SAFEGUARDING ADULT REVIEW REPORT

"Richard"

2025

CAMBRIDGESHIRE & PETERBOROUGH SAFEGUARDING ADULTS BOARD

Contents

1. Introduction

This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of Cambridgeshire & Peterborough Safeguarding Adults Board (CPSAB) relating to the care of an adult (referred to as Richard throughout this report to preserve his anonymity). The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the safeguarding and wellbeing of adults at risk in the future.

The review was conducted in light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews. The Department of Health Care and Support Statutory Guidance – published to support the operation of the Care Act 2014, (14.168).

"SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[1].

1.1. Why was this case chosen to be reviewed?

Richard was 88 years old when he passed away, in February 2023. Richard was from the Showmen community, having worked in fairs for most of his life. He had been living alone in a small caravan, on a plot of land which he owned, outside of a village in a rural part of Cambridgeshire.

His death appeared to be accidental. However, there were concerns about both the risks of Self Neglect & the risks to his wellbeing in the community. These were related to his dementia and how well his needs were assessed prior to his discharge from hospital. The grounds for a SAR were met in line with Care and Support Statutory Guidance (S14.162)[2], on the basis that Richard had Care and Support Needs, was experiencing harm from self-neglect before he died and that there was potential for learning about how agencies worked together. The review was commissioned in May 2023 to ensure that the circumstances of the case were analysed, and multi-agency learning is identified and disseminated.

1.2. Brief Overview of the Case

Richard was born and brought up in Cambridge. He left school at 14 with no qualifications, helped out in family businesses (aunt's pub, fairground rides) from spring to autumn. In the winter he would work for a company in agricultural equipment maintenance. He only gave up working in his mid to late 70s and sold off fairground

[1] [1]https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

[2]

ride equipment when his wife's health started failing. Richard had 4 children, 2 sons and 2 daughters. He had to leave the area following civil action taken by his wife, due to her reports of domestic abuse from Richard. He was then estranged from most of his family and following his wife taking out an injunction on him he moved into a housing association bungalow in a town nearby.

Richard's wife passed away in 2021, after which his daughter (Mary) resumed contact with Richard and enabled him to move back into his caravan on the same plot of land. Richard reported being depressed, isolated and lonely whilst he had been living in the bungalow. He had clearly indicated that his desire was to live in his caravan, something he had done all his life. This was only accessible down a country lane where other members of his community also lived in mobile accommodation, when not away working on fairs as Showmen. He was quite isolated there but his daughter, (Mary) lived in her mobile home on the same plot of land, to access Richard's caravan, he had to go past Mary's mobile home.

Richard's granddaughter, Diane, had also been actively involved in Richard's life, although she lived some distance away. There was a history of concerns raised from Diane about Mary and vice versa, mainly in relation to the alleged financial abuse of Richard by each other. This ongoing dispute was never completely clarified and posed complexities for family involvement with agencies that sought to support Richard. Richard had been in hospital multiple times in the month immediately prior to his death, for recurring physical health conditions and he had suffered from a progressive dementia, of a mixed Alzheimer's and Lewy Body type.

"Alzheimer's disease is caused by a build-up of faulty proteins in and around brain cells – particularly cells that help to form memories. Earlier stages of Alzheimer's disease are strongly associated with memory problems, language difficulties, and becoming confused more easily. Less often, dementia can be caused by a mixture of Alzheimer's disease and Lewy body disease. Lewy bodies are the clumps of faulty proteins that build up in the brain cells of people who have Parkinson's disease or dementia with Lewy bodies. Lewy body disease has quite distinct features not seen in the other dementias.

It tends to affect different parts of the brain that control body movement and processing of sensory information. People with Lewy body disease often have very disturbed sleep and visual hallucinations. They may also experience rapid 'fluctuations' in their ability to function properly, feeling confused or disorientated quite suddenly. Memory tends to be less affected than in people with Alzheimer's disease".[3]

Richard was significantly affected by the above symptoms of his condition in the months leading up to his death and this affected his mental capacity to make decisions and to cope with the challenges of his lifestyle and culture as a member of the Showmen community. Living in his small caravan, especially in wintertime exposed him to significant risks. He had no running water, sewage facilities, heating and the

[3] https://www.alzheimers.org.uk/blog/what-is-mixed-dementia#:~:text=Less%20often%2C%20dementia%20can%20be,disease%20and%20Lewy%20body%20disease.&text=Lewy%20bodies%20are%20the%20clumps,seen%20in%20the%20other%20dementias.
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

power was somewhat intermittent. His home was a small, quite basic caravan, being very hot during the summertime and cold in winter. He was discharged from hospital in February 2023 despite his daughter pleading for him not to be released. At this time his GP recorded that he did not have mental capacity and was unsafe to be in his caravan alone.

A nurse from his local GP surgery attended the caravan two days after his discharge from hospital but could get no response. Richard was found deceased on the floor by police when called to gain entry. It appeared he had fallen, hit his head and died in the same position. The caravan was locked and secure with no signs of the involvement of any other person and so was not being treated as suspicious by police. The case was referred to the coroner. Richard had been well known to police for the historic domestic abuse against his wife and was also known to police due to his daughter (Mary) reporting several incidents where his dementia had caused him to become aggressive towards her.

1.2.1. Definition of Showpeople

"Members of a group organised for the purposes of holding fairs, circuses or shows (whether or not travelling together as such). This includes such persons who on the grounds of their family's or dependent's more localised pattern of trading, educational or health needs or old age have ceased to travel temporarily or permanently, but excludes Gypsies and Travellers as defined above."(Planning Policy for Traveller sites, CLG, March 2012.) Although their work is of a mobile nature, Showpeople nevertheless require secure, permanent bases for the storage and repair of their equipment and to live when not on the road. In recent years many Showpeople have had to leave traditional sites, which have been displaced by other forms of development.

Many Showpeople are members of the Showmen's Guild of Great Britain and are required by the Guild to follow a strict code of practice regulating the use of their sites. Membership of the Guild provides Showpeople with exemption from the site licensing requirements of the Caravan Sites and Control of Development Act 1960 when they are travelling for the purpose of their business, or where they only occupy quarters for a period between the beginning of October and the end of March in the following year”[4].

1.3. Timeframe, Terms of Reference, Methodology and Scope

The SAR Panel was established with representation from all relevant services to work with the Independent Reviewer, the Panel first met in July 2023 and thereafter regularly during the Review period.

An integrated chronology was produced for the SAR from individual agency chronologies and Individual Management Reports were provided by a range of agencies, covering the period from January 2022 to February 2023. The focus of

[4] https://www.dorsetcouncil.gov.uk/w/definitions-of-gypsies-travellers-and-travelling-showpeople

learning for this review was agreed in the following Terms of Reference by the SAR panel in November 2023.

Areas of Practice for the SAR to Focus on;

1. Diversity and cultural issues - the subject was from a Showmen community; what impact (if any) did this have on how services engaged and assessed his needs/risks and is there wider learning for agencies to improve working with the Showman community?
2. How did the impact of historical domestic abuse affect Richard's family around the caring role for Richard when he became unwell, and how well did agencies recognise potential carer abuse & respond to this?
3. How well was Richard's mental capacity assessed during the period subject to review and what does the practice in his case tell us about the challenges of working with people who may mask decision making difficulties?
4. Were there appropriate reviews of the Richard's medication, including the impact/side effects of his treatment on his health and wellbeing, while in hospital and in the community?
5. What was the impact of repeated falls on his health & safety and how well were the risks of this assessed and managed?
6. Were the discharges from hospital effectively planned, was appropriate support considered and offered for his return to the community?
7. How well was Richard and his informal network engaged with by services during the period of the review?
8. What does this case tell us about practice regarding Self-Neglect and the use of the MARM process?

1.4. Involvement of family members

The input and opinions of family members is an important aspect of the SAR process, both to inform them of the review, and to take account of their first-hand experience of services provided to them/their relative. For this SAR Richard's daughter (Mary) and granddaughter (Diane) were identified as important family to consult, as both were closely involved with his care. They were approached, by letter and invited to participate in the process, however, did not respond to this invitation and have not been spoken to as part of the SAR, which is recognised as a weakness in the process and subsequent learning for this case.

1.5. Involvement of Subject Area Specialists

In this case, the SAR Panel identified the need to consider the culture of the Showmen Community, a set out above in ToR 1 and the need to involve a subject matter expert to assist with this aspect of the review. Initially a lead nurse practitioner for the Traveller Community was included in the Panel, but

unfortunately moved onto a new role and could not be replaced. This compromised any detailed understanding of the cultural aspects of Richard's life and the potential relevance to safeguarding practice for him and his family.

1.6. Involvement of Agencies in the SAR Panel.

The following agencies and associated leads were represented on the Panel for this SAR and ensured all relevant materials, including original documentation was made available.

- Cambridgeshire County Council (CCC); Principal Social Worker Adult Social Care (ASC)
- Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership
- Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust (CUHFT); Adult Safeguarding Lead
- Haddenham GP Surgery, Advanced Nurse Practitioner
- Cambridgeshire Constabulary, Detective Inspector
- East of England Ambulance Service NHS Trust, Sector Safeguarding Lead & Named Professional
- NHS Cambridgeshire and Peterborough ICB, Designated Nurse for Safeguarding Adults
- DWP, Advanced Customer Support Senior Leader
- Cambridge and Peterborough Foundation NHS Trust (CPFT) Named Nurse for Safeguarding Adults
- Cambridge and Peterborough Safeguarding Adults Board (CPSAB), Communications & Acting Adult Lead, Independent Safeguarding team

1.7. Reviewing expertise and independence

An Independent reviewer (Mick Haggar) was appointed by the CPSAB to undertake the SAR and is the author of this report. Mick is a registered social worker, has worked in safeguarding adults, mental health and learning disabilities for over 25 years and is an experienced reviewer, having completed more than 20 reviews (SARs, SCRs). This report has been completed based on submissions of Individual Agency Documents, conversations with individuals, reports and Chronologies (outlined above).

1.8. Structure of the Report, Acronyms and terminology explained.

Section 2 of the report considers what happened in the period subject to review, this is sub-divided into a series of periods of the chronology, called Key Practice Episodes. Section 3 then analyses the practice found against each of the Terms of Reference for the SAR (see 1.3.). The Findings with associated recommendations for the CPSAB following this review are set out in Section 4. In Appendix 1 the abbreviations used are explained. References are also made to professional jargon and key supporting documents, which are both in footnotes throughout the report and these are further explained in Appendices 2 and 3 respectively.

2.SUMMARY OF THE CASE

This section sets out a summary of Richard's involvement with services from January 2022 until his death in February 2023. These are divided up into a series of Key Practice Episodes to assist with the subsequent analysis of practice.

2.1. History and summary of events prior to the Period subject to review Summary Prior to Timeframe subject to SAR

2020

In April 2020, Richard went to his GP, with chest pains and because he was feeling faint. He had a normal ECG but had further pains upon returning home by car. His granddaughter (Diane) was worried about him as he wasn't responding to calls, so she phoned an ambulance, but he refused to go to hospital. The ambulance crew called his GP, who insisted he be taken in-however, as he had capacity and didn't want to go, there was no basis to remove him. The crew called Diane to explain, she drove 70 miles from her home to see him and organised some food.

The Ambulance referred him to both ASC and a local volunteer service to organise some more food for him. The next day Richard collapsed again outside his home and another ambulance called, this time he was taken in to Addenbrookes Hospital. The referral was received into Adult Early Help, who followed up but as he had been admitted to hospital closed it and suggested he would need support on discharge. This was not followed up by the hospital social care team nor the ward, as he had been assessed by OT and Physio who recommended he be discharged home without care/therapy.

He fell again in May 2020 and summoned help via a Careline, he had hit his head, was bleeding and conveyed to hospital again. Had several further falls at home and referred again for both a falls assessment and an ASC assessment of needs, (although there was no information on an outcome of these, as they were outside the time frame for the SAR).

2021

In July 2021, Richard had further falls and felt dizzy on standing up initially from bed, leading to an ambulance being called out by him again and further attendance at ED. He was not admitted but consented to a referral to a community frailty MDT along with another falls referral. At this time Richard lived in sheltered accommodation, where he had been for 2 years, following an injunction being taken out by his late wife. Richard then contacted police as he had heard his wife had died, but no one had told him. In the officer's view, Richard appeared isolated, frustrated, and emotionally distressed on hearing the news. Officers were concerned that he appeared as not being capable of caring for himself and in need of some domestic support.

An adult at risk referral cited that he had apparent signs of dementia. The adult at risk referral was shared by the MASH Team with partner agencies on the 12th April 2021. After being notified that his wife had passed away Richard then returned to the land that he jointly owned with his daughter (Mary) in April. Mary lived in a mobile home on this land and Richard was living in a caravan at the other end of the half acre field, his caravan was small and had no heating or electricity, so Richard stayed temporarily

with his daughter, while it was being fixed. There was no running water, but Richard was able to get water from a tap outside, which was something that he was used to doing and posed no problem while he was fit and well.

2.2. Key Practice Episode 1. (January 2022-June 2022)

Richard attended the Minor Injuries Unit at Ely on the 15th January, having driven himself there after backpain from another fall (he reported it was 3 days ago, but was actually 10).

Attendance at Hospital Emergency Dept (ED) 1 (chest pains, safeguarding related concerns) 24/01/22-25/01/22.
He then experienced chest pain and called Mary who phoned for an ambulance, leading to him being taken to hospital. He was seen in ED and after assessment he didn't need admission, so was planning to return home. Mary was called to collect him from the ED, and he was happy to go with her. Diane had stated, as part of her allegations, that he hadn't spoken with Mary for the past 10 years. However, this was incorrect as at this time Richard was currently living with Mary. He was about to leave when he returned for hospital transport to be arranged for him, as he couldn't get into Mary's car. While waiting for the hospital transport to arrive Diane phoned ED again and further alleged that Mary had hit Richard. There was a confusing series of entries following this, although it appeared that due to these concerns about a risk of further physical abuse Richard was then brought back to ED by Hospital Transport and subsequently stayed overnight at the hospital.

Mary also raised her own concerns with the medical team, over Richard's memory and possible signs of dementia. Richard stated that he wanted to return to live with Mary and hospital ED notes indicated that he had capacity for this decision, despite the concerns raised by Diane. She stated she would raise her concerns directly with ASC. Meanwhile ward staff raised a Safeguarding Referral themselves, which was also shared with ASC. Richard was then spoken with in detail about the allegations by a Dr on the ward, Richard wanted to go to stay with Mary while his caravan had some heating and electricity repairs done. Richard stated his family argue all the time (over his money), but that he was safe with Mary, and he was discharged later that day via hospital transport. This was not investigated at the time, by the Adult Social Care (ASC) Hospital Team, as he was discharged without them being notified and they referred the safeguarding concern on for follow up in the community. Medication, including Zopiclone[5] was requested by Mary, for Richard from his GP.

In February Richard was visited at home by a social worker to undertake the Safeguarding Enquiry following Diane's allegations, describing his caravan was warm and comfortable. At that time Richard was able to make his own meals and was quite independent. Richard had no concerns over financial abuse, but said he needed help with some paperwork, as "he wasn't very educated"**.** A community OT and PT referral had been made by ward staff prior to his discharge. Following these referrals Richard was phoned to arrange this and said he didn't need an OT assessment and he could

[5] Zopiclone is addictive and used with caution because of this. Can also make people unsteady on their feet (incoordination) 15mgs is a large dose. Recommendation is to take at lowest dose possible for 2-3 weeks.

access his property fine. His referral was then closed, which was an early missed opportunity to assess the risks of trips and falls in his caravan.

Richard requested help from ASC to complete a welfare benefits form and asked if anyone could help, but this was not provided to him at the time, and he was advised to return the form to ASC as there was 'no hurry'. He did not do this and here was another missed opportunity to help, as he may have subsequently had avoidable financial difficulties. It was known that he had been accessing a local foodbank in Ely at this stage, although his financial circumstances remained unassessed, so it was unclear why he needed to use this. Richard was then seen at a falls clinic, where he was unsteady/unsafe and they requested review of medication (solifenacin[6]) by his GP, although it's unclear whether this then happened.

Mary reported that something was wrong with Richard, and she called the police as he had become more aggressive, and she had asked him to move back into his caravan. Mary was contacted by a social worker, as police had raised concerns, following her call out to them. Richard was then called by the social worker, he acknowledged that he had made threats and that he had since moved back to his caravan, he denied any intent to harm and refused the offer of an assessment.

Three weeks later Mary called police again as Richard had accused her of stealing his phone and keys, he threatened to throw a brick through her window when she wouldn't let him in. When police attended Richard appeared frail and forgetful. Police raised a safeguarding referral and took him directly to see his GP. Police also contacted the Intermediate Mental Health Team (IMHT), where he was on the waiting list for a Memory Clinic assessment, but they couldn't help him.

Mary was deemed not to meet the threshold for a S42 Enquiry regarding the violence from Richard and the concern was closed. Richard was called in June to remind him of his memory clinic appt, which he attended and was diagnosed with dementia. He was advised to stop driving, which he had been doing up to this point, although it's unclear whether he did stop driving. His GP was asked to review Richard's medication (Zopiclone) which was thought to be contributing to his falls and confusion.

Key Practice Episode 2 (July 2022-December 2022)
Admission 2 (due to poor physical and mental health at home) 13/07/22-28/07/22

A nurse from CPFT referred Mary for a carers assessment & support, via Caring Together, after discussing the situation with her, Richard still wanted to drive, and his GP had not reviewed his medication.

Richard was visited at home by the nurse from the Memory Clinic and discussed referring him to the Community Response Home Treatment Team (CRHTT) due to the severity of his "psychiatric symptoms". During this assessment, an ambulance was called as Richard slumped over, which was thought to be from heatstroke, as his caravan was hot. He was shallow breathing, unresponsive, lethargic and had conveyed him to hospital. The ambulance crew found that Richard had 4 bags of cash

[6] https://my.clevelandclinic.org/health/drugs/20376-solifenacin-tablets (treatment for nocturnal urination)

with a total of £1,400 on him. This was logged by them and as Richard refused to leave this at home it was put into the safe for him.

When spoken to in hospital, Richard didn't know why he was there and refused the doctor permission to speak to Mary, as he said he doesn't trust her, she stole his car keys, will lie about him. Later he changed his mind and was happy for the ward staff to contact her. He was noted to be wandering at night on the ward but appeared more orientated when spoken to the following day. Mary was then contacted, and she said he had increased confusion, paranoia and aggression toward her. He had driven his car, got lost and ended up at Heathrow Airport. He had also been hearing the voice of his dead wife lately.

He was seen by a social worker on the ward. He was thought to have been hallucinating, as he believed that children were climbing in through the windows of his caravan, leading to him wiring them shut. Richard stated there was no water pump working in his caravan and insufficient funds to fix it, Mary then raised further financial abuse allegations vs Diane, as Richard was withdrawing money to give her every week. These were discussed with Richard. He was aware he had given money to Diane and that his water pump wasn't broken (his statements were not checked) and the safeguarding concern was closed with no further action.

Richard felt to be OK to be discharged, was assessed as having capacity for his discharge by an Early Intervention Nurse, although insight into his care needs was not discussed. Mary felt this was unsafe and requested help from the mental health nurse from the memory clinic, who spoke to the hospital psychiatric liaison services. The nurse from the Memory Clinic also called the ward, as she felt it was unsafe to discharge him, due to his confusion arising from the Lewy Body Dementia and the associated risks to Mary. Plans for Richard's discharge were then put on hold, pending further consultation with the Psychiatric Liaison Team (PLT).

Three days later the PLT saw Richard on the ward and assessed him. He did not have insight into memory problems and hallucinations, but in other ways he was thought to be orientated in time and place. PLT suggested Richard could be discharged home with CRHTT follow up and made a referral to the hospital safeguarding team, as he made further allegations Mary was stealing from him. Richard was discussed at a ward round, where he was thought to have improved and have capacity, although this was not assessed (and the decision for which he had capacity was not specified). The Older Persons PLT spoke to Mary advising her to stay away from Richard and let home carers support him, as he had agreed to let carers visit. She reported she had been referred for carers support 2 weeks previously. A physiotherapist observed him walking safely on the ward with stick, as he appeared safe, he was discharged from physiotherapy. It was not recorded if he retrieved his cash from the hospital safe at this time, as there were no further notes about this.

Mary raised safeguarding concern 2 days later which was documented by CPFT, on Datix about financial abuse by Diane, regarding the weekly payments to Diane for the rent on a property he no longer lived at. This was shared with the hospital safeguarding team, who then shared it with ASC six days later and a plan for a discussion with Richard about this, with the similarity to previous concerns also noted. Richard was spoken to on the ward, by Social Care Assessor, who had no concerns about his

capacity and felt he was safe to be discharged home, without any support from carers. This was based on Richard's views that he was capable of looking after himself. He said he was aware of what the issues were and how he would manage them.

CPFT notes at this time however stated that although Richard was vulnerable, he was not detainable, under the MHA '83 and as he owned the land where his caravan was he could not be prevented from returning. He had agreed to accept health support on discharge, however a discharge note, from the above assessment stated that as his daughter supports him, no carer support was required. However, this was the opposite view to that of PLT, who felt it was unsafe for Mary to support him. He was then discharged home with no social care support set up.

When a community nurse followed up by making a call to Mary, she said that he was still accusing her of stealing things, she had cooked a meal for him. She had seen him the previous night at 11.30 pm. He was using a torch at his open door, confused as to where he was & where the toilet was. Further conversation the next day with Mary outlined her views about his paranoia towards her, plus his self-neglect and hostility to her ongoing care & support, she also shared her concerns about his vulnerability particularly around cash (£5000 had been found in his caravan), she felt he wasn't eating, and the community nurse arranged a home visit for the next day.

When seen Richard denied having dementia but had slight memory issues and that he did not need help with cooking at home, as he could heat food in microwave. He still had no running water, but demonstrated how he filled a tank from outside and heated water up using a microwave. He was noted to be unsteady on his feet and underweight. He showed that he was taking medication, but not as prescribed (15mg of Zopiclone instead of 7.5mg). It appeared this had not been reviewed by his GP. This was a long home visit, and an extensive assessment was done. Mary said she was frightened of him, locked her doors at night after he threatened her and that she could no longer meet his needs. She had previously sold him some land for his caravan when he returned to live with her.

Richard was discussed at the Community Rehabilitation and Home Treatment (OP CRHTT) meeting at the beginning of August, where it was agreed to visit him in pairs, due to risks from a dog in the yard and as he was living near a traveller site. A joint home visit was then arranged for later in the week with a consultant psychiatrist and a nurse. His social history and current mental state were assessed, with a subsequent letter sent to his GP, asking to increase his Donepezil[7], documenting ongoing threats to his daughter, who was advised to contact the police.

If Richard continued to threaten her there was a plan to consider MHA '83 assessment. Also, an antipsychotic was to be considered for his paranoia, although the psychiatrist had concerns about side effects and possible risks to him. At a subsequent home visit by the CRHTT, it was noted that his revised blister pack for medication hadn't arrived, plus he said that he had carers, although he didn't. Richard stated that he now goes out on a mobility scooter to a village nearby to get food. He stated there was an option to live with his brother, but he did not want this. He declined offers of assistive technology, such as a tracker or panic alarm and had been told now he was ineligible

[7] https://www.nhs.uk/medicines/donepezil/ (treatment for Dementia)

for food parcels from the foodbank in Ely but did not know why. Mary stated elsewhere this was because he had money, including a pension so was told he wasn't eligible. Richard was also quoted as saying he resented spending money on food and knew he wasn't supposed to go to the foodbank.

Mary was then referred again to Caring Together, the pharmacy planned to deliver the revised medication in a blister pack. The issue of Richard's foodbank eligibility was queried. At a home visit to Richard, Mary identified that he had a recent fall, causing bruised knees and elbows.

Hospital Admission 3 (10/08/22-10/08/22) Seen in Emergency Dept
Richard was unsure why he fell, he thought he had hit his gas heater he seemed unsteady on his feet and after consultation with the Joint Emergency Team he was taken to ED for a suspected stroke, due to his lopsided mouth and impaired speech. An ambulance was called and arrived an hour and a half later. By this time Richard seemed to be able to recall events and to walk unaided. He was taken to hospital; his facial weakness had resolved. He didn't want to stay in hospital and was thought capacitated. A cab was called for him and he went home. He agreed to see his GP and was followed up by a phone call from a CPN 2 days later, at which he said he was fine.

He was referred to nursing service for ongoing support, following the above presentation to hospital, for monitoring his medications and the risks of self-neglect. Home visits continued, but as staff were unable to contact Richard by phone, contact was made with Mary, who said he was home and ok. However, when seen he was in stained clothes, all the windows were open as his caravan was very hot. He was given fluids and encouraged to drink regularly by the nurse.

Richard's speech seemed normal, although he was noted to be low when he talked about his wife. Richard showed staff that he had tins of food, he complained of pain in his knees, which were bruised from the fall. He had not showered as still had no water supply and he complained of isolation and boredom since being unable to drive and was now stuck at home in his caravan. He agreed to a plan for referring him for a falls alarm and for community services to be involved from a local neighbourhood team. Richard presented well and staff recommended closing his case, as they felt his aggressive behaviour was more due to his personality and not his mental health decline. They advised Mary to contact police if he threatened her.

The next day there was an incident where Richard threatened Mary with his stick, further he threatened to haunt her when he died and to damage her car/property. She called the police, as she had been advised to do this. As she didn't want to prosecute her father, the police noted this as a crime and raised a safeguarding referral for both Mary and Richard to ASC. Mary also spoke to the Mental Health Crisis Team. Mary phoned the police again, as Richard was driving around the field, threatening to ram her with his car and kill her. Police attended and gave advice, they also called an ambulance, who refused to attend as they said it was a dispute between family. However, from ambulance records it appeared they did in fact attend and examined him but felt there was no need for an admission. Police referred another safeguarding about Richard to ASC. 3 days later ASC contacted Mary who reported an increase in Richard's bizarre behaviour, he had left his TV remote in the fridge and claimed it was

stolen. Mental Health Social Work Team then made five unsuccessful attempts to call Richard.

ASC noted that the police referral which was made after Richard threatened Mary, included that Richard was physically strong and there were dangerous items onsite, Mary was described by police as small and frail. CRHTT notes confirmed that he was discharged from their services and that Richard had been referred to a male CPN from the local neighbourhood team (NT) although he couldn't be seen for the next 10 days.

Further ASC notes acknowledged the concerns and complexities of the relationship between Richard & Mary (including ownership of the land), also that Mary was isolated and felt unable to offer Richard any more care & support. This was noted as a MASH referral although it was unclear what the outcome of all these concerns were for the subsequent ASC responsibilities for assessment of Richard or Mary's needs for a Care & Support, or for a Safeguarding enquiry. There were no further notes for the next two weeks.

At the end of August, CRHTT sent a discharge summary to GP, which included an expectation for the above ASC assessment to be done and that Richard was compliant with his blister packs for medication. His Zopiclone had still not been reviewed by his GP. Mary called police again, due to further threats from Richard who was extremely confused when the police attended, they recorded a crime but for NFA and did not make any onward referrals to any health or social care service, which should have been done. In September, after advice from her GP, Mary self-referred to the First Response Service at old age psychiatry, unclear what this was for at the time, but presumably she was requesting some more support for Richard and herself. She was told to contact the CPN from the Neighbourhood Team (NT) and was advised of the correct pathways for a future referral, if there was a Crisis in the meantime.

A week later, the Mental Health Social Work Team Manager recorded on ASC client records, the outcome of a home visit by a CPN. This noted Richard's confusion about days of the week and associated problems managing his medication via a Dossett box. The ongoing risk to Mary from Richard's paranoia was also noted, despite which further assessments were not done and that there was no need for further social work involvement, but the CPN would continue to monitor. The CPN (from the NT), described the long-term difficulties between Mary/Richard and his need for care, as a minimum he needed someone to prompt him to take his medication. There were no further home visits until one was tried at the end of September, when there was no reply to an attempt to visit again by the CPN. There were no recorded updates from any other agency.

A Mental Health SW attempted to speak to Richard three weeks later in October apparently in response to the safeguarding referral, from the police. This was unsuccessful as he wasn't at home or didn't respond. There were no more notes regarding this safeguarding referral. Another CPN visited later, which was also unsuccessful as the gates were closed and neither Mary nor Richard answered the phone. The CPN planned to discuss case closure at an MDT, due to this and previous failed visits. Following a report from the Mental Health Crisis Team Richard's GP Clinical Pharmacist changed the dose of his Zopiclone (from 7.5mg to 3.75mg). As he

was used to taking two tablets his dose was halved, so that he would continue his usual routine, of two tablets in his Dossett box, but was then at less risk of dizziness.

The Mental Health SW recorded a note in November to close Richard as he had declined support, which was presumably as he wasn't at home/didn't respond during the visits that had been attempted above. At the end of November Richard called the NT. He said that he had missed a visit from the social worker and had found a message from him but wasn't expecting him which was presumably the note left a month earlier on the failed visit. This was passed onto the SW to request that he called Richard back, but there was no indication this was done.

His GP then referred Richard to district nurses (DN) for administering his eyedrops- but this was refused by DN as it was not a service they provided. He was not seen during this month by anyone. There was a telephone call in early December with his GP, Richard said he "was alright thanks" and the GP noted negative depression screening. His previous named CPN from NT called Richard and he said he doesn't need a Mental Health nurse; he couldn't remember his call-in requesting contact with SW & CPN ten days previously. Following this there was a discussion between the Nurse and social worker, who had both discharged him, due to his non-engagement. However, the context and Richard's poor memory and capacity to remember appointments was not considered when this was done.

Key Practice Episode 3. December 2022-February 2023

Admission 4 (Fall, hypothermia) 17/12/22-05/01/23

A week later Mary called an ambulance for Richard after returning home at nine in the evening and finding him on the floor of a shed, following another fall at home. She had last seen him at eight in the morning, it was unclear how long he had been on the floor outside for, in very low temperatures (-5). He was confused and had blood on his hands and head. Richard was taken to hospital, where he was admitted, he had hypothermia, he said he tripped when was in the barn.

Three days later ward staff discussed Richard with Diane, but did not call Mary, due to previous concerns about her that was recorded on the hospital records. Richard had rib fractures, hypothermia, pneumonia and renal failure. Diane said she had offered for Richard to live with her, but he refused, and she remained concerned about the risk of further abuse by Mary. This was recorded and progressed to the hospital social work team. The next day Richard was felt to be medically fit for discharge, despite his pain and his difficulties with transfers. He was noted by SALT to have signs of confusion and poor memory, non-contextual speech (due to dementia). The ward consultant noted that Richard could recall his fall and how cold it was outside at the time.

The Safeguarding Concern about Mary was progressed to the information gathering stage and Richard was seen on ward, at this time there were no concerns regarding his capacity. Following day SW spoke to him about his general living arrangements, Diane's allegations of financial abuse by Mary, which he denied, despite calling her a thief and a liar, stating that things were going missing from his caravan. Richard again asked for support with benefits. This conversation was then shared with Diane and

there didn't appear to have been any further enquiries done, with his case being closed.

Richard was keen to go home when seen during the next ward round but accepted he needed care to be put in place before this. An "MSP discussion" before and then again after Xmas noted no physical abuse from his daughter, but that there was a strain on the relationship. Richard said he can cook and get to town on his scooter for shopping. As a result, no action was thought needed by safeguarding, but Diane was given advice about applying for LPA and benefits.

An OT discussed his needs for equipment prior to his discharge and noted the ongoing problems at home regarding the lack of plumbing, leading to contact with Mary over plumbing and electric problems, which needed sorting before his caravan was safe for him to return to. Mary said that Richard would need to arrange for this and pay for it, but she had a key so could let people in to do the work. The discharge coordinator saw him on ward, and he agreed to a referral for handy person to fix the electric at his caravan, he reported that he had no heating, plumbing.

Richard was discharged home on the 5th January without any further assessment of his needs for care & support. It was also unclear if anyone had attempted to sort out his electricity, heating or plumbing at home. Notes at the time showed no response from the referral for handy person. However, the discharge planning team had noted this needed to be followed up, as they also had not had a response to confirm that voluntary services had picked up the concerns re; electrics in Richard's caravan and the work had been completed. In other hospital records it appeared this had been done, although it was not clarified how, or when.

A Community Nurse received a referral to change a dressing but was unable to contact him at home. Reablement workers went to see him the next day and had concerns about both his physical state and the poor environment in his caravan. He had mouldy food, was unable to sit, or move, he had blacked out was in pain and had slept last night on his sofa. The worker asked Mary for emergency provisions, for him but she declined to help, as she didn't want to get involved any longer. He had electricity and his water tap was outside. The workers found food for him and called an ambulance. Richard was readmitted to hospital. The ambulance crew also noted concerns and felt he was pale, dehydrated, confused and frail. He couldn't move and kept blacking out when he tried to stand.

Admission 5. (unable to stand, dizzy) 06/01/23-01/02/23.
Richard was readmitted to hospital. The ambulance crew had raised a safeguarding concern with the ASC hospital team, but this was not deemed to be appropriate for safeguarding, as ASC was already aware of Richard's situation at home.

ASC then contacted Diane, who was concerned Richard was not managing but he was not wanting to admit it. She felt that he should not be discharged home to his caravan without access to sufficient food and running water, he was unable to source this himself and Mary had declined to support him. Richard was isolated and she had concerns about Richard sleeping in his caravan and not being able to mobilise around inside. While Richard was in hospital a CPN had attempted a home visit, but found he had been re-admitted, so discharged him again from their care.

A week after his admission began, medical notes showed that contact was attempted unsuccessfully with Mary twice, to try and facilitate his discharge again. As Mary was not contactable the ward called Diane. Her view was that Mary still posed a risk to Richard and she gave her history of the ongoing safeguarding concerns, she was reassured that Richard would not be discharged until care was set up for him and further that Mary would not be involved or contacted about this.

However, the next day Richard stated he wanted to self-discharge and didn't want to wait for care to be set up, as he found the ward too noisy and said he now felt fine. A Junior Dr on the ward spoke to him and felt he had capacity for this decision. There was no assessment noted, although he spoke with a consultant who agreed with this view, based on her previous insights. Richard was visited on the ward over the weekend by a physiotherapist, but refused any input and was anxious to leave hospital. Two days later he was seen again by discharge services, and declined offers of a referral for a handy person to fix up his caravan, but he agreed to a "care network" to help with shopping. Meanwhile his GP recorded medication changes in his notes, following receipt of a discharge letter received hospital (Amlopidine, Calichew, Colecalciferol and Cosmocol)[8]. However, by this time he was already back in hospital again, with his medication again subject to review.

Five days later Mary called the ward and shared her concerns over the proposed discharge plan, as she couldn't support him and feared further falls if he went home. Also, that Diane lived far away in Essex and practically speaking could not be involved. Mary recommended a residential placement but was told Richard had capacity so could decide where he went. She wanted to look after him, but he wouldn't let her, they then spoke by phone, afterwards he said to the ward staff that Mary was greedy, she wanted him in a home and wanted his money, but he had left it to Diane in his will.

Richard was then referred to the Intermediate Care Team as part of discharge plans. He was then discharged home with a plan for 3 visits a day by the Intermediate Care Team (ICT) to help with his personal care, medication and meals. Diane was informed of his discharge, but Mary wasn't. Additional medication was prescribed for low blood pressure (Midodrine & Fludrocortisone for low BP).

An OT visit the next day noted that there had been no changes to his environment since his last failed discharge, Richard now acknowledged he shouldn't have come home as he still had no power or running water. There was mould in the fridge, soiled clothes on a radiator, Richard felt dizzy and was unsafe on standing but he refused permission for the OT to contact his daughter. An ambulance was called, by the time they arrived Richard was having lunch and no issues noted by the crew on assessment, but they returned Richard to hospital again for re-assessment over his "dizziness and postural drop on standing", with the ambulance crew stating, "he needs residential care, but is refusing".

[8] Medication for High blood Pressure, Low Calcium, constipation and Vitamin D.

Admission 6. (dizzy and unsafe home environment) 02/02/23-06/02/23
At hospital he reported that he couldn't get up out of bed and had two dizzy spells when this was attempted, fell back onto bed, that he had eaten and drunk v little and that he shouldn't have left hospital after all.

A CPN from the CPFT included safeguarding issues in case notes, without detailing what these were. Three days later, a hospital social worker noted Richard hadn't previously been referred to the Traveller/Gypsy Team and got his consent for a referral. They also noted his recent failed discharge (unwise decision making/MCA). A ward nurse then documented a conversation with Richard about his caravan and returning home, which he wanted to do again. He felt he didn't need care and the nurse considered that he could recall this conversation 30 minutes later evidence that he had capacity and could therefore be discharged home if that was what he wanted. The nurse observed Richard walking 40m with a frame along the ward and getting dressed/washed, he was viewed to have capacity to return home without any therapy assessments, or care in place.

He said that he didn't like the previous carer, because she called an ambulance on him (this was in fact an OT). A food parcel was to be offered for him and a referral was made for the Care Network to do a welfare check on him. Later that day a note from the Early Intervention Team stated Richard was unable to be discharged home to the same environment without a thorough MCA assessment and discharge planning assessment, despite which he was then discharged home without either being completed. The Traveller Health Team called Richard once he arrived home, he agreed to their offer for a food parcel to be dropped off for him but said he "just gets on with it" when they offered further help. ASC notes of this contact incorrectly recorded that they had visited him, and he had declined support.

Admission 7. (fell, after feeling dizzy, hit head and back) 09/02/23-11/02/23.
That night he fell again inside his caravan. He called a support worker who then called an ambulance at 10 am the next day, to take him back to hospital. According to the ambulance record he said that he thought Mary had taken away his Dossett box and he had not been taking any medication (which included Rivaroxaban (an anticoagulant). He was admitted again, and ward notes indicated that it was challenging to assess him as he was fixated on his medications going missing and believed that Mary had stolen them.

He was adamant that he had support in place, but staff were unable to clarify this, despite an attempt to contact hospital social workers by ED staff, to ascertain whether he had care already set up. Ward notes stated that the Early Intervention Team were able to establish there was no care in place. A social worker discussed this with him and recorded that he had declined support. A physiotherapist clarified Richard's safeguarding concerns about Mary having access to his caravan, Richard said he would buy a lock, (previously Richard said he had a padlock for it). The next day he self-discharged again. ASC notes from hospital social work stated that Richard said he needs no support with ADLs, but just someone to help him get milk. He was told he couldn't have help just to get his shopping and was referred to ICT again. The social worker had spoken with Richard over the phone but did not visit him on the ward to discuss this with him. He said he didn't need any help and was discharged home again.

Admission 8. (fell, feeling dizzy and faint) 12/02/23-20/02/23.
Richard called an ambulance later the next day, as he was passing out and fell, he was faint at home. An ambulance crew took Richard back to hospital and he was readmitted after another fall. He made further allegations against Mary stealing his money and these were passed onto ASC. A previous Safeguarding concern was still open to them on the same matter (at that time he didn't want any further action). The Gypsy/Traveller Health Team had been about to visit with a food voucher for him later that day. Richard said that he felt safer being back in hospital but when options were discussed with him he didn't want to go into a care home.

Early Intervention Team speculated whether sheltered accommodation might be an option, when they spoke with Richard two days later, he was felt to be fully insightful and engaged with discussion about his needs/discharge options, stated he has insight into his care needs. Although Richard was still adamant he could go to Screwfix to get a lock on the door to stop Mary getting into his caravan. Mary shared some issues with the medical team about Richard (she felt he was being crafty and taking advantage of the system to get fed at hospital). There was then a request to clarify who his Next of Kin was and who the medical team should talk to, Richard wanted Diane, to be his contact.

Another phone call with the hospital social worker took place, during which Richard remained preoccupied with Mary stealing from him. He was resistant to discuss his falls, admissions, or his needs at home. Hospital ASC Team had discussed safeguarding concerns with Richard, and he said he didn't want any action while in hospital, but they could be followed up after he was discharged home.

A physiotherapist discussion was held with him, at which he declined all care offers, and refused to be referred. The physiotherapist discussed the risks of discharging Richard with Diane and gave her view that he had capacity to make an unwise decision about this. Diane was advised to contact the Red Cross, who could help with welfare checks, shopping, or she could speak to his GP, who could refer him for community care. Richard was discharged home again, with no support. The tone of the notes at this time were that he could make a capacitated albeit unwise decision to accept/refuse care and he clearly wanted to go home. Relevant information regarding his earlier failed discharges, the concerns from his family, the Traveller Team and others who had been to his caravan were not sufficiently considered.

A nurse from his GP surgery had attempted to follow up with visits to him at his caravan after discharge, when she visited she as unable to gain access to Richard and phoned the police. They called an ambulance, who gained access via an open window and found him on the floor next to his bed, deceased and this seemed to have been because of a heart attack and then a fall, where he hit his head.

Richard Deceased on 23/02/23 (3 days after discharge)

3. Analysis of Practice against Terms of Reference

This section contains a summary of the relevant practice found in this case, within each of the KPEs against each of the Terms of Reference. These were taken from a review of a full multi-agency chronology, which has been omitted from the report for brevity. There is then a summary appraisal of the practice found in each area.

3.1. Term of Reference 1.

Diversity and cultural issues - the subject was from a Showmen community; what impact (if any) did this have on how services engaged and assessed his needs/risks and is there wider learning for agencies to improve working with the Showman community?

Richard lived in a caravan for most of his life and this was respected as his choice appropriately at the beginning of the period subject to review. However, when he began to experience much more significant challenges with aspects of his safety and needs for care and support, especially during more extreme conditions, both the heat of summertime when he suffered heat stroke and dehydration, leading to Admission 2 and in the winter months, when he suffered hypothermia after a fall outside in freezing conditions, leading to admission 4. Following this he had a further four admissions after a series of failed discharges, indicating that he was clearly physically and mentally unable to cope with continuing to pursue the lifestyle of his Showmen lifestyle. This does raise the issue of whether sufficient consideration was given to the extreme demands and risks he was exposed to, especially as he became more physically and mentally unwell.

Apart from living outside, the other challenge to Richard was his extreme isolation and how hard it became for him to access necessities, such as food from shops, when he had to stop driving. For a while he continued to use a scooter to travel to Ely to a foodbank. When that became unavailable as he was deemed ineligible, he struggled to purchase food, despite large sums of money being found on him or in his caravan. Best Practice would have been to assess his needs for Care and Support at his home, rather than what was done in this case, which was to assess how he functioned in a hospital setting, this was not a good indicator of the challenges he faced in his caravan home environment.

There was little consideration given to Richard statement that he was ‘not well educated’ and required support with forms/letters, which he requested on three occasions during the review period. He did not receive this help and a practitioner wrote to him to advise to him contact again, if he needed help. When Richard asked for support with buying milk, this was refused, but would have been a way to engage and support him/check in on his welfare following the numerous failed discharges from hospital.

The wider impact of his culture and how this could have been taken into consideration was an important part of this SAR, but unfortunately without a subject matter expert, little more can be said about this aspect of his case which was a recognised weakness

in this review. Anecdotal evidence was shared for the report that people from this community do not like the term traveller and feel that they are from a separate Showmen cultural identity. They are clear that their lifestyle of working in the traditional fairground industry sets them apart from other travellers and don't want to be associated with gypsy/traveller negative stereotypes. However, there has been research that has identified some of the health inequalities faced by men from the Traveller Community, which may be relevant to this case, although the specific cultural differences between Showmen and other Travellers has not been explored.

"O'Neill et al, (2008) identified a number of barriers to Traveller men engaging with health, including disconnection, fear of scrutiny, hierarchy and challenge of engagement, the need to be convinced, feeling left behind by Traveller women, machismo (The Men's Development Network, 2008), rigid paths to learning, previous experience of agencies, historical and economic suspicions."[9]

Richard was at several points described as "hard to engage" during the period between August-December, and his case was closed by both the mental health social worker and nurse, due to his non-engagement. However, there were limited attempts made, with one visit attempted in September and October, this seemed not to consider the practical and cultural difficulties Richard was facing at the time. Richard called in November, having found a note left by the social worker, he was phoned back 10 days later by which time he had forgotten calling and said he didn't need help. This may have been taken as a sign of his cognitive decline rather than he was not engaging. Shortly after community services withdrew from his case, he began the period of rapid decline and repeated falls/hospital admissions prior to his death.

There was a Traveller/Gypsy team within the LA, but it was unclear why Richard had not been referred for their input until a few weeks before he died. It would be pertinent to consider why a referral was not made sooner if Richard was 'difficult to engage'. The cultural sensitivity of this team would have made any assessment much more informed, regarding the reality of living as he did, in an isolated caravan in a field. They may have also given valuable insight into the differences between issues faced by Showmen and other traveller groups. When he was called by this team Richard agreed to have a food parcel delivered when he got home, but also said "he just gets on with it", despite falling and being readmitted the next day. They did offer him a food voucher and he said just prior to his final discharge that he found them helpful during a telephone call to a social worker, in which he said he can cope on his on and wanted to be discharged.

Richard's perceptions of his needs at home were that he when he was there he felt he should be able to cope and seemed in line with the attitudes found in other research, as quoted in "The health of Gypsies and Travellers in the UK".

'Van Cleemput *et al*. (2007) refer to many Gypsies and Travellers sense of fatalism about treatable health conditions and low expectations of enjoying good health (particularly as they age). They also mention the commonly held belief that professionals are unable to significantly improve patients health status and may in fact

[9] https://cypsp.hscni.net/wp-content/uploads/2015/02/hscni_uu_dying-fifteen-years-early-traveller-men-report.pdf

diminish resilience by imparting bad news, such as a diagnosis of cancer. The impact of such beliefs is a heightened suspicion of health professionals and a reluctance to attend for screening or preventative treatment'[10]. Also quoted in this report is research into the strains placed on family carers looking after a relative with complex health conditions, which for Mary seemed to be so stressful for her that she ended up having to withdraw from the care of her father.

"The report by Parry *et al*. (2004), entitled *The Health Status of Gypsies and Travellers in England*, shows that both men and women often experience chronic ill health, frequently suffering from more than one condition; that carers experience a high level of stress; and that secrecy about depression keeps it hidden and increases the burden on both the individual and the family as they try to manage."

And more locally the CPFT Equality Diversity & Inclusion Strategy 2019 - 2024 stated that;

"We also know that gypsies and travellers continue to have the lowest life expectancy of any ethnic group in UK. This trend also applies in Cambridgeshire"[11].

The GP surgery that Richard was registered with, for a rural farming community with practice delivers primary care to multiple outlying villages, including travelling community sites and high number of Showmen. However, currently the ethnicity of Showmen are not recorded to enable an understanding of the specific healthcare needs of this community.

"Gaining an understanding of the general health status of Gypsies and Travellers in the UK is hampered by the lack of systematic large-scale data or routine monitoring of these populations by health authorities. Despite improved ethnic monitoring being a key priority in the Government's strategy to reduce ethnic health inequalities, Gypsies, Roma and Travellers are not included in the National Health Services' (NHS) ethnic monitoring codes meaning that no national level health data exists"[12].

Finding 1.

3.2. Term of Reference 2.

How did the impact of historical domestic abuse affect Richard's family around the caring role for Richard when he became unwell, and how well did agencies recognise potential carer abuse & respond to this?

Extended Family networks have been found to be extremely significant in Traveller communities; "According to Rozelle (2008) there is now a consensus from this literature that Travellers base their lives around their extended families and are a collectivist society, following a "gemeinschaft" community model rather than the

[10] https://www.gypsy-traveller.org/wp-content/uploads/health-brief.pdf
[11] https://www.cpft.nhs.uk/download.cfm?doc=docm93jijm4n1652.pdf&ver=2296
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6388580/#:~:text=Despite%20improved%20ethnic%20monitoring%20being,national%20level%20health%20data%20exists.

individualistic, competitive “geselleschaft” one in which most contemporary persons live. This means that Travellers do not define themselves by what they do for a living or where they live, but by their genealogies and the names of their relatives”[13].

Given this cultural significance the historical allegations of domestic abuse relating to Richard and his wife led to major impacts on both him and his family. Richard had two daughters and two sons, all of whom he was estranged from following the allegations of domestic abuse and Richard was ostracised from his family network. An occupation order removed him from his local community, to protect his wife from abuse and he was accommodated in a bungalow away from the site where he had lived. It was not until his wife passed away, that Richard was able to return and only one daughter (Mary) thereafter had regular communication with him. It was unclear exactly the nature of the situation, but some records indicated that she had sold him some land where he lived in a caravan, behind the half acre plot where she lived.

The only other member of his extended family that was referred to be his granddaughter (the daughter of Richard’s other daughter, Diane), who lived in Essex and with whom Richard had stayed previously. There were allegations and counter allegations of abuse between Diane and Mary, which were complicated and never fully investigated satisfactorily, nor understood during the time of the review. These were significant in how agencies worked with both Richard and his family, at times staff would speak to Diane as Richard’s designated next of kin and at other times Mary would be involved..

Diane first reported allegations of financial and physical abuse vs Mary during admission 1 (February 22), which led to Richard being returned to hospital, when he was on his way home. He was later discharged as he said he felt safe, he was living with Mary at this time, while his caravan had some repairs. When later visited as part of a safeguarding enquiry he had no concerns and said his family argued over money all the time. There did not appear to be any basis in fact for Diane’s allegations, although no evidence was explored other than Richard’s views on this.

The suspicion about Mary abusing Richard seemed to re-appear, particularly in hospital records, later. During admission 5, ward staff tried to contact Mary initially and when they couldn’t get through they rang Diane to facilitate his discharge and as she re-iterated the previous allegations, including that Mary still posed a risk to him. Diane was told that Mary would not be involved with Richard’s discharge and when he did leave it was Diane who was informed of this, but Mary was not told about it. Given that Diane lived 70 miles away and Mary was in the same field as Richard, this left him with no informal carer support. Mary felt she couldn’t be involved anymore as Richard wouldn’t let her care for him. It did appear that he was quite paranoid at this time, repeatedly accusing her of stealing things from him.

Mary was providing significant care for Richard during most of the time of KPE 1 & 2, she was also experiencing threats of violence and abuse from him at times. She was not sufficiently supported during these times, despite being advised to call police if she felt threatened by Richard, which she did on many occasions. The first of these was

[13] https://cypsp.hscni.net/wp-content/uploads/2015/02/hscni_uu_dying-fifteen-years-early-traveller-men-report.pdf

in March 2022, when he was living with her in her caravan. She reported that something had changed with him, and he was threatening her. In response to this Police shared information with ASC, who phoned her and Richard. He had moved back to his own caravan and denied any intent to harm Mary, whereupon the case was closed.

Three weeks later Mary called police again as Richard accused her of stealing his phone and keys, he threatened to put a brick through her window. Again, this was shared with ASC by police, but no action was taken as Mary was deemed not to meet the S42 Criteria for a safeguarding enquiry. In August, after admission 2, when he was known to CHRHTT, threats to Mary were ongoing with Richard considered to be hallucinating and paranoid. Mary was advised to call police and that an assessment under MHA'83 would be considered. She then did this twice in quick succession, after he threatened her with his stick and then attempted to ram her in his car. Police dealt with the immediate risk on attending, made appropriate crime reports and made onward referrals for Mary and Richard as adults at risk. Police records at the time stated that,

"Mary appears to have been isolated from others with caring for her father since the death of her mother in April 2021. Mary was also frail, of pensionable age and was herself physically incapable of managing her father on her own. Mary had frequently alluded to her father having been difficult for many years, which may be reflective of the issues between her father and mother. On occasions, the reporting officers have also considered Mary to be at risk given that although Richard was more elderly and despite his dementia, he retained a strong physical presence".

Mental Health Crisis support, Police and Ambulance had all attended, leaving Mary feeling isolated because she felt unable to get help from any of the services. Richard wasn't thought to be well enough to be detained in custody. But because he was physically quite well, the ambulance crew felt there were no reasons to remove him, as they felt that he had capacity. Richard was aware of this, and Mary believed this made him think that the Police were unable to touch him, and he continued to make threats towards her. Furthermore, ASC noted police said Richard was strong and powerful, but Mary was frail and small, but there were no records of decision-making regarding action under Safeguarding responsibilities, for either Richard or Mary.

Mary made one further call to police at the end of August, due to more threats. Police recorded that Richard was very confused at this time, but they made no onward referrals for either Richard or Mary to ASC, GP or Mental Health, which was an oversight. Other than this occasion, the police officers had always followed appropriate procedures to refer onto appropriate health and adult social care services. It was at this point that Mary withdrew from supporting Richard, as she felt threatened by him and because no action was taken by the police, nor Mental Health Services to protect her.

It did not appear that any agency recognised Mary was experiencing "carer abuse", Richard's threats to Mary were not addressed through either Criminal Justice or Mental Health routes. It would have not been appropriate to arrest Richard, given that his aggression appeared to have arisen in the context of his dementia. He would not have been accepted into police custody and would have returned to his caravan a short time

later, causing potential unnecessary distress to him and possibly Mary. Although an assessment under MHA'83 had been discussed, it was not done. Furthermore, no safeguarding enquiry was considered. Because of this omission both Mary and Richard were left at risk and socially isolated and unsupported. This became increasingly significant towards the end of the review period. There did not seem to be any process for effective joint working between health, adult social care, and police to establish a strategy to manage the risks to Mary as Richard's carer.

In July Mary had been referred to Caring Together by a nurse from CPFT for an assessment, although there were no records of this being done. Two weeks later she advised she was still waiting to hear from them and in the meantime was told to leave Richard alone, by PLT, following an assessment in hospital. She was informed that carers would look after Richard, as he had agreed to this, but this was not done, and he was discharged with no carers in place. There was no indication that either Mary of Richard had an assessment of their needs under the S9 or S10 of the Care Act 2014, for Care & Support at any time. Furthermore, from ASC notes following a meeting with Richard while in hospital in July it stated;

"Issues raised were discussed, Richard has recall and was aware of the issues and spoke of how he was managing/addressing them. Richard voiced what he does independently and what his daughter Mary supports him with. **No carer support required."**

Research into the experiences of professionals working with carers who may be abused states; "policies, laws and cultural practices that inform contemporary understandings of who is 'vulnerable' and what it means to have 'capacity' make it particularly difficult to identify and respond to affected carers because they rest on an implicit assumption that those with fewer or no care needs can (and should) be able to look after them- selves. Critically, the coupling of vulnerability and health and care needs obfuscates consideration of how people can be both vulnerable and have capacity—intentionally or unintentionally—to instigate violence and to cause harm to another person. This creates the conditions in which hermeneutic injustices may develop namely that carers who experience harm cannot explain their experience to themselves or be understood by others[14].
(British Journal of Social Work (2021))

Furthermore, in the Journal Of Adult Protection the complexities of this issue were discussed; In a study of female carers' experiences of abuse by older people for whom they care Isham *et al*, *Female family carers' experiences of violent, abusive or harmful behaviour by the older person for whom they care* (2020) carers were sensitive to anticipatory stigma and loss of moral autonomy, resulting in self-censure of what they

[14]https://www.researchgate.net/publication/344886394_'This_is_Still_All_about_Love'_Practitioners'_Perspectives_of_Working_with_Family_Carers_Affected_by_the_Harmful_Behaviour_of_the_Older_Person_for_Whom_They_Care

shared. Moreover, carers had limited linguistic and conceptual resources to explain the emotional and social aspects of the harm they experienced, exacerbated by implicit social norms about the 'private' and gendered nature of familial care. If the abusive behaviours are, or appear to be, a result of the cared-for person having an illness, then the carer can be even more reluctant to seek support and feel guilty about doing so as they think the person is not to blame for their behaviour.

However, it should not be assumed that abusive behaviours are due to illness – recent guidance around Domestic Abuse and Dementia (Dewis Choice Project*, Domestic Abuse and Dementia (2022*)) examines the relationship between the two and emphasises the importance of looking at the longer-term history and pattern of abuse rather than assuming that illnesses such as dementia are the cause of abusive behaviours[15].

Mary was likely to have been in a very difficult position – the IDVA Service supported Richard's wife and daughter for a short time following a referral in 2018 where it was reported that the abuse had been ongoing for a very long time. However, when Richard became unwell, she likely felt a cultural/family obligation to care for him. The subsequent abuse of Mary by Richard should have been recognised as "Carers abuse" and investigated as a Safeguarding matter, both the recent history of threats and previous domestic abuse in the family could have given a far better understanding of the risks and complexities of their relationship. Potentially supporting Mary in her caring role, (in line with S10 The Care Act 2014[16]) which was of major significance in the risks to Richard living in a caravan while she was the only person around, may have affected the outcome of this case.

Finding 2

3.3. Term of Reference 3

How well was Richard's mental capacity assessed during the period subject to review and what does the practice in his case tell us about the challenges of working with people who may mask decision making difficulties?

3.3.1. Summary of references to capacity from Chronology

In 2020 his GP was concerned about him, and Mary called an ambulance to him having chest pains, but as the crew felt he had capacity and didn't want to go to hospital, there was no basis to take him against his will.

In January 2022 Richard was in hospital after having chest pains and Mary had called him an ambulance, the following day he wanted to return to live with Mary and left against medical advice. Ward staff at this time felt he had capacity for this decision. Mary raised her concerns about his memory and signs of dementia.

In June 2022 Richard had an assessment with the memory clinic and was diagnosed with mixed dementia (Alzheimer's and Lewy body) after his threats to Mary and moving back into his own caravan.

[15] https://www.emerald.com/insight/content/doi/10.1108/JAP-09-2022-0018/full/html
[16] https://www.legislation.gov.uk/ukpga/2014/23/section/10

In July 2022 Richard was again in hospital, after heatstroke having wired closed his windows as he had been hallucinating children were trying to get into his caravan. He was thought to have capacity to leave, but after Mary and the nurse from the memory clinic raised concerns he was kept in hospital. He was assessed by the Psychiatric Liaison Team, despite not having insight into his hallucinations or care needs he was thought to have capacity and discharged home.

In December 2022 Richard was again seen in hospital, this time after a fall and suffering hypothermia, he was seen by a social worker in relation to safeguarding allegations and again thought to have capacity.

In January 2023 Richard was admitted again, with the ambulance crew finding him confused, cold and frail at home one day after having been discharged. After returning to hospital, he was seen by a Junior doctor on the ward, as he found the environment too noisy and wanted to go home. The doctor felt he had capacity for this decision and discussed this with a consultant, who agreed. Mary contacted the hospital as she felt he was unable to cope at home, she couldn't care for him, and he needed to be in a care setting but was told he had capacity and could go home.

In February 2023 Richard was in hospital after further falls at home a ward nurse recorded that he had capacity as he could recall a conversation about going home from 30 mins earlier. Two weeks later Richard was seen by a physiotherapist in hospital after a further admission and she felt he had capacity to refuse all care offers and referrals, he was thought able to make this unwise decision to return to his caravan with no care in place. He was also spoken to on the ward by a social worker over the phone. On this brief call he seemed to be capacitated, have insight into his care needs which he said he could manage on his own. He was preoccupied with his daughter stealing things, including his medication and was planning to buy new locks. He was found deceased having fallen at home and hit his head two days later.

From a review of the above contacts with Richard, there are consistent themes around his capacity, irrespective of who documented their views there was a consensus that Richard presented as capacitated. Virtually all these views were documented when Richard was in hospital and in the context of Richard wanting to leave and to go home, without care being in place. Richard was thought to be plausible in his reasoning, although no formal functional assessment of his decision making was available for this review. Conversations were had with Richard at various times, by nurses, doctors, social workers, physiotherapists and psychiatrists.

There were three key areas of this process which revealed learning about the practice of MCA assessments in this case.

1. All professionals recorded their view on his capacity based on conversations with him, often held in hospital, but none documented an actual assessment in line the requirements of the MCA and Code of Practice.
2. Given the risks of his decision and the concerns about how he presented when seen at home, a more in-depth assessment which investigated both the relevant information for his decision not to have his needs met with care services, and his ability to process this, may have revealed more clearly the impact of his mixed dementia on his decision making.

3. The fluctuating nature of both his mental and physical health and the relevance of this for the time when he had to make decisions about the risks his care needs not being met, (i.e.. When was at home in his caravan) was not when he was “assessed”, it was when he was more physically settled in hospital.

Considering other information from his family and the services that saw him at home including concerns/risks about how he was coping and behaving at home, were of relevance to his MCA assessments, although they don’t seem to have been included in the above conversations held with Richard in hospital to determine his capacity.

3.3.2. Summary of relevant information at home from chronology

In February 2022, he had been living with Mary in her mobile home, she reported something was wrong with him, she thought he was showing signs of dementia, he was also increasingly aggressive towards her, she phoned the police, and she asked him to move out into his caravan in the field. Later she phoned police again, he had accused her of stealing his phone and keys, he threatened to put a brick through her window. Police documented he was frail and forgetful.

In June 2022 he suffered heatstroke after wiring his windows shut as he was thought to have been hallucinating and paranoid about kids breaking in. He had been advised to stop driving and Mary reported he had got lost while driving and ended up in Heathrow. When concerns about his safety to be discharged were raised he was spoken to again in hospital, though not to have insight into his memory problems and confusion.

In July 2022 when he was visited at home after Mary’s concerns he wasn’t eating or coping, he denied having dementia, Mary was still being threatened by him, as he blamed her when he couldn’t find things. When seen at home by mental health workers his agitation and paranoia was recorded as getting worse, but “his sharp and demeaning personality can make it difficult to differentiate”. Antipsychotics were considered but not prescribed, due possible risks associated with side effects to his physical health.

In August 2022, his threatening behaviour escalated with two incidents leading to police being called, where he threatened Mary with a stick and to ram her in his car. He had left his remote in his fridge and blamed her for stealing it. Another incident at the end of the month led to police recording he was extremely confused and threatening to Mary.

In September 2022 he was described as presenting with confusion and not knowing the day of the week, being unsafe to use his Dossett box.

In December 2022 he was found outside having fallen and described as confused by the ambulance crew that saw him. On the ward a SaLT described him as having poor memory, being confused and non-contextual speech, due to his dementia.

In January 2022 after this admission when he was seen again at home by reablement workers who called an ambulance crew, they again described him as pale, dehydrated, frail and confused.

In February 2022 he was described as hard to assess on the ward as he was fixated on Mary stealing his medications and wanting to buy a padlock.

3.3.3. Considerations for Capacity Assessments in this case.

Considering how he presented very differently when spoken to on the ward and at home, the picture of his capacity was complicated both by the circumstances and timing of the assessment and the fluctuating nature of his mixed dementia. The particular type of dementia experienced by Richard seemed to be significant here, as Lewy Body dementia has been noted to affect capacity and to fluctuate more than in other forms of dementia.

"Between dementia with Lewy bodies and Alzheimer's disease, the following differences have been found:

Descriptions of fluctuating cognition in DLB [dementia with Lewy bodies] had a spontaneous, periodic, transient quality, which appeared to reflect an interruption in the ongoing flow of awareness or attention that impacted on functional abilities. Descriptions of fluctuations in AD [Alzheimer's disease] frequently highlighted episodes of memory failure, or a more enduring state shift in the form of 'good' and 'bad' days, typically occurring in response to the cognitive demands of the immediate environment[17]"

While it was clear on conversations with Richard he appeared to be capacitated there is learning about how well this reflected the requirements of a formal MCA assessment. The lack of a structured assessment record makes the views on capacity clearly lacking in evidence but more importantly Richard's ability to take decisions were superficially plausible but may have given a misguided impression of his true decision-making ability. This was partly due to the conversations being held on the ward, but the consequences of these decisions were experienced at home.

Therefore, assessing capacity should be done when the consequences of the decisions are happening rather than speculated about. Also, this became particularly important for Richard because of the nature of his "impairment or disturbance in the mind or brain" (Lewy body dementia) causes more rapid and significant fluctuations in decision making ability. Furthermore, both the mental health social worker and the hospital based social workers did not actually meet Richard in person. A decision was made to not to assess his capacity based on information gathered over the phone with Richard and other professionals i.e., CPN, discharge planning nurse, OT etc.

Finding 3.

[17] Cognitive Fluctuations as a Challenge for the Assessment of Decision-Making Capacity in Patients With Dementia.https://journals.sagepub.com/doi/pdf/10.1177/1533317514539377

3.4. Term of Reference 4.

Were there appropriate reviews of Richard's medication, including the impact/side effects of his treatment on his health and wellbeing, while in hospital and in the community?

Richard was prescribed medication throughout the SAR period, with input from his GP, Mental Health Services and Hospital services. Some medication prescribed to him was known to have risks of side effects and it was unclear whether these were adequately managed to minimise adverse effects on him.

In January 2022, when Richard was admitted to hospital after chest pains, his medication was reviewed by CPFT, with a letter to the GP regarding his medication. He was prescribed Zopiclone15mg, to aid his sleep, which was a large dose and noted to potentially make people unsteady on their feet and possibly increase his risk of falls. He was recommended to have a reduced dose of this, but later In August 2022, Richard appeared to still be taking it at the previous 15mg dose. This did not appear to have been reviewed and he was advised to take half of this dose, due to the contraindications for falls.

In March 2022 Richard seen for an assessment at the falls clinic, where he was noted to be unsteady on his feet and at risk of falls. A further medication review was requested from his GP in relation to Solifenacin[18], which was to help with nocturia (urination at night). This was also recognised at this time to also potentially increase his risk of falls. It can increase dehydration and risk of heatstroke, which was what Richard then suffered during hot weather in July.

In July 2022, when seen in hospital by a psychiatrist from PLT, it was recommended he have care in place to support him taking medication, as he acknowledged his memory was not good with taking them. Later when he was discharged from this admission, Mary was spoken to about this and stated she was not sure what he was taking. When he was then visited he showed staff his blister pack and it was thought he was taking it appropriately but did also have old packets of medication. The GP Advanced Nurse practitioner did discuss her concerns about his living situation with the elderly care Psychiatrist in Addenbrookes and requested a capacity assessment, Richard was discharged with secondary mental health services in place, however the team subsequently discharged him.

In August 2022, on a home visit he was noted to have medication and his pharmacy were contacted to arrange delivery of this. Later in the month Mary asked if he could be given something to reduce his aggression to her and this was discussed at MDT, with an outcome for anti-psychotics to be considered but also an awareness of further risks to his health from potential side effects. No anti

[18] This medication may affect your coordination, reaction time, or judgment. Do not drive or operate machinery until you know how this medication affects you. Sit up or stand slowly to reduce the risk of dizzy or fainting spells. Drinking alcohol with medication can increase the risk of these side effects. https://my.clevelandclinic.org/health/drugs/20376-solifenacin-tablets

psychotics were prescribed to him. Post admission there was a request for a blood test to be done within seven days, but this was not done. GP was continuing to prescribe his medication and he was due to be followed up by the CRHTT, however partly due to access issues Richard was only seen twice prior to being discharged.

In September 2022 he was noted to be unsafe to take medication on a social work visit, he had a Dossett box at this time, but he was not sure of what day of the week it was. Not clear if anything was done about this from the records. When he was seen by a CPN later in the month, he was again noted to be compliant but forgetful when taking medication.

In January 2023 a letter sent to his GP noted a change in medication as part of his discharge summary.

In February 2023 notes from ICT the aim there was to visit him three times a day to support him with medication, which had been changed again, with a reduction in Midodrine & Fludrocortisone if blood pressure was raised when checked again within a week. When Richard was admitted to hospital again, he stated he thought Mary had stolen his medication, he couldn't find his Dossett box, and he hadn't taken anything for the past two days. During this admission there were notes requesting a pharmacist to review his medication, but this was not done as the self-discharged the next day. Later in the month when again discharged with further changes to his medications, a letter was again sent to his GP. He was on a high-risk medication monitoring plan, including blood pressure monitoring. However, when the nurse visited him he was then found to be deceased. Letters coming to the GP regarding medications were filed but not always acted upon.

Clearly Richard had multiple changes to his recommended medication, with his frequent admissions toward the end of his life, the systems in place for administering this and monitoring it were not sufficient. He lived in an isolated place and required assertive outreach to ensure he was seen, made more complicated by the practice of joint visits being required. The complexity of his prescription along with the frequent admissions also made this hard to oversee by primary care services. Due to his poor memory and increasing confusion, he was not reliable able to take all medication independently in the prescribed way, some of which increased his risk of falls, especially at night.

Finding 4

3.5. Term of Reference 5.

What was the impact of repeated falls on his health & safety and how well were the risks of this assessed and managed?

Richard had a significant history of falls throughout the time of the chronology which were associated with trips, postural hypotension (drop in blood pressure upon

standing)[19] and associated dizziness, which increased his risk of falls at became a significant problem for him towards the end of the time of the review.
A summary of his falls is set out below;

In May 2020, when Richard lived in a bungalow he had a series of falls at home, and on one occasion hit his head, cutting it and his arm. Richard used to Careline to call an ambulance, as he was taking anticoagulants, he was taken to hospital and a falls referral was done by the crew. It's not known the outcome of this.

In July 2021, Richard had further falls upon waking at night to use the bathroom, he became dizzy and fell twice in the night, he was again conveyed to hospital, with another falls referral made.

In January 2022, Richard had further falls and requested pain killers for back pain at a Minor Injuries Unit, he was noted to be taking Zopiclone which can make people unsteady and increase the risk of falls, notes indicated that Primary Care were to investigate the appropriateness of this continuing and recommended it was reduced.

In March 2022 Richard was seen at the Health You Falls Clinic, where he was seen to be unsteady on his feet and a medication review was requested by his GP for Solifenacin for nocturia (needing to urinate at night). At this time, he felt it was in his best interests to keep taking this and recognised it did increase the risk of falls.

In June 2022 he was seen at a Memory clinic for assessment, following GP referral in October 2021. It was at this assessment that Richard was diagnosed with dementia, again his GP was asked to review his Zopiclone as it was felt to be contributing to his falls and confusion.

In July 2022 during a community nursing visit, Richard was seen to be very unsteady on his feet in his caravan, he was still taking 15mg Zopiclone (he was prescribed 7.5 mg but feels that doesn't work).

In August 2022 Richard had a fall, hitting and bruising his knee and elbow, he was seen again by nurses who consulted the JET Team as there was indicators of a possible stroke (slurred speech, right sided weakness), so he was taken to hospital but discharged as symptoms had resolved. He had been taking Donepezil[20] (a medication that can help with mixed dementia) but appeared to have been taking too high a dose, by mistake. He was followed up in the community by a nurse with a recommendation to discuss him in a MDT and possibly to provide a falls alarm (which was not done). He was still taking the higher dose of Zopiclone when seen later in the month and referred to the CRHTT.

In December 2022 he was found by Mary unconscious outside in a barn, having fallen and collapsed earlier in the day, he was admitted to hospital until early January, due to this.

[19] https://www.guysandstthomas.nhs.uk/health-information/postural-hypotension#:~:text=Postural%20hypotension%20(also%20called%20orthostatic,or%20dizzy%20when%20you%20stand

[20] https://www.nhs.uk/medicines/donepezil/about-donepezil/#:~:text=Donepezil%20is%20a%20medicine%20that,also%20help%20with%20mixed%20dementia.

In January 2023, the day after above hospital discharge he called an ambulance due to a fall in his caravan, he hadn't been able to stand since due to dizziness. Later in January Mary expressed her concerns that he would fall again if discharged back to his caravan.

In February 2023, The day after discharge from above admission, he was found by carers, having had 2 further falls and an ambulance was called to return him to hospital. Three days after being discharged from this admission he fell again, cutting his arm and was readmitted to hospital again. He self-discharged three days later as he felt nothing more could be done about his falls. A day after returning home he fell again, couldn't get up from the floor so called another ambulance and returned to hospital. He was found deceased at home, having fallen again and hit his head after being discharged home again.

During the repeated admissions for falls in February, there was a focus on Richard's concerns about Mary stealing his medication and on his wishes to return home, rather than on his risk of further falls and no assessment of the risks of his home environment. He was at home very briefly before returning to hospital multiple times, but ward-based assessments (where he was seen to be able to walk) were clearly not a reliable indicator of his risks of falls at home.

He also had a very complex series of medication prescribed at this time, which would have been very confusing for him to try to manage, and he thought Mary was stealing his medication, he was clearly struggling with all this and had stated he wasn't taking medication by the end of the period See Section (3.4 for details).

Clearly he was at high risk of falls by the time he was admitted in December, exacerbated by his low blood pressure on standing, his unsteady gait, his environment, which had multiple trip hazards from electrical cables across the floor and from his isolated social and geographical circumstances.

Finding 5.

3.6. Term of Reference 6.

Were the discharges from hospital effectively planned, was appropriate support considered and offered for his return to the community?

Richard had 9 hospital admissions of varying lengths during the period subject to review;

	Dates	Reason for Admission	Discharge Plan
1.	24/01/22-25/01/22	Chest pains (didn't need admission stayed overnight in ED, due to safeguarding concerns)	Unclear, stayed with Mary

2.	13/07/2022 – 28/07/22	poor physical and mental health, dehydrated	Returned to caravan, no aftercare
3.	10/08/22-10/08/22	Seen in ED after a fall, didn't need admission	Returned to caravan, no aftercare
4.	17/12/22-05/01/23	Collapsed, head injury, hypothermia	Handyman service to fix electricity in caravan. Reablement x3 per day, (1 visit)
5.	06/01/23-01/02/23	Unable to stand, dizzy	OT recommends ICT visit x3 per day. (1 visit)
6.	02/02/23-06/02/23	Two falls and postural hypotension	Declined care, given blankets and a food parcel
7.	09/02/23-11/02/23	Fall and head injury	No aftercare
8.	12/02/23-20/02/23	Fall and feeling dizzy on standing	No aftercare

During this period Richard was admitted eight times and spent time on 3 assessment units and five different wards. On each admission concerns were raised about Richard's mental capacity to make decisions, there was clear evidence within the medical notes that he was often confused and in his later admissions was experiencing hallucinations. Richard would often give what appeared to be very plausible explanations and many of his decisions would be seen to be unwise rather than due to a lack of capacity. Richard gave contradictory information regarding how he was managing at home often changing his versions of events during each admission. This lack of consistency along with the poor application of mental capacity assessments contributed to the view he could be discharged with no aftercare plan, as a capacitated albeit unwise decision.

Given that he was readmitted within 1-3 days of his final 5 admissions clearly showed how his version of events related to how he viewed his ability to be able cope when he returned to his caravan was clearly unfounded. As previously stated, a more thorough assessment of capacity which took account of the previous failed discharges as part of subsequent relevant information for discharge decisions may have revealed whether he was making incapacitated rather than unwise decisions. Furthermore, better oversight of his presentation across different hospital wards would have helped with this. Also, where he had consented to follow up in the community, either from reablement or the ICT, on the first visit both services called an ambulance when they saw the poor conditions he was living in.

Finding 6

3.7. Term of Reference 7.

How well was Richard and his informal network engaged with by services during the period of the review?

Richard, Mary and Diane, were contacted by community and hospital services at various points throughout the period of review. However, there was a significant focus on the safeguarding concerns raised, which related to financial abuse/risk of Richard. As these were never resolved with sufficient robust evidence, but closed as Richard felt he didn't want services involved, it remained unclear whether Richard was at risk from either Mary, or Diane. This complicated subsequent contact with Mary by both ASC and Hospital services, as there remained a suspicion that she was stealing from him. It was never made entirely clear whether his concerns about this were a feature of his paranoia arising from his declining cognitive abilities or had any basis in fact. This was further complicated by Mary's allegations about Diane financially abusing Richard.

For the first half of the review period Mary was clearly a carer for Richard, but as he became more hostile and threatening she withdrew from both his care and from involvement with services. Due to his geographic isolation this had huge ramifications for the subsequent risks of living in his caravan, with no other regular source of support. If Mary had been supported and safeguarded more robustly (as identified earlier) this would have been hugely beneficial for both her and Richard.

Also, there was insufficient consideration as to how well Richard was able to meet his own needs and what support may be required to help him meet these. More work should have been done to try to engage with Richard at home to complete an assessment in line with S9 Care Act 2014 statutory duties.

There was an example of Richard being recorded as 'declining' support though it appeared that the practitioner was just unable to contact Richard rather than him declining support. Richard was spoken to when he was admitted to hospital on most occasions. When Richard was discharged in Jan 2023, neither Mary nor Diane were engaged in the discharge planning by ASC, with Diane consulted by ward staff on her views, as they still viewed Mary as a possible source of financial abuse, based on Richard's allegations.

When Mary did call the ward to share her concerns about Richard's return and that she felt a residential placement ought to be considered, she was told he had capacity and could make his own decisions. Mary was not contacted again about his subsequent discharges, which were so frequent and so close together it was difficult to clarify from the recorded information what the engagement was around these admissions/discharges. On his final discharge ward notes did include a conversation with Diane by a physiotherapist who advised her to contact the Red Cross who could give Richard some support, or to contact his GP, who could refer him for an ASC assessment. This would appear inappropriate and a plan to follow him up in partnership with community services should have been agreed before he was discharged home.

It is unclear whether there was any unconscious bias, or prejudice about Richard and his family being from the Showmen community which affected services engagement with them. However, their cultural needs were overlooked and only latterly were the Traveller's Team involved in his care. The earlier finding (Finding 1, Recommendation 2) about engaging more sensitively to his community did address this issue to some extent.

Finding 7

3.8. Term of Reference 8.

What does this case tell us about practice regarding Self-Neglect and the use of the MARM process?

"The Multi-Agency Risk Management (MARM) process provides professionals from all agencies with a framework to facilitate effective multi-agency working with adults (aged 18+) with care and support needs and at risk of harm **who are deemed to have mental capacity** for specific decisions that may result **in serious harm/death through severe self-neglect or risk-taking behaviours and refuses or is unable to engage with services"[21].**

As has been established earlier (in section 3.3) Richard was deemed to have capacity by a range of professionals who met him during contacts in the community and in hospital. The grounds for raising a referral using the MARM process would therefore have been met on this basis were his behaviour was also thought to meet the criteria set out above, for severe self-neglect or risk-taking behaviours and a refusal to engage with services. The MARM policy goes on to give further guidance of the threshold for use of the procedures defining both serious harm and self-neglect.

"Definition of Serious Harm

For the purpose of this policy, "serious harm" refers to the death or injury (either physical or psychological) which is life threatening and/or traumatic and which is viewed to be imminent or very likely to occur.

Definition of Self-Neglect

The Social Care Institute of Excellence (SCIE) defines self-neglect as having three possible strands:

1. Self-care – lack of care over personal hygiene, health, nutrition or hydration leading to potentially severe harm or death.
2. Environment – lack of care leading to squalor or hoarding.
3. Refusal of services which may mitigate harm - such as help with alcoholism, or risk- taking behaviour.

[21] https://www.safeguardingcambspeterborough.org.uk/adults-board/cpsabprocedures/multi-agency-risk-management-guidance/

The Care Act (2014) includes self-neglect within adult safeguarding and some self-neglect cases will be managed through the safeguarding procedures under a Section 42 enquiry. However, not every case of self-neglect will meet the criteria for a safeguarding enquiry. The critical factor is likely to be if an adult can manage their own behaviour to prevent harm to themselves". However, there were very few references to self-neglect made following contacts with Richard;

In July 2022 Mary raised this in conversation with a community nurse, where she said she was concerned about his paranoia, hostility to her and his self-neglect. In August 2022 after Richard had a presentation but not an admission following chest pains he was referred to community nursing for support with medications and self-neglect. When seen he was in soiled and stained clothes, all the windows were open as his caravan was very hot. He was given fluids and encouraged to drink regularly by the nurse.

In subsequent contacts with hospital professionals, mental health and ASC social work practitioners Richard was not considered to have been experiencing or at risk of severe self-neglect, neither in terms of the MARM process nor as part of a safeguarding consideration/concern, by anyone. There had been no escalation for support/case guidance, little evidence of professional curiosity, critical reflection or effective planning/reviewing of Richard's case history to make an informed professional decision.

The reasons for this omission are not immediately clear, but it may have been that he was not thought at risk of severe harm from not being able to meet his self-care or environmental needs and that his refusal of offers of assessments for services may have been a lifestyle choice as a Showmen, rather than a feature of self-neglect. It is hard to avoid the inference that some prejudice or at least unconscious bias may have a factor in this oversight.

Finding 8.

4. Findings from the Review

This section contains the priority findings from this SAR, from analysis of the work done with Richard and his family. Recommended actions in response to each Finding for service improvement are set out for the Safeguarding Adults Board to consider.

4.1. Finding 1

The health and social care needs of the Showmen Community in Cambridgeshire poses some challenges to services, which are currently not recognised or well understood and this needs to be explored further to understand and reduce health and social care inequalities for this group.

Recommendation 1

As a priority for all agencies to raise the recording of ethnicity within their organisation for Showmen to be recorded separately to Gypsy/Traveller in their records of contacts with this community to enable improved recognition of this population and their specific needs.

Recommendation 2

CSAB to receive sufficient assurance from partner agencies that the needs of the Showmen community are considered to better understand any barriers they face to engagement and that referrals are made promptly to the Gypsy Traveller Health Team when these difficulties arise with mainstream services.

4.2. Finding 2

Carers are vulnerable to abuse in their relationship with adults, especially where there has been a previous history prior to the adult becoming unwell. This is not currently sufficiently recognised by either hospital, or community-based health and care services. Expectations that carers without care and support needs should be able to protect themselves can put both them and the cared for person at risk of harm.

Recommendation 3

CSAB to review current practice and awareness of carers abuse in partner agencies, to improve the understanding of the risks surrounding unpaid carers and where necessary to consider undertaking discretionary safeguarding enquiries, if the carer does not meet the Care Act 2014 S42.1 eligibility criteria.

Recommendation 4

Adult Social Care to provide the CSAB with evidence that Carers assessments are appropriately completed, in line with statutory duties, where the grounds are met under The Care Act S10 including the carers ability and willingness to continue caring for the adult, as part of a review of workstreams with Carers in 2024.

4.3. Finding 3

Mental Capacity is often considered by health and social care professionals in hospital-based assessments, but rarely results in a formal structured written assessment of Functional Decision-Making Ability and its links with an impairment or disturbance in the mind or brain, as required by the Mental Capacity Act 2005. This can undermine the evidence base that an adult has

capacity when taking an unwise decision relating to the risks of not having their care and support needs met on discharge from hospital, especially when assessments do not take account of recent information relevant to the decision.

Recommendation 5
Assessing mental capacity when considering decisions relating to hospital discharge needs to be significantly improved by both health and social care professionals to assure the CPSAB that partner agencies are competent to complete these based on a sufficient functional ability that includes all relevant information (including previous admissions) for this decision and in line with the recording requirements of the MCA'05.

For example, if the adult refuses a plan to manage risks on discharge that this is considered as key relevant information for any subsequent functional assessment of mental capacity. This could form part of a themed audit of MCA practice as part of hospital discharge arrangements in 2024.

4.4. Finding 4

The current arrangements for medication reviews by primary care services for older adults with both physical and mental health problems are not clear, especially where medication is subject to several changes during hospital admissions.

Recommendation 6
Prior to hospital discharge there needs to be a detailed plan shared and agreed with GP services, about what follow up medication is required to be prescribed, on an ongoing basis, including what support the adult requires to consistently take the medication and who this will be done by.

4.5. Finding 5

Where adults are known to be at high risk of falls and are frequently re-admitted to hospital following repeated falls within 1-3 days of discharge, the decision to discharge to an appropriate placement needs to take account of this risk, with a risk management plan to both identify the risk factors and how they can be mitigated.

Recommendation 7
That discharge coordination from hospital reviews current arrangements for ensuring falls risk assessments and recommended management plans are completed prior to hospital discharge. For example, to use the Cryer Falls Risk Assessment, as a basis to improve practice in this area.[22]

4.6. Finding 6

Where adults are assumed to have capacity for unsafe discharges and are then readmitted they may not be adequately assessed for either their needs for care and support, or their capacity to refuse this, if information about their lack of executive ability to cope at home is not included as part of subsequent assessments.

[22] Medical-Evaluation-Of-Patients-Presenting-With-Falls-CA5016-V5.1.pdf

Recommendation 8
When assessing capacity for hospital discharge decisions this needs to be followed up, reviewed and where necessary repeated in the community, especially where an adults' mental disorder is known to fluctuate and where there have been more than one previous failed hospital discharge in the past month.

Recommendation 9
Where an adult is frequently re-admitted to different hospital wards, information from named clinicians needs to be formally reviewed with consultation considered where possible between primary and secondary care, as part of decisions about subsequent treatment and discharge proposals.

4.7. Finding 7

Where allegations and counter allegations are made about abuse within families, by other family members, these are often difficult to conclusively investigate with an evidence-based outcome. Where family members are accused of abuse and the outcome is not known this can have serious repercussions for subsequent contacts with family members and carers.

Recommendation 10
That a sample of S42 safeguarding enquiries about alleged financial abuse within families, (where the person was known to, but not necessarily living with the adult) are reviewed by ASC in the preceding 12 months, to explore the outcomes of their enquiries and where these are closed with no determined outcome, what (if any) subsequent impacts there have been on the wellbeing of the adult. If this is a widespread issue for the CPSAB to then explore further practice guidance on this area.

4.8. Finding 8

The awareness and use of the MARM process by all professionals who work with adults thought to have capacity around issues of self-neglect and to be at high risk of harm needs to be reviewed to determine that assumptions about lifestyle choice are not leading to some adults being excluded through unconscious bias.

Recommendation 11
That the current training strategy for all staff around the MARM process and eligibility criteria is increased to give the CSAB assurance that there is sufficient knowledge and competency in this area.

Recommendation 12
That the ethnic identity of clients who have been subject to MARM and/or self-neglect is compared with the ethnicity of all adults in the area, to explore whether there is any significant over or under representation of any group, based on their ethnic identity.

Mick Haggar

2024

Appendix 1

List of Abbreviations used in the report.

Abbreviation	Full Version	Explanation
SAR	Safeguarding Adult Review	A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. It is a statutory review, commissioned by SAB, under Section 44 of the Care Act 2014.
KPE	Key Practice Episode	Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term 'key practice episodes' to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not restricted to specific actions or inactions but can extend over longer periods. The term 'key' emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects. https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp

Appendix 2
Terminology used in report.

Terminology	Explanation	Reference
Amlodipine	Amlodipine is a calcium channel blocker used to treat high blood pressure (hypertension).	https://www.nhs.uk/medicines/amlodipine/
Calcichew	Chewable Tablets are to be chewed as a supplemental source of calcium in the correction of dietary deficiencies or when normal requirements are high.	https://www.medicines.org.uk/emc/product/12847/smpc#gref
Colecalciferol	Colecalciferol is a form of vitamin D. It helps your body to take in more calcium and phosphorous from the food you eat and helps your kidneys to keep more calcium instead of peeing it out.	https://www.nhs.uk/medicines/colecalciferol/about-colecalciferol/#:~:text=Colecalciferol%20is%20a%20form%20of,to%20sunlight%20and%20our%20diet.
Cosmocol	Macrogol (or macrogols) is a laxative taken to treat constipation	https://www.nhs.uk/medicines/macrogol/
Midodrine & Fludrocortisone for low BP	midodrine is often used with fludrocortisone (with or without salt supplementation) for the treatment of orthostatic hypotension, this combination may lead to excessive increases in blood pressure and intraocular pressure. Glaucoma may be aggravated in some patients.	https://www.drugs.com/drug-interactions/florinef-with-midodrine-1100-633-1629-0.html?professional=1
Rivaroxaban	Rivaroxaban is a type of medicine known as an anticoagulant. It makes your blood flow through your veins more easily. This means your blood will be less likely to make a dangerous blood clot.	https://www.nhs.uk/medicines/rivaroxaban/

Appendix 3
Reference documents cited in report.

1. Definitions of Gypsies, Travellers and Travelling Showpeople. https://www.dorsetcouncil.gov.uk/w/definitions-of-gypsies-travellers-and-travelling-showpeople
2. Dying fifteen years early – what can Traveller men and relevant agencies do? University of Ulster & Partners Application of Research Methods in Social Work Fergal O'Brien https://cypsp.hscni.net/wp-content/uploads/2015/02/hscni_uu_dying-fifteen-years-early-traveller-men-report.pdf
3. "The health of Gypsies and Travellers in the UK" "The health of Gypsies and Travellers in the UK"https://www.gypsy-traveller.org/wp-content/uploads/health-brief.pdf
4. A Comparative Sociology of Gypsy Traveller Health in the uk https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6388580/#
5. 'This is Still All about Love': Practitioners' Perspectives of Working with Family Carers Affected by the Harmful Behaviour of the Older Person for Whom They Care. https://www.researchgate.net/publication/344886394_'This_is_Still_All_about_Love'_Practitioners'_Perspectives_of_Working_with_Family_Carers_Affected_by_the_Harmful_Behaviour_of_the_Older_Person_for_Whom_They_Care
6. **Carers and Domestic Abuse - the elephant in the room?** https://www.emerald.com/insight/content/doi/10.1108/JAP-09-2022-0018/full/html
7. Cognitive Fluctuations as a Challenge for the Assessment of Decision-Making Capacity in Patients With Dementia https://journals.sagepub.com/doi/pdf/10.1177/1533317514539377