for the safeguarding referral, no action could be taken buy Adult Social Care. In 2021, concerns such as these would present an opportunity to consider whether the threshold for the Multi-Agency Risk Management process had been met, although this was not in place in 2017. Additionally, there is no recorded suggestion that Esther's capacity had been considered based on the fact that she had been observed to have been under the influence of alcohol by the District Nurses. The District Nurse also completed a referral for Esther to the CPFT Tissue Viability Nurse due to a sacral pressure ulcer.

10 days later on 21st September, Esther was admitted back into Addenbrookes hospital as a result of concerns raised by the GP regarding the grade four sacral pressure ulcer. Initially Esther refused to accept some of the care from the hospital staff such as a catheter change, blood tests and input from the tissue viability nurse.

On 25th September 2017 Esther signed a tenancy with Cambridge City Council for a fully disabled adapted property. Cambridge City Council records state that Esther was the only occupier of the property during her tenancy and that she claimed Single Person Discount[1] until the time of her death. On 28th September 2017 Esther was discharged from hospital.

A joint visit to Esther was conducted on 9th October 2017 by the Physiotherapist, Occupational Therapist and a Tenancy Officer from Cambridge City Council. Esther mentioned to those

[1] Single person discount is a reduction applied to a council tax bill for a property if the liable person lives alone or with anyone else who does not count as an adult, for example a child or full time student.

professionals about a 'friend' believed to be Joe and that they don't always 'get on with each other.'

2018

On 15th January 2018 a review was conducted by Continuing Health Care into the care required and being received at that time by Esther. Esther appears to have been present and whilst the care agency did not raise any new concerns, there does not appear to have been consideration of Esther's lifestyle and any potential risk to her. A greater level of professional curiosity could have been exercised, particularly considering the significant change that Esther had experienced in relation to her mobility and independence and the resulting dependence on Joe.

Esther is admitted to Addenbrookes again on 3rd February 2018 for abdominal pain. She was discharged the same day following treatment for a urinary tract infection.

On 23rd March 2018, Esther was visited by a Dietician who noted that Joe was present and that Esther appear to be 'low in mood' which Esther explained by saying she had a chest infection.

During a District Nurse visit on 17th April 2018 Esther disclosed that her 'friend' Joe helps himself to her money when he uses her bank card. In response the District Nurse asked for Esther's consent to submit a safeguarding referral but Esther refused, she also refused additional support or advice. There was no reason to question her capacity to make this decision.

On 2nd May the District Nurse documents a safeguarding concern relating to self-neglect. It is not clear whether this was discussed with Esther but the information does appear in the GP chronology. On 5th May when the District Nurse visited, Esther described tension in the relationship between herself and her 'partner' Joe 'due to anger episodes'. During the District Nurse visit on 13th May, an 'aggressive' argument was observed between Esther and Joe. The District Nurse logged this observation as an incident and sought advice from the Named Nurse for Adult Safeguarding the following day. The District Nurse was advised to seek consent from Esther to make a MASH referral, gain advice on Esther's 'housing situation' and to contact the care agency supporting Esther, who reported no concerns. CPFT records show that the District Nurse visits to Esther were 'doubled up' from this date. This demonstrates a recognition of the potential risk to staff from either Esther or Joe.

On 17th May 2018, Esther informed the District Nurses that Joe had stolen money from her and owed her money. She believed he may have also stolen her cigarettes. Again a MASH referral was suggested to Esther but she declined her consent. Esther's capacity was considered in relation to this decision. Four days later on 21st May the District Nurse noted concerns relating to Esther's access to clean needles and her reliance on Joe to collect them for her. The District Nurse offered to arrange for the pharmacy to deliver clean needles but Esther declined this offer and said that her son was around, and he would do it for her. It does not appear that Esther was receiving any support from drug and alcohol services and it does not appear that support to assist her in accessing these services was made on this occasion.

Cambridgeshire Constabulary records from 18th June 2018 state that Esther's son Tom called the Police after a verbal and physical altercation between Joe and Tom at Esther's address.

Esther's vulnerability is evident in Cambridgeshire Constabulary's recording of this incident as they recorded that she described feeling fearful of the physical fight between Joe and Tom and couldn't access the telephone herself due to her disability. She expressed that she wanted Joe to stay at the property but for her son to leave. There was a missed opportunity on this occasion for submission of an Adult at Risk referral, known as a '102 form' by the Police owing to the fact that Esther did not have access to a telephone and was disabled.

On 1st July the District Nurses noted that Esther's general appearance was 'dirty and dishevelled'. Joe was asked to ensure the carers offered Esther a wash. It is not clear whether the concern was primarily of self-neglect or insufficient care from the care agency but the District Nurse noted that there were no toilet roll, wipes or flannels in the property. An escalation should have been made to the care agency to determine whether Esther was refusing a wash or whether the care agency were neglecting to provide this.

During the District Nurse visit on 18th July 2018, Esther disclosed that she was a victim of abuse by Joe. She stated that he had hit her in the face with an ashtray and she no longer wanted him in her property. The District Nurse requested Esther's consent to make a safeguarding referral, but Esther expressed that she was concerned she would lose her tenancy if this action was taken despite the District Nurse attempting to give assurances that this would not be the case. Esther was left with contact details for the contact centre and the District Nurse noted that the conversation had been difficult as Joe was present in the property. There is no suggestion that the District Nurse offered to complete a DASH (Domestic Abuse, Stalking and Harassment) form with Esther or sought advice from their safeguarding lead. Given that Esther had disclosed an assault against her, consideration should have been given to whether information could have been shared without Esther's consent. This is action that would be expected in response to a similar incident now following extensive training and awareness raising in relation to domestic abuse.

Seven days later, on 25th July 2018, the District Nurse noted concerns for Esther's physical and mental state as well as a 'notable increase in IV injections sites'. But there is no record of Esther's views although it was noted that she may have been under the influence of drugs at the time. Records state that the GP was informed but this does not appear in the GP records and as such is a missed opportunity to explore safety planning for Esther relating to her drug use.

On 28th September 2018, the District Nurse witnessed an altercation between Esther and her daughter. The District Nurse offered to make a MASH referral but Esther declined her consent for this. The details of the incident are well recorded and the District Nurse sought advice from the Named Nurse for Safeguarding, as well as sharing information with the carers. It is unclear however whether Joe was present at the time as the recording is contradictory.

During the visit on 19th October 2018, Esther told the District Nurse that she wanted to live alone but she declined an offer of support from the District Nurse to contact housing services or Adult Social Care.

Officers from Cambridgeshire Constabulary attended Esther's property on 16th November 2018 following a report of a broken window and an altercation between Joe and Esther's daughter's boyfriend. Four days later, on 20th November 2018, whilst discussing the incident which resulted in the broken window, Esther disclosed to the District Nurse that there was a

homemade weapon within the property and that she was afraid Joe may use this weapon if there were further altercations. The District Nurse sought advice from the Named Nurse for Safeguarding and again offered to make a MASH referral, contact the Police and support Esther with accessing a refuge. The records state that Esther refused the offers of support and told the District Nurse that the Police were aware. Whilst the District Nurses did seek advice from their safeguarding lead, who suggested providing the telephone number for Women's Aid, there does not appear to have been a consideration of the risk to both Esther and the wider public, nor the District Nurses themselves who were visiting regularly. This could have presented an opportunity to ask Esther to attend appointments at a local clinic in order to see her away from the home environment, an option which is more widely considered in practice now.

On the same day, 20th November 2018, Continuing Health Care completed a Care Package Review confirming Esther's ongoing eligibility for funding but noted the 'long term grade 4 pressure ulcer'.

The following day, 21st November 2018, the District Nurse noted two new wounds to Esther's abdomen which had the appearance of cigarette burns. There is no recording of Esther's response to this. Again, this is a missed opportunity for professional curiosity to determine precisely what the risk of harm to Esther was and related safety planning.

On 30th November the District Nurse raised concerns with the Care Agency Manager based on Esther's suggestion that sometimes she was only receiving a visit from carers once a day and that the first visit was sometimes as late as 11am. There were also concerns shared by the District Nurse that Esther's drain had become blocked with gloves and wipes. The Care Agency Manager informed the District Nurse that Esther frequently cancelled her visits but agreed to follow up on the issues raised.

2019

During a District Nurse visit on 7th January 2019, Esther disclosed that Joe sometimes took her food when he visited but declined again the offer of a MASH referral.

On 25th February the District Nurse provided Esther with contact details for Change Grow Live (CGL) a local drug and alcohol support service. The District Nurse made a telephone call to CGL but the office was closed.

On 10th March 2019, the District Nurse observed an argument between Esther and Joe at the property.

The District Nurse raised concerns with the care agency on 15th March that Esther was not being provided with a 45 minute visit which was required for hygiene purposes. The District Nurse had observed Esther receiving a 10 minute visit on 10th March and a similar concern had been raised on 14th December 2018.

On 20th April 2019 Esther was taken to Addenbrookes hospital by Ambulance for treatment of a tooth abscess and facial swelling because of a concern of sepsis. Initially Esther refused to have blood samples taken and expressed her wish to be discharged but the records state that she agreed with the proposed treatment plan. She remained in hospital until 24th April 2019.

On 23rd of June 2019, Esther told a District Nurse that Joe had 'burst her groin abscesses'. There is no further detail in the chronology to suggest what action was taken in response to this.

On 1st August 2019 Esther disclosed to the District Nurse that Joe had been 'belting her' on the arms and that she was 'sick of him being violent'. The District Nurse noted in the records that Joe was present during this visit and that Esther refused an offer of support. The District Nurse did ask to see Esther's arms but she refused. This was a missed opportunity to explore what Esther meant by 'belting', and possibly to have offered her an appointment away from her property in a local clinic in order to see her alone and in a safe environment.

On 2nd September 2019 a referral was received by the MASH from Esther's son's hostel. He had disclosed to the staff member within the hostel that Esther was a victim of domestic abuse. The referral was detailed regarding the concerns and their severity, as well as the offers of support made to Esther by the hostel when she attended to visit her son. Esther had declined these offers of support and because her consent had not been sought for the referral, Adult Social Care did not take any action but suggested to the care agency supporting Esther with four times daily visits, that they should complete a referral if they had any concerns. The care agency confirmed that they did not have any concerns.

A MASH referral was made on 3rd October 2019 for self-neglect by a District Nurse as Esther was refusing medical care, was frequently under the influence of recreational drugs and believed to be using the same needle repeatedly to inject drugs. The referral was received by Adult Early Help and the referrer was advised to contact Continuing Health Care if there were concerns relating to the level of care being provided to Esther. This referral could have triggered a professionals meeting to include the relevant agencies working with Esther and a multi-agency plan.

On 22nd October 2019, Esther disclosed to a Physiotherapist that her relationship with her partner had ended but she was concerned he would come back to the property and she would be unable to stop him. She also said that she was considering changing her address. No action is recorded as having been taken, demonstrating a missed opportunity for professional curiosity and safety planning. Esther also told the Physiotherapist that the carers did not have time to give her a shower but it is unclear whether any action was taken by the Physio, or the Occupational Therapist who was also present, in relation to this.

On 15th November, Esther declined an Occupational Therapy assessment.

On 26th November, a District Nurse made a 999 call because Esther was experiencing breathing problems. Esther refused to be admitted to hospital despite being strongly advised that this was the most appropriate action. Instead, Esther was supported to make an appointment later that day with her GP. Esther's capacity to refuse a hospital admission was accepted. The Paramedics who attended outlined their mental capacity assessment in their records.

Esther was admitted to Addenbrookes hospital the following day, 27th November 2019. She had made a 999 call as a result of worsening breathing difficulties and requested to be taken to hospital. Again, concerns of sepsis are recorded, as well as apparent illicit methadone in Esther's possessions. Esther was admitted to critical care and a mental capacity assessment

was completed which determined that Esther lacked capacity relating to her medical care and treatment at that time.

Esther's mental capacity was again assessed the following day, on 28th November 2019 and this assessment determined that Esther did have capacity to consent to care and treatment.

On 29th November 2019 Esther agreed to a referral to Change Grow Live (CGL), a local support service for drug treatment and rehabilitation, at the point of discharge from hospital. Hospital records suggest that Esther had a good understanding of her own medical needs and medication. It is recorded on this date that Esther continued to be closely supervised when having visitors.

On 30th November and 1st December 2019 Esther is recorded as having refused both medical and personal care. The following day, 2nd December 2019, Esther was assessed by the psychiatry team in Addenbrookes. She was considered to be more stable in mood and happy with the established dose of medication. The psychiatry team contacted CGL to arrange for CGL to take over prescribing Esther's medication.

On 5th December a referral was made to the diabetic outreach team as Esther was found to have steroid induced hyperglycaemia and impaired glucose tolerance. She was offered metformin on 9th December for a diagnosis of Type 2 Diabetes. On 10th December Esther was deemed to be medically fit for discharge. She requested to see someone from the liaison psychiatry team to complete a drug and alcohol assessment they had attempted to complete the day before.

On 11th December Esther developed a temperature so remained in hospital. Continuing Health Care requested a tissue viability review of Esther's pressure ulcer before recommissioning the package of care in the community.

The CGL assessment was completed on 18th December 2019. Barriers to engagement were identified relating to Esther's disability and possible solutions identified. Esther's wishes were also recorded.

On 25th December 2019 hospital records state that Esther was leaving and not returning to the ward until 1am. There was no record of anyone having been with her, she was able to move around with the use of a wheelchair at this time and it was considered to have been usual behaviour for Esther to do this. She refused an ECG, requesting it be conducted later that morning. The following day, 26th December Esther refused further medical care.

On 30th December and 2nd January 2020, discussions are recorded between Addenbrookes and Continuing Health Care relating to a change to the care package for Esther in the community to support increased repositioning.

2020

On 5th January 2020 Addenbrookes hospital records state that Esther had regularly been leaving the ward and had been found outside the hospital with two males. Again on 9th January 2020 Esther was seen leaving the ward with a male and was still regularly leaving the ward. At this point Esther's discharge was still being planned for and an assessment of risk to the carers was requested by Continuing Health Care, although it does not appear that potential risk to Esther was considered. Again when medication and discharge support were discussed

with Esther she demonstrated a good understanding of her own needs, and her views are well recorded in hospitals records: she expressed that the time the carers were supporting her to get into bed was too early and she preferred to go to bed later. Consideration was being given to her pressure sores and an increase in the number of daily visits from four times to five times daily was suggested to support Esther with repositioning.

On 15th January 2020 Esther refused a urine test and blood test. Again her capacity was considered.

On 20th January 2020 Esther left hospital. Numerous calls were made to her phone asking her to return to hospital and informing her of what would happen if she failed to return. At 03:00am Esther chose to return to her home address, effectively discharging herself from hospital. During the course of that day, Addenbrookes and the Clinical Commissioning Group (CCG) undertook to re-establish a package of care for Esther in the community which included daily District Nurse visits and five times daily visits from a care agency.

On 22nd January 2020 a meeting was held with Esther and representatives from Continuing Health Care and the care agency supporting Esther. Discussions included Esther's drug use and lifestyle and the potential risk to the carers. Esther then disclosed that she was experiencing emotional abuse from her 'ex-partner' Joe. She described, in what appears from the records to be significant detail, the abuse she had been experiencing including controlling behaviour and physical abuse. Esther was asked whether she wished to report this behaviour but she declined. Esther stated that Joe also helped her with things around the house and that she was concerned about being lonely.

Support was also offered to Esther to prevent Joe from being able to access her property, as well as moving her away from the property but she declined this also and her reasons were recorded. A referral to the multi-agency safeguarding hub (MASH) was discussed and explained to Esther who did agree to this after some discussion. The records state that advice was sought from the CCG safeguarding team who suggested that Esther be given appropriate contact details for the Domestic Abuse National Helpline and safeguarding agencies should she need them.

A referral to the MASH was made the following day by the Continuing Health Care nurse repeating the details disclosed by Esther. A Section 42 enquiry (s42)[2] was opened and passed to the Physical Disabilities Team with an instruction for the referring agency to make contact with Esther and ascertain what her desired outcome might be. It was noted that she must be seen alone. A Domestic Abuse, Stalking and Harassment (DASH) form was also suggested to determine the level of risk. This form was not completed until the Police responded to a call from Esther on 19th May 2020.

[2] **42 of the Care Act 2014:**

Enquiry by local authority

(1)This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—(a)has needs for care and support (whether or not the authority is meeting any of those needs),

(b)is experiencing, or is at risk of, abuse or neglect, and

(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The following day Adult Social Care communicated to Continuing Health Care that as CHC were funding Esther's care, they would need to 'carry out the investigation' but that Adult Social Care would oversee the s42 enquiry. The CHC nurse requested advice on how to proceed with supporting Esther and this was provided including consideration of making safeguarding personal (MSP) principles and Esther's wishes. The completion of the DASH form in order to refer for support from an Independent Domestic Violence Advocate (IDVA) was also reiterated.

On 28th January 2020 Esther attended for an assessment by Change Grow Live. Clinical observations were recorded within the assessment, but there is not a sense of Esther's views. It is recorded that a plan was made and that she agreed with this plan but it does not appear that she had provided information relating to Joe and that she might be experiencing domestic abuse at this point.

On 29th January Esther was visited at home by a Continuing Health Care nurse and disclosed further details of abuse perpetrated by Joe. She had been keeping notes and allowed for the nurse to take photos of these notes but refused consent for the information to be shared with the Police. Esther's capacity was considered in relation to this decision. There is evidence within the records that the CHC nurse sought advice in supporting Esther and ensured that she had access to the telephone numbers she might need, as well as asking her to consider again informing the Police of the abuse. Internal discussions as to who should lead on the safeguarding enquiry were held and it is recorded that CHC felt that Adult Social Care should be leading.

During an appointment with a Dietician on 30th January 2020 Esther stated that her 'flatmate', Joe, 'stole her food'. She declined consent for a referral to Adult Social Care to be completed as she said 'they are aware'.

The following day, 31st January 2020, Esther had a telephone appointment with a practitioner from CGL. She disclosed that she felt unsafe in her home because of her 'ex-partner', who refused to leave when asked and exposed her to drug use. Esther was advised to call the Police and her housing provider and was offered support in doing this but she declined. Esther did agree to contact Women's Aid with support and a safety plan was formulated which Esther also agreed to. The CGL practitioner agreed to visit Esther at home the following week. The records do not show that a phone call was made to Women's Aid on this date by the CGL worker. Given that Esther was expressing that she felt unsafe, more immediate action should have been taken to support Esther to make contact with Women's Aid on this date.

On 3rd February 2020 details of the safeguarding concerns relating to Esther were presented at a CGL multi-disciplinary meeting. The agreed action was for a home visit to be conducted to assess risk. A home visit was not undertaken but a telephone call was made to Esther on 10th February.

On 4th February 2020 there are recorded discussions between Adult Social Care and Continuing Health Care as to which agency should lead on the section 42 enquiry. The CHC nurse was advised to discuss the completion of a DASH form with Esther again. This was two weeks following the commencement of the section 42 enquiry.

On 5th February 2020 the Continuing Health Care nurse contacted Adult Social Care again to reiterate the position that Adult Social Care were considered to be the most appropriate

agency to lead on the s42 enquiry. Records included within the combined chronology show very detailed notes taken by the CHC nurse following the home visit to Esther on 29th January 2020, including Esther's worries, wishes and feelings, as well as considerations for Esther's safety, which are all examples of good practice. On the same day Adult Social Care made contact with Cambridgeshire and Peterborough Foundation Trust (CPFT) to discuss the possibility of CPFT supporting the CHC nurse to complete a DASH form with Esther.

The Named Nurse for Safeguarding at CPFT responded on 7th February to advise the Social Worker from Adult Social Care of the contact details for the Safeguarding Lead within the Clinical Commissioning Group who it was believed would be better placed to offer support. The Social Worker then contacted the Safeguarding Lead within the CCG to request support for the CHC nurse in completing the DASH form with Esther. This was an area which provoked lengthy discussion between the chronology authors, as well as with wider partners in the adult safeguarding workforce. It was agreed that the pathways for domestic abuse support, particularly Independent Domestic Violence Advocate (IDVA) support via a completed DASH form is not widely understood. This area is explored further in the later part of this report.

On 10th February, CGL completed a welfare check with Esther via telephone during which Esther said she no longer felt unsafe as her 'ex-boyfriend' was no longer visiting her house so often. This information was then shared internally within CGL.

The following day, 11th February 2020, during an assessment by a Respiratory Nurse Esther disclosed that 'she sometimes argues with flatmate'.

On 17th February a welfare telephone call was made to Esther by a CGL practitioner who noted that Esther sounded positive in mood and stated that she had lots of professionals visiting her home.

There are further discussions between Adult Social Care and Continuing Health Care regarding the completion of a DASH form with Esther recorded on 18th February 2020. It was agreed that the CHC nurse would gain consent from Esther and make a direct referral to the IDVA service. The completion of the DASH form appears to be on the only action planned within the s42 enquiry. Esther agreed for a referral to be made provided the Police were not involved. This area was discussed at the author's meeting and it was agreed that the question of how to support a person at risk of domestic abuse when they refuse consent for involvement from the Police is not well understood. This will be explored further later in this report.

Following the CHC nurse making contact with the IDVA service, the IDVA attempted to contact Esther on 21st February 2020 but Joe was present. Esther was asked what time might be good for the IDVA to call back but she stated she did not know.

On the same day the CHC nurse also called Esther to inform her of the IDVA referral. Esther stated again that she didn't know when she might be alone in order for the IDVA to call her. She also stated that she felt five times daily visits from the care agency was too much and requested these be reduced to four times daily. This was agreed and completed.

Between 27th February and 12th March 2020 discussions are recorded within the chronology between the IDVA service and Adult Social Care regarding the referral route used to refer Esther for IDVA support. The question was raised as to why a DASH form had not been

completed. Adult Social Care then make a request to the CHC nurse for the DASH to be completed by Continuing Health Care.

On 19th March 2020 Esther requested a change to the collection arrangements for her prescription from Change Grow Live as she said she had been advised to self-isolate due to the Coronavirus pandemic[3].

On 31st March 2020 there are further recorded discussions between the Clinical Commissioning Group and Adult Social Care regarding the completion of a DASH form. A CHC Nurse contacted Esther the same day to discuss the DASH form and related Police involvement. Esther stated that her 'ex-partner' Joe was now with her in the property all of the time as he was not working due to COVID-19 and there was therefore not an appropriate time for her to have discussions relating to domestic abuse. This clearly represents an increased risk to Esther from both the perspective that she and Joe were in the property for extended periods of time together and that she would have had far fewer opportunities to leave her property in order to get help if she needed it.

On 9th April 2020 Esther cases was closed to the IDVA service as a completed DASH had not been received.

On 22nd April a confirmed change to Esther's medication collection was made to weekly collection.

On 23rd April 2020 there are discussions recorded between Continuing Health Care and Adult Social Care regarding the completion of a DASH form to secure support from an IDVA. The Social Worker suggested that the care agency could try to speak to Esther without Joe being present but recognised that this could be difficult.

On 14th May 2020, the care agency raised safeguarding concerns with Continuing Health Care. Two needles were found on Esther's bed and two unknown males were asleep in the house. The agreed action was for the care agency manager to visit Esther and if Joe was not present, to discuss the completion of a DASH form and possible Police involvement.

On 18th May 2020 a MASH referral was completed by the care agency relating to the incident on 14th May. The referral was not deemed to relate to the safeguarding of Esther as it concerned the safety of the carers who were not adults at risk. Adult Social Care records state that the care agency manager was asked whether there were concerns relating to Esther's drug use but the care agency manager said that there were not. On the same day, Esther reported to the care agency that she had changed the key safe on her property for her own safety and called the Police due to arguments with Joe. There was a missed opportunity to demonstrate appropriate professional curiosity and explore what Esther meant by this.

Later that evening, Esther called Cambridgeshire Constabulary reporting that her 'ex-partner' Joe was 'kicking off' in her property. Police attended and Esther disclosed that she had been assaulted by Joe when he had hit her on the arm with a mug. Joe was asked to leave the property as per Esther's wishes but Esther did not support any further police action. A DASH

[3] A 'lockdown' was effective in England from 23rd March 2020 which placed significant restrictions on all members of society. This was as a result of the spread of the COVID-19 viral disease. In the early stages of the pandemic, members of society with existing medical conditions were advised to be particularly cautious and remain at home to reduce the risk of contracting the disease.

was not completed as both parties told officers that they were not intimate partners. Police records did indicate there had been previous incidents recorded as Domestic Abuse, although Joe had stated that he was Esther's carer. Police did make an Adult at Risk referral, but more information would have been available to Police on responding to this incident had the DASH forms been completed.

The following day, 19th May 2020, Esther placed a call to the 111 service for a 'suspected dislocated shoulder'. An ambulance was sent to allow Esther to attend the accident and emergency department at Addenbrookes hospital. The Ambulance arrived at 02:45am. The initial account provided by Esther was that her carers had tried to move her manually. (She would usually be moved with the use of a hoist). Esther then informed the ambulance crew that her shoulder injury had been caused by a 'male friend' who had tried to reposition Esther manually despite her asking him not to.

Esther then disclosed that she had had a disagreement with the male friend earlier the previous day and he had returned to her property, forced entry and dragged Esther from the bed by her arm, causing the injury to her arm and shoulder. She described that he had kicked her and verbally abused her for calling the police the previous day and threatened to harm her further if she spoke to the police again. Esther stated that she was scared of what he might do and did not feel safe at home.

The ambulance crew reported the information that Esther had disclosed to Cambridgeshire Constabulary and completed a referral to the MASH. Both the NHS 111 service and the Ambulance service made appropriate referrals to the MASH with the information they had at the time. A third referral was made by the Addenbrookes Transfer of Care Team and there was communication between the MASH and Addenbrookes with the outcome that all information was collated alongside the open s42 enquiry.

At Addenbrookes, there was bruising noted to Esther's eye. The hospital completed an internal referral to their safeguarding team. A member of the team spoke with Esther who disclosed that she was 'scared to return home as Joe said he would 'kill her''. Esther also stated that she did not want the Police to be involved because she had felt that they had not believed her. Esther also said that she wanted to move to Wales but was informed that this would be difficult to achieve due to the coronavirus pandemic. Esther was offered support via a referral to the Independent Domestic Violence Advocacy service (IDVA) but declined. Esther later spoke with a member of the nursing staff. When she expressed her fear of going home because of Joe and how she might be able to care for herself with the injury to her arm, she was offered reassurance that she would not be discharged until it was safe for her to go home.

The police crime record shows that Esther gave different accounts to paramedics of what had happened on 19/05/20, initially telling them at the house that she had slipped down the bed and Joe had tried to help her back into position and had pulled on her arm. She did not appear to Police to be upset or distressed at that time and did not indicate that Joe was her partner. The paramedics believed this account and did not see anything to contradict it, until they were at the hospital where Esther stated that Joe had assaulted her and that he had forced his way into the house breaking the chain on the door.

Police officers attended Addenbrookes on 19/05/20 and spoke with Esther who told them that Joe had forced his way into the house, pulled her out of bed, punched her, threatened her and

placed his hands around her throat, strangling her. Esther refused to provide a statement or complete a DASH risk assessment with officers however officers completed a high risk DASH assessment based on information provided and shared this with Adult Social Care and the IDVA service on that day.

Joe was arrested during that morning for suspected Grievous Bodily Harm of Esther and for possession of a knife. He was charged with possession of the knife and bailed regarding the assault on Esther with conditions not to contact Esther or go to her street.

Esther remained in hospital due to the concerns for her safety and during a conversation with a member of Addenbrookes Early Intervention Team, she did give her consent for a referral for the IDVA service to be made. Esther expressed her concern that she might lose her property if she was supported by an IDVA and her concerns were well recorded.

That same day, 20th May, Esther had refused personal care and medical treatment until later in the day when she was offered pain medication. She was found to be in a very unsanitary condition due to her refusal for personal care, as well as having 'multiple undocumented wounds' which Esther refused to allow nurses to assess.

The following day 21st May 2020, Esther is described in the hospital notes as being 'physically unwell' and needing to remain in hospital. By 7pm a computerised tomography (CT) scan had shown Esther had a right lung collapse, and an orthopaedic review confirmed a humeral head fracture which did not require surgery at that time. Esther was moved to Critical Care that evening and just before 9pm was assessed under the Mental Capacity Act[4] (MCA) and was deemed to lack capacity due to being sedated and ventilated.

On 22nd May 2020 the locks were changed at Esther's property by Cambridge City Council with support from Cambridgeshire Constabulary as a result of the referral to the IDVA service.

On 26th May 2020, Adult Social Care confirmed with Change Grow Live that a Multi-Agency Risk Assessment Conference (MARAC) would be discussing Esther's case relating to the risk of domestic abuse on 27th May 2020.

The same day, the hospital records show a deterioration to Esther's condition and a referral for an independent mental capacity assessment (IMCA) to determine what Esther's wishes might be should her condition continue to deteriorate, was made. The records evidence consideration of Esther's wishes. The records state that on 27th May 2020 Esther's case was heard at the MARAC and that the action was for the IDVA to liaise with the hospital Social Worker to coordinate a discharge plan.

There are extensive medical notes covering the date of 28th May 2020 within the combined chronology. On this date, Esther's condition continued to worsen and finally medical care was withdrawn following reviews of her care and discussion where Esther's perceived wishes and feelings were considered. The time of Esther's death is recorded as 2:10pm.

[4] Mental Capacity Act 2005 'An Act to make new provision relating to persons who lack capacity;' www.legislation.gov.uk

6. Analysis and Learning

A facilitated multi-agency meeting was held for the authors of the individual agency chronologies to discuss this case. This group were asked to consider the details within the combined chronology and the following key themes, the aim of which was to extrapolate learning for those agencies who had been involved in the case, as well as those in the wider safeguarding adults' workforce. A follow up meeting was held to gain additional information relating to some of the questions posed within the terms of reference, which appear below. Those questions which cover similar areas have been addressed simultaneously.

1. *Was Esther sufficiently safeguarded by agencies?*
   How were risk and protective factors identified, assessed and managed?

2. *Did professionals share information adequately to ensure she was kept safe?*
   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?

3. *Were there any indications of domestic abuse, controlling or coercive behaviour in Esther's relationships and if so, how were these addressed?*

4. *Did Esther receive appropriate support to assist her with her disability and did the disability present any barrier to her accessing services?*

5. *What consideration was given to Esther being safeguarded when she had mental capacity but did not engage?*

6. *Are there any areas of good practice?*

1. Was Esther sufficiently safeguarded by agencies? How were risk and protective factors identified, assessed and managed?

It was unanimously agreed by those agency representatives present at the chronology author's meeting, that Esther had very high care and support needs and would have met the criteria for an adult at risk. She was receiving support from Continuing Health Care (CHC) to address her complex needs, as well as additional support from Cambridgeshire and Peterborough Foundation Trust (CPFT) via District Nurses, Occupational Therapist and Physiotherapists.

It was clear from the combined chronology that there were multiple occasions where safeguarding concerns were raised relating to Esther. On 31st May 2017 there were concerns recorded by the care agency in place at that time, that Esther was being financially exploited by a 'friend' upon whom she was reliant for support. On 11th September 2017 concerns were expressed by the District Nurse relating to self-neglect and again possible financial exploitation by an unnamed male. In April and May 2018 LS expressed further concerns herself that her 'friend' was stealing her money in the process of helping her with her shopping. There are also a number of occasions when concerns are noted, or Esther herself expresses that she is being abused by her 'partner' Joe. These concerns relating to domestic abuse will be explored further, later in this report

Self-neglect appears to have been a recurrent concern throughout the time period of the chronology, a concern that was interlinked with Esther's drug use and associated lifestyle. Concerns are recorded by the District Nurse in May 2018 as well as by Continuing Health Care during a care package review in November 2018 and a District Nurse again in October 2019. All of these concerns were relating to Esther's refusal to accept the medical care she needed and the pressure ulcers she was suffering from. Although in September 2017 and October 2019 referrals to the MASH were made, there is not clear evidence of concerns relating to self-neglect being explored with Esther and any support for her being offered relating to her mental health, or her inability to care for herself as a result of her disability.

The chronology demonstrates missed opportunities for those agencies involved in supporting Esther to take action following the recording of their concerns. Specifically, on 31st March 2017 concerns were raised by the care agency in place at the time, that Esther's male friend might be taking money from her. Esther is recorded to have suggested that she did not wish to report this to Police as she was reliant on this male to support her with tasks she was unable to do herself. This was a missed opportunity to explore with Esther the relationship with this male and what support she might be willing to accept to decrease her reliance upon him and therefore reduce her vulnerability.

Similarly on 17th April 2018, Esther told the District Nurse that she believed Joe had stolen money from her. Whilst she declined support via a referral to the MASH, this could have been another opportunity to explore this relationship and what her wishes and feelings might be in relation to improving the situation.

There were multiple other occasions within the chronology where Esther made discloses or situations were observed by the visiting District Nurse who then sought Esther's consent to make a safeguarding referral to the MASH but Esther declined. It cannot be said therefore that there was a lack of recognition of the safeguarding risks to Esther. There is not however, clear evidence in the chronology of alternative routes of support being considered or offered.

Additionally, it might be the case that Esther would have refused to give her consent for safeguarding referrals to be made, or for additional support to have been explored, as she had done on other occasions. It might equally be the case that acknowledging the concerns and speaking with Esther regarding her views on each occasion might have served to increase Esther's trust in the agencies who were supporting her and provided her with a better understanding of the ways in which her situation could have been better. This is not to suggest that Esther did not build trust in the professionals who were supporting her as she had made disclosures to the District Nurses on a number of occasions.

Those agencies present at the author's meeting agreed that there had been missed opportunities to join together the information that each agency held relating to Esther, in order to gain a better understanding of her needs. A holistic assessment may have drawn out the potential areas for concern and inter-linking risk factors such as Esther's drug use, self-neglect, and the risk of harm from domestic abuse. In May 2017 when Esther was awaiting discharge from Addenbrookes, a Continuing Health Care Assessment was completed which detailed Esther's support needs as a result of her disability and the formal support that could be put in place in line with her desired outcome of living in her own property. Whilst this assessment was detailed, there was a missed opportunity at this point to explore with Esther her relationships and support network, particularly given the concerns relating to Joe whilst in hospital. Now, these assessments are completed by the Discharge Planning Team within the hospital, who would be able to see any concerns or relationships which have been recorded whilst the patient has been in the hospital. The important lesson from the author's point of

view here is that there was a missed opportunity to open a conversation with Esther about her personal relationships and support network at a time when she was adapting to a significant change in her life.

On 3rd October 2019, A District Nurse made a referral into the MASH relating to Esther's refusal to accept daily care. The referral was received by Adult Social Care who suggested that the District Nurse speak with Continuing Health Care. It is unclear whether this suggestion was made because of a misunderstanding that the District Nurse was concerned about the level of care Esther was receiving, or because Continuing Health Care were considered to be the 'lead' agency in supporting Esther. It was agreed by those agencies at the author's meeting that there was a missed opportunity on this occasion for information to have been gathered and a professionals meeting held, in line with the Multi-Agency Policy and Procedures to Support People who Self-Neglect which came into effect in May 2018.

Similarly, a professionals meeting to share information and discuss possible safety strategies could have been held following Esther's detailed disclosure of physical and emotional abuse to Continuing Health Care and the care agency in place at the time. This disclosure was shared with Adult Social Care via a referral to the MASH by Continuing Health Care and there follows multiple discussions between these two agencies which may have been aided by an agreed plan for supporting Esther and strategies for promoting her safety.

It does appear however that there was increased consideration of safeguarding concerns at this point following Esther's agreement to consent to this MASH referral, however there was ongoing disagreement between Continuing Health Care and Adult Social Care regarding which agency should lead on supporting Esther and specifically completing a domestic abuse, stalking and harassment (DASH) form. This disagreement meant that the DASH was not completed by either agency and was completed four months later when the Police attended Esther's home on 19th May 2020.

This specific issue was discussed at some length within the author's meeting and it is the author's opinion that there remains a lack of clarity relating to the completion of DASH forms and who the most appropriate person might be to complete them with the adult. Training to support the completion of DASH forms has been made widely available via the Cambridgeshire and Peterborough Safeguarding Adult Partnership Board as well as the Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership. The other recurring theme in the safeguarding concerns for Esther, raised by multiple professionals throughout the timeframe of this review, is that of possible domestic abuse and coercion and control. The relationship between Esther and Joe appears complex as she refers to him as her 'friend', her 'partner', her 'ex-partner', her 'flatmate' and her 'carer' interchangeably. It is reasonable to assume that his role within Esther's life *was* changeable, and that during their relationship, he did indeed fulfil all of these roles, but the lack of exploration of this relationship from Esther's perspective may have hindered an offering of appropriate support. It was not clear either, how much time Joe spent in Esther's property and therefore both the levels of risk and reliance could not be accurately understood and assessed.

The issue of domestic abuse will be explored further in this report under question 3 *Were there any indications of domestic abuse, controlling or coercive behaviour in Esther's relationships and if so, how were these addressed?* It is worth noting here however that whilst the potential indicators of coercion and control were well identified and documented by safeguarding agencies, Esther did not consistently engage with offers of support which resulted in a

stagnancy of her situation. When discussing this issue the multi-agency group present at the facilitated agency meeting agreed that a lack of professional curiosity relating to the relationship between Esther and Joe meant that the relationship between the two was not fully understood and therefore the group could not say with certainty that the right support had been offered.

To summarise with reference to the posed questions: 'Was Esther sufficiently safeguarded by agencies?' And 'how were risk and protective factors identified, assessed and managed?' Esther was safeguarded by those agencies working with her to the extent possible with someone who is unwilling to consent to additional support. It cannot be argued that she did not have care in place to meet her needs and when she requested changes to the care she received: her wish not to be cared for in a care home and later, a change from five visits daily to four visits daily by the care agency in place, her wishes were heard and responded to.

However, the information presented in the combined chronology, alongside the additional information provided during the author's meeting did not demonstrate that Esther's wishes and feelings had been considered on each occasion that she raised a concern or a concern for her wellbeing was noted. Given Esther's sustained drug use over a long period of time, previous periods of homelessness, experiences of domestic violence and the life choices she had made, alongside the significantly increased vulnerability she experienced as a result of the fact that she became paraplegic, it is reasonable to suggest that she might have needed support to understand how her life could be better. In the author's opinion, the key principle of making safeguarding personal: 'to support and empower each adult to make choices and have control about how they want to live their own life'[5] could have been implemented to a much greater extent in supporting Esther, which might have empowered her to envision how her circumstances could have been improved, therefore allowing her to accept referrals for intervention at an earlier point in time.

2. **Did professionals share information adequately to ensure Esther was kept safe?**
   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?

It is clear from the combined chronology that at any one time during the time period of the review, there were numerous agencies involved in supporting Esther. What is not evident, is if there was regular information sharing between agencies to facilitate a co-ordinated approach to the support she received.

The combined chronology and discussions at the chronology author's event highlighted a number of missed opportunities to potentially share information relating to Esther. When she was admitted to hospital in November 2019, Esther was assessed and treated for a grade 4 pressure ulcer on 12th December 2019. This presented a potential opportunity to request Esther's consent for a multi-agency discussion surrounding her care. As previously outlined, whilst Esther was offered additional support via referrals to Adult Social Care throughout the time frame of the review, there is no evidence to suggest that her consent for a multi-agency discussion was sought on this occasion or any other.

Multi-agency Safeguarding Adults Board Procedures which included information sharing guidance were available in 2017. These procedures include the following statement: 'Effective information sharing is key to effective safeguarding. It is therefore important that a balance is

[5] https://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/msp/

found between maintaining confidentiality and sharing information on a need to know basis with relevant parties.'[6]

Single agency safeguarding discussions are evident in the chronology. The standard of detail within the records provided by Addenbrookes Hospital was very good and included detail from various departments within the hospital who assessed or supported Esther during the six admissions within the time frame of the review. Additionally, Cambridgeshire and Peterborough Foundation Trust and Change Grow Live both provided evidence of multi-disciplinary meetings or discussions within their chronology submissions.

Other missed opportunities for multi-agency information sharing are present within the chronology. Examples include: when the District Nurse observes potential cigarette burns on 21st November 2018 and later on 17th February 2020 when Esther tells the representative from Change Grow Live that there are multiple professionals visiting her home. At this time, Esther was receiving services from six agencies, and multiple professionals within those agencies including Change Grow Live, the care agency, Continuing Health Care and an Independent Domestic Violence Advocate. It may have been beneficial to all of those involved to have been able to discuss concerns, details of the care they were providing and any safety plans. It cannot of course be assumed that Esther would have consented to this multi-agency information sharing, but it is reasonable to suggest that she should have been asked or even invited to attend a multi-agency meeting.

The Care Act statutory guidance states:: *"If the adult has the mental capacity to make informed decisions about their safety and they do not want any action to be taken, this does not preclude the sharing of information with relevant professional colleagues. This is to enable professionals to assess the risk of harm and to be confident that the adult is not being unduly influenced, coerced or intimidated and is aware of all the options. This will also enable professionals to check the safety and validity of decisions made. It is good practice to inform the adult that this action is being taken unless doing so would increase the risk of harm."*[7] (14.92)
The chronology authors present at the author's meeting agreed that the public interest threshold had not been met to allow for the sharing of information without Esther's consent but it was accepted that there were events within the chronology, such as the disclosure to the Change Grow Live representative on 31st January 2020 of domestic abuse that, if additional information had been gathered, might have supported a multi-agency discussion under the Multi-Agency Risk Management (MARM) process. It was agreed that this process could have been initiated in this case in the latter part of the timeframe. The MARM process having been launched in 2019 with workshops to promote it in April and May of that year.

3. Were there any indications of domestic abuse, controlling or coercive behaviour in Esther's relationships and if so, how were these addressed?

There are indicators of concern relating to Esther, Joe and their drug use early in the chronology in 14th November 2016 when Addenbrookes Hospital were concerned regarding Joe's behaviour in the hospital. As detailed earlier in the report. These concerns resulted in the action of supervising Joe's visits and then later to ban all visitors. On discussion in relation to this action, it was thought by the group present at the author's meeting that this action to ban visitors appeared extreme and must have reflected severe concerns for Esther's safety

[6] https://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/safeguarding-adults-board-procedures/#8_INFORMATION_SHARING
[7] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

and wellbeing. It was an omission for the hospital staff not to have explored with Esther what support network she had in place at the point where her discharge was being planned, given that she would be returning to the community with significant care and support needs. As previously outlined in this report, this was a missed opportunity to use such questions to explore Esther's relationship with Joe and to evaluate what safeguarding concerns there might, or might not, have been.

Esther later makes a number of disclosures to the District Nurses including on 18th July 2018 which is the first disclosure of physical abuse within the time frame of this review. Whilst safeguarding referrals were offered, these were declined by Esther and no domestic abuse specific support was discussed with Esther. Support via a DASH or from non-statutory services such as the IDVA service or Women's Aid could have been discussed with Esther, who demonstrated mistrust and misunderstanding of the consequences of a referral to statutory safeguarding services. Whilst recording of the fact that Joe was present in the property was good practice, an opportunity was missed to have a further discussion with Esther a week later when a deterioration in Esther's presentation was noted. It is not recorded that Esther's views were sought regarding what outcome she wished for.

There are incidences within the chronology of possible indicators of domestic abuse, alongside disclosures by both Esther and her family members. On 2nd September 2019, Esther's son informed staff at the hostel where he was living that he believed his mother to be the victim of domestic abuse. The hostel then completed a safeguarding referral and contact was made with the care agency supporting Esther who did not express any concerns. Contact was not made with Esther herself which was a missed opportunity again to ascertain her own views. No further action resulted from this referral.

It is important to note that the care agencies who provided care to Esther within the timeframe of this report, of which there were three, did not share any concerns with Continuing Health Care in relation to Joe and Esther, despite the District Nurses making a number of observations and Esther making disclosures of domestic abuse.

Despite observations relating to Esther's vulnerability to abuse and her direct disclosures, there was limited action by agencies in relation to domestic abuse until 23rd January 2020 when Continuing Health Care make a safeguarding referral following a disclosure from Esther and her consent for the referral. There is good recording on this date including Esther's reluctance to agree to a referral and her reasoning. Adult Social Care opened a section 42 safeguarding enquiry with the suggestion that a Domestic Abuse, Stalking and Harassment form (DASH) be completed. Again there is detailed recording by Continuing Health Care of the home visit conducted by the CHC Nurse on 29th January 2020. Esther revealed her dependence on Joe for physical tasks but that she was also afraid of him and why she felt unable to speak to the Police. Esther had been taking notes of the abuse she was suffering and agreed to share these notes with the CHC nurse. The CHC nurse conducted some safety planning with Esther in ensuring she knew how to get help in an emergency and requested that she give further thought to speaking to the Police.

Esther then made a disclosure to her Change Grow Live worker on 31st January 2020 that she was feeling unsafe. Esther agreed to call Women's Aid with support from CGL but details in the recording suggest this did not happen. A safety plan was agreed and a home visit was arranged for the following week. There is then evidence that the CGL worker sought advice within their agency and were advised to undertake an urgent home visit. This visit then took place seven days later over the telephone and Esther advised that her situation had changed and she no longer had the same concerns. This was another missed opportunity.

Esther provided her consent for the DASH form to be completed by the CHC nurse on 18th February 2020 but there was a delay in this action being completed. An Independent Domestic

Violence Advocate (IDVA) then became involved. Despite making contact with the MASH to gather information, another opportunity was missed for multi-agency information sharing to gain a clearer picture of the risk to Esther.

By 9th March 2020 problems relating to the referral process for IDVA support became apparent. The DASH form had still not been completed and in addition to the fact that this meant a procedure had not been followed correctly, there was also not a clear understanding of the level of risk and the key elements of that risk. This process for IDVA referrals was discussed within the author's meeting and the inconsistencies identified. At the time of writing this report there was a Health IDVA who was funded to work with victims who were receiving care from Addenbrookes and Hinchingbrooke hospitals as well as Peterborough City Hospital. The process for referral for this support did not require a DASH to be completed and this was the process that had been followed in order to secure support for Esther. As Esther was resident in the community at the time the referral was made, she was not eligible for support from this post so a DASH needed to be completed. In the meantime, the IDVA who had been allocated, albeit incorrectly, had been making attempts to contact Esther but Joe had been present which the IDVA suggested meant it was unsafe to continue to try to contact Esther via telephone.

There is a significant amount of detail within the chronology of the communication between CHC and Adult Social Care in relation to this process and the need for the DASH form to be completed and specifically, who the appropriate agency was to lead on this action. Alongside this communication, the country was impacted by the Coronavirus pandemic. When the CHC nurse called Esther on 31st March 2020, she stated that Joe was no longer going to work because of the pandemic, presenting the challenge of communicating with Esther without increasing the risk to her safety from Joe when both telephone conversations and face to face communication were not possible.

The IDVA service ended their involvement with Esther on 9th April 2020 as no DASH form had been completed. Esther called the Police on 18th May 2020 at 7:21pm following an argument with and physical assault by Joe. Esther described Joe to Police as her carer although suggested that he had been helpful in the past, this was no longer the case. Joe agreed to leave but no DASH was completed, as would be standard practice for attendance at an incident relating to domestic abuse because it was believed that there was not, and had not been, an intimate relationship. This was discussed by those present at the author's meeting and it was agreed that this had been an opportunity to discuss the relationship further and assess the ongoing risk.

Four months following the original referral on 23rd January 2020, no direct action had been undertaken by any agency with the exception of a safety plan by the CGL worker to reduce the risk of harm from domestic abuse by Joe. The DASH form had not been completed despite Esther having provided her agreement. This section of the timeline and the details within the chronology relating to domestic abuse against Esther were discussed in detail by those present at the authors meetings. Despite these discussions, there remains a lack of understanding of the pathway for support for domestic abuse for adults with care and support needs, as well as a lack of consistency or agreement as to which agencies complete the DASH forms and which agencies do not do so routinely.

In the early hours on 19th May, Esther called for an ambulance for a suspected dislocated shoulder which arrived at 2:45am. Recording is detailed and extensive for this date in the chronology, as outlined in the earlier section of this report. In summary, Police recorded the incident as a domestic assault resulting in grievous bodily harm after Esther disclosed that Joe had pulled her out of bed, punched, kicked and threatened her and attempted to strangle her. Esther was treated in hospital and on 21st May 2020 an IDVA became involved as a result of the Police having completed a DASH form. Safeguards were quickly implemented including

changing the locks on Esther's property. Unfortunately, by this time, Esther's health had declined in hospital and as had been previously detailed, she passed away in hospital on 28th May 2020.

It is important to note when reflecting on the information in the chronology, there is evidence of Esther opening a conversation with professionals repeatedly about Joe and the turbulence of their relationship. Whilst there is evidence of good practice in the recognition of Esther's vulnerability and those professionals continuing to offer support via statutory services, the authors recognised that wider thinking could have been used. From Esther's perspective, despite reaching out to professionals for support, her situation did not change resulting in a lesser likelihood of her wishing to engage with professionals.

It was discussed by those involved in the author's meeting that training for all adult safeguarding professionals on domestic abuse at the time of Esther's death had been recognised as requiring improvement. Following increased awareness raising and training across the multi-agency workforce, it would now be expected that alternative sources of support and advice would be explored. Internally professionals are able to seek advice from their named safeguarding leads and any professional is able to contact the Duty IDVA for advice on what support might be available, as well as support in completing a DASH form. Additionally, professionals can signpost and support a victim to make contact with Cambridge Women's Aid as the CGL worker had suggested or the National Domestic Violence Helpline. There are further developments required to increase practitioners' understanding of how to support people at risk of domestic abuse who do not consent to Police involvement. This work is best lead by the Domestic Abuse and Sexual Violence partnership and a recommendation will be formulated to cover this area.

It appears from records that the greatest barrier for Esther in seeking help was her fear of Police involvement resulting from her perception of how they had responded to a similar call for help at a time predating this review. Inconsistency in the presence of Esther's views, wishes and feelings in the records does not demonstrate that this barrier was explored fully with her. Although of course this overview is possible with all of the information having been made available. This would not have been possible for any one agency to have achieved given the limited information sharing in this case.

There is a lack of exploration in this case of the relationship between Esther and Joe when she was in a place of safety, as has been previously mentioned. Given the level of care and support Esther required and her intermittent reports that Joe was involved in providing a level of care for her, it is reasonable to expect that this would have been discussed with her. The possibility of respite care to decrease her dependence on Joe and provide her with a place of safety to accept further support does not appear to have been explored. This must be balanced with the later challenge of safely engaging domestic abuse victims during the COVID-19 pandemic when telephone and virtual contact became the primary methods of communication.

4. Did Esther receive appropriate support to assist her with her disability and did the disability present any barrier to her accessing services?

As mentioned at the beginning of this report, Esther underwent an operation on 5th November 2016 to decompress a spinal abscess which left her without the use of both of her legs. Esther remained in Addenbrookes following this surgery for a period for almost seven months. Initially the focus was on her immediate recovery from surgery as well as her drug use and the associated safeguarding concerns relating to Joe, as detailed in this report. On 22nd November 2016 when Esther was offered physiotherapy to assist her recovery, she initially refused. Her words are included within the hospital records which suggest Esther's mental health at this

time might have been poor, however there is no evidence of this being explored with her following the operation and the significant change in her physical abilities which resulted.

There is evidence within the chronology, of staff at Addenbrookes exploring a possible placement at a National Spinal Injuries Centre but Esther was not deemed to be suitable for this placement so support continued at Addenbrookes. Esther was persuaded to engage in physical and occupational therapies as she was keen to have her own accommodation on discharge from hospital over residing in a care home. Her views are well documented in the hospital records from this time until she is discharged on 22nd May 2017, as well as in the Decision Support Tool and Continuing Health Care assessments completed in March and April 2017, although her emotions in relation to her disability appear unexplored.

In addition, there is extensive evidence within the chronology of support being offered and sourced for Esther by the discharge team within Addenbrookes to allow Esther to access her own property and facilities. This support included arranging delivery of a hoist to the property, support with registering with a GP and accessing food shopping.

There are continued offers of physical and occupational therapies when Esther was living in the community from Cambridgeshire and Peterborough Foundation Trust, some of which she engaged with, some of which she did not. On discussion of this issue at the author's meeting, it was agreed that the appropriate rehabilitative support had been offered to Esther in the timescale of this review.

The chronology authors identified that Esther's disability did not present any barriers to her accessing health services as these were largely delivered to her at her home address. However, it may well have created a barrier in terms of her reliance on Joe to complete physical tasks such as shopping or cleaning and therefore a reduced ability for her to end that relationship because of that reliance.

5. What consideration was given to Esther being safeguarded when she had mental capacity but did not engage?

There is evidence of Esther's mental capacity being considered regularly and appropriately throughout the chronology. On the occasions when Esther made disclosures of abuse but did not agree for safeguarding referrals to be made, her capacity to make these decisions was not questioned owing to the absence of indicators to suggest that she did not have capacity. However, it is also true that Esther's continued refusal of support, particularly in relation to the domestic abuse she was subjected to, could be considered to be 'unwise' and to that end the guidance within the Mental Capacity Act Code of Practice may have applied:
"2.11 There may be cause for concern if somebody:
• repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or
• makes a particular unwise decision that is obviously irrational or out of character.

These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices. For example, have they developed a medical condition or disorder that is affecting their capacity to make particular decisions? Are they easily influenced by undue pressure? Or do they need more information to help them understand the consequences of the decision they are making"[8]

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

Esther may have benefited from more information and understanding of what the possible outcomes for her might be should she agree to support from Adult's Social Care, the Police, Women's Aid etc. She may have been, understandably, unaware of how she might be able to live the life she would choose to without Joe's support for day to day tasks, or what a lifestyle which did not include regular drug use might be like. Her previous lifestyle and choices may have presented a barrier to her engagement with support services, as well as influencing the perceptions of those who supported her.

There is evidence of a Mental Capacity Act (MCA) assessment having been completed on 27th November 2019 when Esther was in Addenbrookes Hospital. She was considered to have been unable to make decisions relating to her health and treatment due to her medical condition. Esther's capacity was reassessed less than 24 hours later and she was found to have improved sufficiently to be able to make such decisions once more. A similar procedure was followed on 21st May 2020 when an MCA assessment was completed as Esther was sedated and ventilated. She did not regain capacity before her death but there is evidence of her views being considered during this period.

Whilst there is undoubtedly evidence within the chronology of non-engagement on Esther's part with medical interventions, there is also evidence of responses from professionals when she was compliant or when she did engage with the support she was being offered. Esther appears from the information in the chronology to have been compliant with her carers when they visited, including when these visits increased to five times daily in January 2020. The level of care Esther received when she became paraplegic in 2016 was significant from a number of different agencies and would have been a significant intrusion in her life. It must therefore be noted that on the vast majority of occasions that she was seen, Esther did engage with the support she received.

However, it was when there were concerns that involved agencies outside of health, ie Adult Social Care and the Police that Esther was reluctant to engage. She expressed fears that she would become homeless, a situation she had been in previously, or that she would be subject to further abuse if either agency became involved. Whilst her fears were recognised, her views regarding how specifically she would like her situation to improve were not sought which might have increased her trust in professionals and increased the likelihood that she would engage with further support.

The chronology authors agreed that on the occasions where Esther disclosed serious safeguarding concerns later in the chronology, the Multi-Agency Risk Management (MARM) process[9] could have been implemented to consider what support could be offered to Esther

[9] The MARM is guidance used in Cambridgeshire and Peterborough when the adult:

- **has the mental capacity** to understand the risks posed to them
- continues to place themselves at risk of serious harm or death
- refuses or is unable to engage with necessary care and support services.

The adult must be considered to have need for care and support in line with the definition contained within the Care Act (2014); Care & Support Statutory Guidance (09/07/2018) and the Care & Support (Eligibility Criteria) Regulations (2015):

(a) the adult's needs arise from or are related to a physical or mental impairment or illness

(b) as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified as a consequence there is, or is likely to be, a significant impact on the adult's well-being.

despite her unwillingness to engage. This process was launched in July 2019 although it was recognised that multi-agency professionals' meetings were possible before that date and could have been used as has previously been mentioned in this report.

6. Are there any areas of good practice?

Whilst a number of improvements have been identified throughout this report, there were also examples of good practice. There is evidence of Esther's voice being heard during the period of time she spent in hospital following the operation to her spine. She had expressed that she did not wish to live in a care home and these wishes were followed and significant effort went into supporting Esther into a property which met her needs.

There are examples throughout the chronology of professionals, most notably the District Nurses, seeking advice from their internal safeguarding leads and following the guidance they are given.

As has been mentioned, Esther's mental capacity to make decisions is considered appropriately throughout the time period covered by the chronology and there is evidence of the hospital staff making considerations of her wishes when she is incapacitated.

Recording by Addenbrookes Hospital is very good on each occasion that Esther is admitted. Records demonstrate a good level of detail as well as evidence of Esther's own words, her wishes and on some occasions, consideration of how she might be feeling.

Similarly, record keeping by Adults Social Care in the period of time which followed the opening of a safeguarding enquiry: 23rd January 2020 onwards is detailed and includes evidence of making safeguarding personal principles via Esther's wishes, as well as consideration of how to support her desired outcome.

There is further evidence of the making safeguarding personal principles when, on 21st February 2020, Esther expressed that five times daily visits by carers was too much for her. This was reduced by Continuing Health Care down to four times daily visits.

The level of detail gained by the Ambulance service on 19th May 2020 from Esther relating to the incident that preceded her call to the emergency services on that date should be noted. The information within the chronology show that Esther's own words were detailed including changes to the account that she provided. This allowed for information to be passed onto Police who then made a prompt response to the incident.

When the Independent Domestic Violence Advocate became involved in supporting Esther in May 2020 the action to change the locks on her property was completed promptly by the district council and supported by the Police which demonstrates a good example of collaborative working.

The latter part of the chronology relating to 2020 includes good recording of communication between agencies including Adults Social Care, the IDVA service and Continuing Health Care. This recording then provides a clear picture of the events within that time frame.

7. Summary and conclusions

As detailed above there are areas of good practice relating to Esther before she passed away that should be recognised: excellent recording, including Esther's voice, within the records supplied by Addenbrookes Hospital, examples of practitioners seeking support and advice from their named safeguarding leads within their organisations and mental capacity being considered appropriately.

There is also important learning identified which has been drawn from the chronologies themselves and from discussions with the group of chronology authors.

Esther was undoubtedly a lady with high care and support needs. She received multiple daily care visits as well as support from Physiotherapists, a Dietician, Occupational Therapists and drug and alcohol support workers. As a result of her spinal injury and paraplegia, Esther was dependant on those around her for support with everyday tasks and this dependence increased her vulnerability. In the time period of this review, there were multiple occasions when safeguarding concerns were raised in relation to Esther. These concerns related to financial exploitation, self-neglect and domestic abuse. There is also evidence of Esther's reluctance and refusal to accept or agree to medical care or offers of support in the form of referrals to agencies, most notably Adult Social Care.

There were missed opportunities for practitioners to explore Esther's personal support and relationships with her directly and gain her views on how her situation of significantly reduced independence and therefore increased vulnerability, could be improved. There was an absence of the consideration of multi-agency information sharing under available frameworks and evidence of confusion within and between agencies relating to safeguarding processes for domestic abuse. There was also a lack of safety planning put in place to reduce risk by multiple agencies.

Esther did demonstrate an unwillingness to engage with additional support from statutory services: Adult Social Care and the Police but equally Esther was someone with a lot of intervention from professionals which would have been a significant change to her previous lifestyle. Based on her recorded interactions with practitioners in the chronology, she appears to have coped well with having so many professionals involved in her life and she felt able to make disclosures to them a number of times. That said however, processes could have been implemented to determine if action could have been taken to safeguard her, despite Esther not providing her consent.

8. Recommendations

1. The CPSAB should work with the Domestic Abuse and Sexual Violence Partnership to ensure that:-
   i. There is clear guidance to practitioners on the completion of DASH risk assessments.
   ii. That practitioners are aware of domestic abuse services in the area and what the services can offer.
   iii. That practitioners and their organisations understand the process for referring a case to MARAC.
   iv. There is awareness and training to practitioners to assist them to understand the necessity to consider how coercion and control may impact on a person to be able to make decisions on their wellbeing and protection.

2. The Police should ensure that consideration of previous information on individuals involved in an incident is routinely undertaken, when assessing whether a DASH risk assessment form is required.

3. The Local Authority should ensure that when an organisation undertakes a section 42 enquiry, there is a written request setting out the key lines of enquiry, the tasked organization is appropriately involved in the planning of the enquiry and that the enquiry is undertaken in a timely manner.

4. The CPSAB should work with partners from across the safeguarding adults workforce to develop information sharing guidance for practitioners involved in safeguarding adults to support practitioners in making referrals in safeguarding cases, particularly in situations where the person does not consent to information sharing.

5. The findings of this review should be used to continue to raise the awareness of the Multi Agency Risk Management (MARM) process and Self Neglect Guidance. In particular using these processes in complex multi-agency cases to effectively convene professional's meetings and the role of lead professional.

6. The CPSAB should task the Quality and Effectiveness Group to explore existing data and quality assurance activity relating to safeguarding adult referrals being reported to the MASH and how these are being triaged and decisions made on necessity for section 42 enquiry.