Safeguarding Adults Review

‘Betsy’

Final Draft Dated June 2025

Commissioned by Cambridgeshire & Peterborough Safeguarding Adults Partnership Board

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1. Introduction

1.1 In July 2024 Cambridgeshire & Peterborough Safeguarding Adults Partnership Board [CPSAPB] commissioned a safeguarding adults review into the death of 'Betsy', who was found dead in November 2023 (aged 80).

1.2 Betsy was a white British woman who had uncontrolled insulin dependent diabetes (it is unclear whether this was Type 1 or Type 2), but had always managed independently in the community prior to 2023. She had a Libra device fitted, although she was not consistent in taking readings from this. The 'brittle' nature of her diabetes meant that her blood glucose levels could fluctuate unpredictably and she would often not show 'ordinary' symptoms of being hypoglycaemic, which made it difficult for her to recognise at an early stage when she was becoming unwell. She was admitted to The Queen Elizabeth Hospital [QEH] in January 2023 after being brought to hospital in Diabetic Keto Acidosis [DKA]. During discharge planning, she agreed to accept district nursing support to manage her diabetes, so twice daily visits were arranged through Cambridgeshire and Peterborough Foundation Trust's [CPFT] District Nursing Service [DNS]. Within a short period, nurses became concerned about Betsy's memory, although assessments of this by her GP did not evidence any cognitive difficulties.

1.3 Betsy was approachable, but could present as being quite sad, and was the loving and very protective mother of two sons. She had been very close to her brother, who had provided her with practical as well as emotional support, and his death (shortly before her own) had a profound effect on her. She had lived in the same house since 1976 and knew her neighbours well, finding them supportive. She lived with her son 'Mike' (aged 59) who was known to be schizophrenic and had not been taking his medication for some time. Due to concerns about the son's behaviour, in particular occasions when he tried to prevent nurses accessing the home, DNS visits were carried out by two staff members for their safety. However, Betsy was adamant that he would never hurt her. Concerns had also been flagged that he was neglecting Betsy and/or that she was self-neglecting, and at times the son refused DNS entry. Practitioners were of the view that Betsy was caring for Mike, as he was not able to provide care to her, although he could prepare his own meals, dress himself and maintain his own hygiene, but he was becoming progressively less coherent.

1.4 A number of safeguarding referrals were made to Cambridgeshire County Council's safeguarding team in respect of the DNS's concern that Betsy's memory was deteriorating, which was impacting on her ability to manage her diabetic and nutritional needs, but she refused care assessments after two hospital admissions in Spring 2023. Mental capacity assessments were completed by the hospital, which concluded that she had the capacity to take the decision to decline care. After a third admission in July 2023 she was persuaded to accept reablement support for 6 weeks from Adult Social Care to facilitate a care assessment, however she then declined a package of care. During this assessment, Betsy told the social worker:

> "*I'm 80 and I want to be independent. Some people like the fuss but not me. If I had a problem I'd tell someone. I think I'm doing alright. I take the medication I should when I should. I do have meals. I have my porridge when I get up and a snack and later a hot meal*."

1.5 A mental capacity assessment was undertaken about Betsy's understanding of her diabetes and eating a balanced diet at consistent times, concluding that she had capacity in this regard, however, later that evening she could not recall why the assessors had visited or information about a well-balanced diet. She had been diagnosed with short term memory loss and in the weeks leading to her death, her memory loss seemed to have escalated, so the DNS requested that the GP assess her memory with a view to a referral to the memory clinic.

1.6 One evening late in October 2023, Betsy was noted to be feeling unwell during her DNS visit and an ambulance conveyed her to QEH's emergency department, where she was treated for

high blood sugar. District nurses called the ward to check on her progress the following morning and were told that she was still in the emergency department, but she was then assessed as ready to return home later that day. QEH made a telephone call and sent an email that afternoon to the district nursing referral hub for administration of insulin that evening, together with a discharge letter to the GP. However, the DNS had not recorded that Betsy's visits had been paused on their ICT system, so when their administrator reviewed her case notes, they believed that a visit was already planned and did not notify the district nurses of her return home.

1.7 When the GP visited Betsy later that day (in relation to the earlier request for a memory assessment, unconnected to her hospital attendance), she presented as confused so the GP made a referral to the CPFT Joint Emergency Team, however, they did not have capacity to undertake a visit. The GP asked the surgery's practice nurse to carry out a home visit. She noted that it was unclear whether DNS had been notified of her discharge as they had not visited, so made a referral for the CPFT Community Nursing's Out of Hours team to carry out an unplanned visit that evening to administer insulin. The Out of Hours team noted that Betsy was 'well', but did not make a referral to the DNS for routine visits to resume. DNS did not undertake any home visits as frontline staff remained unaware that she had been discharged from hospital.

1.8 Six days after Betsy returned home, a district nurse checked Betsy's records to see if she was still in hospital, and established that she had returned home. On arriving at the home, Betsy's son would not initially allow entry, so a decision was taken to call the police. At this point, he allowed the nurses in, and Betsy was found dead in a chair, and appeared to have been dead for at least 24 hours. Police attended and noted that there were no signs of assault, and that Betsy's son did not have the mental capacity to care for her so could not be held accountable for failing to administer her medication, if that was the cause of death. The kindness shown to Mike during this incident by both police and health professionals was commendable, as they prioritised his mental health needs and welfare in very difficult circumstances.

1.9 Despite the tragic circumstances of her death, overall, good multi-agency working could be seen across Betsy's case, with professionals working together to address issues collegiately, concerns followed up consistently to ensure these had been actioned and the appropriate legal frameworks applied. Overwhelmingly, there was a sense of compassion and care, towards both Betsy and her son Mike. Practitioners were careful to balance their respect for Betsy's independence with an appropriate level of caution in respect of her wellbeing, given the imminent risks to her health arising from her diabetes due to its unpredictable nature. There were many examples of professionals going beyond expectations. Those who had worked closely with Betsy were very distressed by the circumstances of her death and the reviewer is grateful to all of the practitioners involved in the review, both for their candour and efforts to keep Betsy safe.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and

- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Betsy from harm.

Themes

2.3. The CPSAPB prioritised the following themes for illumination through the SAR, which will cover the period 1 January 2023 - 2 November 2023:

- How was Betsy supported to understand and manage her diabetes and how was her ability to manage this independently risk assessed? Were the principles of the Mental Capacity Act 2005 understood and applied, in particular:
  - if her cognition fluctuated as a result of her blood sugar levels?
  - in light of concerns that her memory was deteriorating?
  - how did practitioners assess whether Betsy had capacity to decline a care package to meet her care and support needs?
- What mechanisms do practitioners use to assess whether informal carers have sufficient skills or capability to meet necessary care? How do practitioners inform carers of the nature of their duties to meet needs to a safe standard and what training is offered to develop these skills? How are abuse and neglect or self-neglect distinguished from carer strain or an inability to meet need?
- Was the safeguarding process (s42 Care Act) used effectively to escalate concerns and secure multi-agency risk management in this case?
- How well did the hospital discharge/restart protocol work in this case, what does this tell us about barriers and enablers to safe discharge?

Methodology

2.4. The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published SARs.[1] Learning from good practice and a discussion of the legal framework have also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to good practice. The review has adopted a whole system focus.[2]

2.5. The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard Betsy. Agencies provided reports setting out a description of their involvement with Betsy, with a chronology of key events. The author used these to draw together an Early Analysis Report, summarising the agency returns to provide a framework for multi-agency discussions at learning events with front-line practitioners who worked directly with Betsy and the leaders who oversaw the services involved in supporting her.

2.6. The learning produced through a SAR concerns 'systems findings', which are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues. Systems

[1] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS

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

findings identify social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies.

Contributing agencies

2.7. The following agencies provided documentation to support the SAR:

- Cambridgeshire County Council [CCC]:
  - Safeguarding Adults Team
  - Adult Social Care
- Cambridgeshire and Peterborough NHS Foundation Trust [CPFT]:
  - District Nursing Service [DNS]
- Clarkson Surgery [GP]
- Cambridgeshire and Peterborough ICB [ICB]
- The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust [QEH]
- East of England Ambulance Service
- Department for Works and Pensions
- Herts Urgent Care
- Cambridgeshire Constabulary

Family involvement

2.8. Careful consideration was given to involving Betsy's family in the review. The author reached out to the professionals currently supporting Mike through his GP, who had been very proactive in ensuring his needs were assessed and met. However, no response was received and given his ongoing mental health need and the distressing circumstances of his mother's death, a decision was taken not to pursue this. The Board explored other opportunities to capture Mike's voice, but as Mike was not detained under the Mental Health Act or Mental Capacity Act, he did not have access to an independent advocate. Although agencies are aware that Betsy had another son, unfortunately his contact details were not available to the Board.

3. Analysis of Agencies' Actions

Assessment of ability to manage care and medical needs

3.1. Overall, good multi-agency working could be seen across Betsy's case, with professionals working together to address issues collegiately, concerns followed up consistently to ensure these had been actioned and the appropriate legal frameworks applied. Referrals were appropriately made by district nurses, the GP and the QEH to specialist services such as occupational therapy and physiotherapy, the memory clinic, community mental health, and ASC, with services proactively provided and effective communication between professionals involved in her care.

3.2. A key feature of this case was Betsy's desire to live independently, with minimal support from health and care services. Betsy had always been self-sufficient and as recently as February 2023, she had been assessed as being independent of all activities of daily living, although she reluctantly agreed to accept support from the DNS to manage her diabetes. It is not uncommon for an elderly person's health and care needs to rapidly escalate late in life, but this can be a difficult thing for people to accept. Practitioners were persistent, ensuring that in circumstances when Betsy had declined a service she was aware that the offer remained open to her, and being alert to changes that indicates that her needs should be reassessed. This approach recognises that the provision of care and treatment is only lawful if the person receiving the

care/treatment has either given capacitated consent or, if the person lacks capacity, acts are done in accordance with the legal obligations under the Mental Capacity Act 2005 (MCA) and the Human Rights Act 1998 (HRA).

3.3. The MCA sets out that a person lacks capacity in relation to a specific issue if at the material time they are unable to make a decision for themself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain, which includes conditions such as dementia. A person is unable to make a decision for themself if they are unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the decision making process, or to communicate their decision by any means. The fact that a person is only able to retain the information for a short period does not prevent them from being able to make the decision and capacity may fluctuate over time. For example, as dementia advances people may have periods of lucidity and confusion, and a person with diabetes may temporarily lack capacity to takes specific decisions during hypo- or hyperglycaemic episodes. There is a presumption of capacity unless otherwise evidenced and a person cannot be treated as lacking capacity, merely because someone else considers their decision to be unwise.

3.4. The executive function of the brain is a set of cognitive or understanding/processing skills that are needed to plan, order, construct and monitor information to set goals or tasks. Executive capacity is the ability to implement decisions taken, to deal with the consequences and to make adjustments to changing risks in the real world. The MCA Code of Practice (para 4.21) notes: "*For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. A person must accept the information and take it into account. A person may appear to be able to weigh facts while sitting in an interview setting but if they do not transfer those facts to real life situations in everyday life (executing the plan) they may lack mental capacity*."

3.5. The Court of Protection has explored 'articulate and demonstrate' models of assessment in the 2014 case of *GW*:

> "*It is not surprising that GW was able to recall some safety issues in oral evidence, or to describe the route she took into town. The question was whether in practice she had the ability to apply insight and understanding about road safety when she was out and about. Every time someone walks into town, it is a different experience, no matter how well they know the route. The question is whether GW has an appreciation of the risks that may arise every time she steps out of the front door*." (*GW v A Local Authority* [2014] EWCOP20)

3.6. Further, NICE guidance[3] advises assessments should take into account observations of the person's ability to execute decisions in real life situations, highlighting the situational aspect of decision making. Where there is evidence that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, particularly when unprompted, this should be thoroughly explored, being mindful that the assessment process itself will often act as a prompt. Assessors may therefore need to observe the person in their own home over time, or consult with colleagues who are in daily contact with them. The presumption of capacity under section 1 of the MCA does not override professional and statutory duties to ensure that adults with care and support needs are safe from abuse, neglect or self-neglect.

3.7. In the leading Court of Protection case of *Royal Borough of Greenwich v CDM* [2019],[4] the court had to decide whether the assessment of capacity to make decisions about diabetic management should be one global macro-decision, embodying all of the micro-decisions

[3] NICE (2018) Decision Making and Mental Capacity. London: Overview | Decision-making and mental capacity | Guidance | NICE.

[4] Royal Borough of Greenwich v CDM (Rev 1) [2019] EWCOP 32 (20 February 2019)

required to be made when managing diabetes. Newton J, at paragraph 48 of the written judgement, stated that *"I have reached very clear conclusions, both on the evidence and on the law, on the powerful experts' analysis, which I adopt:*

"on the assessment of capacity to make decisions about diabetes management, in all its health consequences, the matter is a global decision, arising from the inter dependence of diet; testing her blood glucose and ketone levels; administration of insulin; and, admission to hospital when necessary in the light of blood glucose levels. And that CDM lacks the capacity to make those decisions, and having regard to the enduring nature of her personality disorder which is lifelong and therefore unlikely to change."

3.8. Newton J acknowledged that CDM's capacity could fluctuate in respect of micro-decisions, but concluded his judgment by stating that CDM's diabetes management is a global decision and is one that CDM did not have the capacity to decide. As a result, he directed that all decisions to be made in relating to the management of CDM's diabetes must be made for her, in her best interests. This judgement highlights the importance of steps being taken to assess a person's capacity to make decisions about diabetic management, should there be a reason to believe that the individual lacks capacity due to a mental impairment, and the correct approach to assessing capacity to make decisions about diabetes management.

3.9. In Betsy's case, very careful consideration was given to her mental capacity in respect of her health needs and her care and support needs, and how this was changing over time. There was evidence that the QEH regularly assessed her cognition by completing Abbreviated Mental Test Scores [AMTS] during hospital admissions. At points when she declined referrals for care assessments, records indicated that her mental capacity had been considered.

3.10. Once the DNS became involved, they quickly identified concerns about Betsy's memory, and approached the CPFT's Community Memory team for a cognitive assessment, but they advised that further exploration was needed to determine whether this was an organic issue, or her erratic insulin management was impacting her memory. DNS therefore spoke to the GP to arrange a series of assessments over the next few months. The GP was very responsive, speaking with Betsy by telephone and conducting home visits, and reviewing the impact of her blood glucose and insulin levels on her cognition, making adjustments to her medication as required. There was evidence of regular, effective communication about this issue between the GP and district nurses, and it was clear that this was a mutually respectful and effective professional relationship, with a true 'team around the person' ethos.

3.11. During Betsy's admission to QEH in May 2023, following a safeguarding referral from the DNS, a mental capacity assessment was completed and Betsy was deemed to have capacity to take a decision to decline support around nutritional meals, able to weigh up the information and the risks. She was noted to remain independent with needs on the ward. The district nursing team telephoned the QEH and expressed their concerns that Betsy had declined a package of care. The ward staff agreed to conduct another MCA in respect of Betsy's refusal of a package of care, which was completed, using a 'green sticker' process that was in place at QEH at that time, although this has since been replaced with a flowchart to better support staff when completing an MCA.

3.12. When Betsy was discharged from hospital in July 2023, ASC took an appropriate decision to put in a package of reablement support for six weeks with Betsy's consent. Reablement is a short-term assessment and support programme that builds on what people can do and supports them to regain their skills, confidence and independence to remain in their own home. In September, a Care Act assessment was completed by ASC as reablement was coming to an end. Betsy was assessed as independent and not seeking care and support. The MCA was considered in regard to being able to participate in the assessment due to concerns raised by

district nursing team around insulin/diabetes management, however a formal MCA assessment was not completed as Betsy was fully able to engage and participate in the assessment. The care assessment captured discussion around concerns for safety due to not taking insulin correctly, but relied on the daily routine district nursing visits to manage this risk, and the assessing social worker considered that Betsy's willingness to accept daily nursing visits, despite her fierce independence, showed insight. Good communication took place between the social worker, district nursing and the GP to complete this assessment. The social worker considered whether Betsy's executive capacity was impacted by her inconsistent blood sugar levels, but noted that the benefit of reablement was to build a body of evidence of her abilities over time, and the social worker could see physical evidence that supported Betsy's assertions that she was managing her own needs (for example dishes in the sink). This demonstrates that the social worker had considered Betsy's executive capacity to manage her own care and support needs unprompted, using a real life 'articulate and demonstrate' model, and overall, the social worker approached the care assessment in a thoughtful, person-centric manner.

3.13. In each of the different assessments of Betsy's cognition, memory and mental capacity, the assessing professionals concluded that she did have capacity to take decisions in respect of her care needs or the other specific issues being assessed. However, given that the DNS continued to raise concerns about Betsy's ability to manage her nutrition in accordance with her diabetes needs, and reported that she struggled to retain information over time, it may have been appropriate to draw together a more comprehensive, multi-disciplinary assessment of her capacity to manage her diabetes as a macro-decision in accordance with the test set out in *Royal Borough of Greenwich v CDM* [2019]. It is important to note that in that case Newham J, highlighted the importance of steps being taken to assess a person's capacity to make global decisions about diabetic management, should there be a reason to believe that the individual lacks capacity due to a mental impairment. The steps being taken by the GP to refer Betsy to the Memory Clinic was therefore important, as this would establish whether her difficulties related to a mental impairment. This would then have set the foundation for a multi-disciplinary analysis, incorporating the daily observations by the district nurses within the analysis of Betsy's executive functioning.

3.14. Subsequent to Betsy's death, CPSAPB published a safeguarding adults review in respect of Richard,[5] which also identified learning about the importance of building an understanding of the person's capacity over time in circumstances where this can fluctuate. This SAR also noted concerns that practitioners had not formally recorded assessments of capacity, which was not a feature in Betsy's case, where practice was stronger.

3.15. Betsy may also have benefitted from a comprehensive geriatric assessment [CGA], a multidisciplinary diagnostic and treatment process that identifies the medical, psychosocial, and functional limitations of a frail older person, with a view to developing a coordinated plan to maximise overall health with aging.[6] This would have enabled practitioners to identify what Betsy's support needs were in respect of her environment and support system as opposed to just her health needs, taking a personalised approach to her wishes and priorities. A CGA of Betsy's needs may have facilitated a development of a holistic assessment of her functional and psychosocial needs that may have slowed the deterioration of her health.

Systems finding

3.16. There was good evidence of multi-agency working in response to health, care and safeguarding concerns and referrals were made promptly to ensure emerging needs were assessed as they were identified. A more nuanced understanding of the impact of co-occurring health needs on executive functioning will better support practitioners when assessing a person's capacity to

[5] LSAB SAR Thematic Review

[6] Comprehensive geriatric assessment: a meta-analysis of controlled trials; Stuck et. al; Lancet; 1993; 342(8878):1032

take macro-decisions in respect of risks and medical treatment. A standardised multidisciplinary approach to comprehensive geriatric assessment may support a consistent approach across Cambridgeshire and Peterborough, promote an early response to emerging needs, better support frontline carers to meet the needs of individuals including their safety and safeguarding needs.

Recommendation 1: *Partner agencies should give assurance to CPSAPB about the robustness of the training, competency and accountability framework for mental capacity, including executive capacity. Relevant teams may benefit from specific guidance in respect of assessing macro-decisions.*

Recommendation 2: *In complex cases, practitioners from key partner agencies working with the individual should collaborate to formulate a shared analysis of how the individual's cognitive function is impacted in different circumstances, to support frontline practitioners in undertaking mental capacity assessments in respect of macro-decisions.*

Recommendation 3: *Health partners should consider the introduction of comprehensive geriatric assessments, with a view to developing a standardised approach to assessments of the holistic needs of older patients.*

Whole family approach

3.17. The Care and Support Statutory guidance sets out:

"*The intention of the whole-family approach is for local authorities to take a holistic view of the person's needs and to identify how the adult's needs for care and support impact on family members or others in their support network*."[7]

3.18. There are a number of specific duties linked to this approach. Section 10 of the Care Act 2014 gives anyone who is looking after another adult with care and support needs the right to a carer's assessment. These assessments should address the carers' mental and physical health, their ability and willingness to care, and their relationships with others. Section 9 of the Care Act 2014 clarifies that an assessment of a person's eligibility for care must consider all of the person's care needs, regardless of any support being provided by a carer, and that this informal care must not influence the eligibility determination. In addition, s20 places a duty on local authorities to meet carers' needs in accordance with a national eligibility threshold.

3.19. Although referrals were made in early 2023 for carer assessments as part of an assessment of Betsy's care and support needs, these were not carried out as Betsy declined the assessments. It appears that although Mike had moved in to live with his mother in 2003 after a mental health crisis, in general, each of them attended to their own needs, preparing meals and attending to their own personal hygiene etc. As they became increasingly concerned about Betsy's memory, practitioners from the DNS noted that they had considered him to be in a position to support his mother with her nutrition, prompting him to make her meals. However, their concerns about his mental state also increased and although he usually avoided the nurses during their visits, he could be heard muttering incoherently in other rooms, leading to the decision that two nurses should attend all visits for safety reasons. They were also concerned that he believed that when unwell, Betsy would only need glucose tablets, and seemed very focussed on this.

3.20. It was clear that Betsy was very worried about Mike, and at times she was noted to be very tired because he was wandering at night. At times, she refused hospital admissions as she was concerned about leaving him home alone. For example, in May 2023, Betsy declined admission despite being in DKA as she was worried about her son's care, but nurses reminded her that

[7] Care and support statutory guidance paragraph 1.14(f)

he had been fine when she was last admitted, and they spoke to Mike, who said he was happy to look after himself. Likewise, whilst in hospital she expressed her anxiety about his welfare, and staff called him to reassure her that he was doing well.

3.21. When the assessment of Betsy's care needs was completed in September 2023, Mike was not involved in the assessment, and was not identified as an unpaid carer as there was no indication that he was providing physical care to his mother. However, it was not clear the extent to which she may have been providing care to him, or whether Betsy's decision to decline a package of care from ASC related to her concern about the impact of frequent visits from professionals on Mike's anxiety or paranoia. Further exploration of this issue may have facilitated a discussion about alternative care offers that would impact less on Mike, whilst still meeting Betsy's needs.

3.22. Throughout this period, there was clear evidence that practitioners were mindful of Mike's needs and the impact these may be having on Betsy. Following her admission to hospital in May 2023, the GP responded to her concerns in relation to his welfare by reviewing Mike's health notes, and identified that his mental health had not been reviewed for over two years, so made an appointment for a review was booked for him the following week, although it is unclear whether he engaged with the telephone appointment.

3.23. Discussions took place in mid-September 2023 between district nurses, the social worker and GP due to concerns that Mike's mental health was deteriorating as on 18 September, he had cut off Betsy's ponytail in her sleep. The GP was persistent in pursuing a psychiatric assessment for Mike and spoke to a psychiatrist, who asked them to refer him to the AMHP service for an assessment under the Mental Health Act, which the GP had agreed to do, advising that in his view, Mike needed to be detained under s2 of the Mental Health Act 1983 for assessment. CPFT's mental health crisis team, First Response Service [FRS] called Mike but he refused to speak to them and Betsy reassured them that he was "ok" so he was discharged from FRS. As Mike was not detained under the MHA, he did not have access to an independent mental health advocate. District nursing completed a Domestic Abuse Stalking and Harassment Risk [DASH] Identification Checklist which came out low. However, it is important to note that DASH assessments have been criticised in national reviews for lacking nuance to adequately identify risk in adult family abuse cases.[8]

3.24. Research has also highlighted that in situations where a perpetrator of domestic abuse was a son or grandson with mental health needs, "*perpetrator vulnerabilities meant that domestic abuse may be missed, either because the victim and/or professional is focussed on these issues as being the cause of abuse, or because ageist stereotypes mean the abusive son or grandson is seen as caring for the victim…risk of missing the woman's perspective*."[9] While there is little question in this case that Mike would not have intentionally harmed his mother, the risk that he may do so unintentionally, for example by giving her sweets when she was hyperglycaemic, required a more nuanced and formal risk assessment.

3.25. During the learning events, practitioners commented about the difficulties they experienced trying to secure a mental health response for Mike. Despite their concerns that he posed a risk to Betsy, the request for an assessment was approached from the perspective of a consent-based referral for a service, rather than consideration of a formal assessment under the Mental Health Act 1983, to determine whether he met the threshold for statutory intervention. Consequently, despite not speaking with Mike or attempting to conduct any type of face-to-face assessment, the case was closed. Little professional curiosity could be seen in respect of Betsy's assertion that Mike was 'ok', in the context of a mother who was fiercely protective of her son and a professional network who were very concerned about the risk he posed to her.

[8] DHR-for-Sofia-2021_Executive-Summary_Final.pdf

[9] Bowes, H, P, Bromley, Walklate, S. Practitioner Understandings of Older Victims of Abuse and Their Perpetrators: Not Ideal Enough. The British Journal of Criminology, 2023, vol 63, 1–18

Practitioners expressed their view that this was not uncommon, and that their experience was that it was difficult to make referrals to mental health, that the team were poor at following up referrals and that even relevant health professionals often received little or no feedback about the outcome of the referrals. However, leaders noted that CPFT had recently established a consultant psychiatrist 'hotline' to enable professionals to check the progress of referrals. Again, use of the MARM process may have helped to pull together a more coordinated multi-agency response to manage the risk that Mike posed.

3.26. On the day that Betsy's sad death was discovered in November 2023, a registered nurse checked Betsy's records as part of their routine checks to see if she was still in hospital, and established that she had returned home. On arriving at the home, Betsy's son would not initially allow entry, so a decision was taken to call the police. At this point, he allowed the nurses in, and Betsy was found dead in a chair, and appeared to have been dead for at least 24 hours. Police attended and noted that there were no signs of assault, and that Betsy's son did not have the mental capacity to care for her so could not be held accountable for failing to administer her medication, if that was the cause of death. Attending officers described the home as being clean and tidy, and that Mike appeared unaware that his mother had died, believing that if she was given glucose tablets, she would wake up. He was unable to explain what had happened leading up to or following her death, and police prioritised securing a safe placement for him, approaching family members and the local authority for accommodation, before a decision was made to take him to hospital where he remained overnight, but was not admitted or detained.

3.27. The approach taken by attending officers was kind and humane. Although it was initially unclear how Betsy had died and whether Mike may have contributed to this, they felt that the extent of his mental health needs were immediately apparent and prioritised the need for him to be taken to a place of safety, although during learning events, the attending officers expressed their frustration at the difficulty in finding him a suitable placement for the night. Likewise, despite arriving to a situation that was quite frightening, the district nurses were thoughtful and proactive, supporting the police by liaising with the GP to secure a mental health response.

3.28. Although practitioners recognised that Betsy had taken the death of her brother very hard, it is unclear whether the extent to which she had relied on his emotional and practical support was fully appreciated, or explored in the context of her care and support needs following his death. While it is not uncommon for people to experience a decline in function or cognition following a bereavement,[10] it is also possible that this was in part because he had been acting as an informal carer (for example, doing her shopping for her), and on his passing, these became unmet needs.

Systems finding

3.29. Practitioners recognised the importance of achieving a balance between Betsy's wellbeing and that of Mike, taking a whole family approach by attempting to meet his mental health needs. However, systemic obstacles to obtain proactive mental health services to meet Mike's needs also meant that the identified safeguarding risk he posed to her was not addressed.

Recommendation 4: *CPFT and Cambridgeshire and Peterborough ICB should explore how to ensure that mental health services provide a proactive response in circumstances where the individual has been identified as a safeguarding risk to an adult with care and support needs.*

[10] Békés, V., Roberts, K., & Németh, D. (2023). Competitive neurocognitive processes following bereavement. *Brain Research Bulletin, 199*, 110663. https://doi.org/10.1016/j.brainresbull.2023.110663

Safeguarding and escalation

3.30. Section 42 of the Care Act 2014 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult with care and support needs is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. An early response to emerging harm is essential to stop risks from escalating. In circumstances where multiple agencies or individuals are making safeguarding referrals, a s42 enquiry should be undertaken, even if individually each concern would not meet the threshold for further investigation.

3.31. In taking a decision as to whether a case meets the criteria for a s42 investigation, the local authority must explore the impact of the adult's care and support needs on their ability to protect themselves. This is important in the context of safeguarding functions because it is the 'ability to protect themselves' and rather than the capacity to make decisions that is the basis for safeguarding legal duties under s42 Care Act 2014. This duty sits alongside a general duty to carry out all social care functions in a way that promotes an adult's wellbeing.[11] The 'wellbeing principle' includes a focus on personal dignity, choice and control, but there '*is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round*'.[12] As such, equal weight should be attributed to duties to protect health and against abuse or neglect. Ultimately, the duty to protect life (protected under article 2, Human Rights Act 1998) requires all public bodies to do whatever is within their legal powers where risk is real and imminent to act to reduce risk. Another SAR published in 2025 by CPSAPB, Joe[13], highlighted national findings about the importance of ensuring that the presumption of capacity was not "…*used to support non-intervention or poor care, leaving vulnerable adults exposed to the risk of harm."*[14]

3.32. From the point the DNS started visiting Betsy in February 2023, they were concerned that she was not able to safely manage her diabetes in the community, even with their twice daily visits to administer insulin. Although they were of the view that this was linked to a decline in her memory, given that the various memory and mental capacity assessments undertaken were concluding that she did have capacity to manage this, it was appropriate for nurses to consider self-neglect as an alternative explanation. They worked closely and collegiately with Betsy's GP to explore ways to improve the medical management of her diabetics by adjusting medication. Additionally, as set out above, there were significant concerns in respect of the risk Mike posed and the impact this could be having on Betsy's wellbeing.

3.33. During Betsy's admission in May 2023, QEH received a safeguarding referral from CPFT, which was discussed during a ward meeting, it was agreed that a mental capacity assessment was to be completed around discharge planning and exploring the dynamics/relationship with her son. Betsy was deemed to have capacity about support around nutritional meals, and was able to weigh up the information and the risks. She was noted to remain independent with needs on the ward and declined any support package at home, but accepted a district nursing referral. It is to the credit of the DNS that they then telephoned QEH to express their concerns that Betsy had declined a package of care. Although a further mental capacity assessment was then completed, it does not appear that the assessor consulted with the DNS to obtain their insight into Betsy's functioning and safety in the community.

3.34. At the end of May 2023, the DNS again made a referral to Adult Safeguarding due to concerns around self-neglect, reporting that Betsy was unable to manage diabetes, her house was a

[11] S1 Care Act 2014

[12] Section 1.6 Care and Support Guidance, DHSC available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#general-responsibilities-and-universal-services

[13] safeguardingcambspeterborough.org.uk/download/safeguarding-adults-review-joe/?wpdmdl=23613&refresh=68ee55846d0171760449924

[14] The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny

'mess', limited food, unable to give an accurate account to district nurses and her son was having an acute psychotic episode, and noting that she 'lacked capacity' in respect of the safeguarding referral. QEH staff followed this up on 30 May, but ASC had no information to share at that point. QEH followed up with ASC again on 31 May and they reported that they had not received a safeguarding referral from district nursing, so the hospital submitted a safeguarding concern. On 1 June 2023, ASC confirmed that they had received the hospital's safeguarding referral. The referral did not record the identity of Betsy's carer, although QEH records indicate that Betsy had spoken to her son on a couple of occasions while on the ward, to check on his welfare. The hospital was notified that the safeguarding referral was closed on 9 June, as the case had been allocated for a care assessment on discharge. However, following a care assessment on 12 June, a decision was taken by the hospital social worker not to take further action, concluding that it was not an appropriate referral for safeguarding as the was '*no need'*. Although Betsy was able to explain to the hospital social worker how she managed her medication and meals, self-neglect and executive capacity do not appear to have been considered. The hospital social worker advised the safeguarding team at QEH to refer Betsy to the diabetic nurse for support with insulin, but this does not reflect the fact that it was CPFT that originally made a safeguarding referral on the basis that DNS visits alone were not adequately managing Betsy's risks.

3.35. On 22 June, the GP made a safeguarding referral to ASC detailing concerns that she was self-neglecting in respect of her diabetic medication, which ASC recorded was because "*Betsy had been admitted to hospital 3 times in 4 weeks*." However, the safeguarding referral closed as Betsy "*was receiving support with insulin, currently an inpatient in hospital and in the process of having care arranged for discharge*". However, QEH has no record that Betsy was in hospital at that time.

3.36. On 28 July 2023, district nursing made a safeguarding referral to ASC reporting that QEH had not made a referral to the district nursing service when Betsy was discharged from hospital, resulting in no home visits taking place to manage her insulin for 2 days. The referral was not progressed as QEH was asked for DATIX and to investigate the issue. Although concerns were raised in respect of Betsy's mental capacity, the safeguarding assessor was unable to complete this due to her high ketone levels. The referral also noted that Betsy and her son appear not to know how to recognise safety risks of how to seek help. The safeguarding referral closed as was in relation to failed discharge, noting that other concerns would be addressed in the "*other safeguarding gathering workstep*". The risks in respect of neglect/self-neglect do not appear to have been addressed, and crucially, the concern raised about Betsy and her son being unable to recognise when to seek help was not considered.

3.37. In early August, the GP, reablement and community nursing raised safeguarding referrals due to concern that Betsy's son posed a risk to her as his mental health was deteriorating, and that during this acute episode he believed her diabetes could be managed with dextrose and not insulin. ASC reported that they gave advice to the GP and reablement to monitor the situation, but did not make a referral to mental health for an assessment of the son's condition or follow up further. The acute risk posed if Betsy's son was to administer her dextrose when hyperglycaemic does not appear to have been recognised.

3.38. On 12 October, a safeguarding referral was received by ASC from district nursing due to Betsy's son cutting off her ponytail while she was asleep (although the DNS also reported that they had made a referral to MASH about this incident on 18 September, it is unclear why ASC have no record of the first referral), but this was not progressed as when asked about this incident, Betsy explained that she thought he was trying to help her. No referral was made to mental health. The referral also noted that Betsy was not managing her nutritional needs again, but this was not explored or followed up.

3.39. Leaders emphasised the importance of being respectful of the individual's autonomy in the context of Making Safeguarding Personal and practitioners also commented on the value Betsy placed on her independence and protecting Mike. However, throughout the triaging process of the various safeguarding referrals, there appeared to be a focus on Betsy's health issues rather than her ability to protect herself in light of her care and support needs. Capacity is one issue to consider, as if the personal lacks the mental capacity to take safeguarding decisions, practitioners will need to take this decision on a best interest basis. However, mental capacity alone does not determine the person's ability to protect themselves, particularly someone who is physically frail or at high risk of experiencing a medical emergency.

3.40. Further, insufficient weight appears to have been given to the fact that the community health services who were visiting Betsy frequently, and therefore likely to have the greatest insight into Betsy's functioning and daily risks, were making the majority of the referrals. Consequently, referrals were often closed on the basis that referrals would be made back to the agencies that had made the safeguarding referral in the first instance. There was palpable frustration on the part of district nurses that although they continued to make referrals to various agencies and make safeguarding referrals over time, this did not result resolution of those concerns. Although each individual triaging or s42 decision may have been appropriate in isolation, the fact that the approach to these was episodic rather than strategic, and partner agencies were not consistently consulted, limited the ability of the Safeguarding team to draw together a holistic understanding of the safeguarding risks, in particular around medical self-neglect. As identified in CPSAPB's Richard SAR, consideration should also have been given to using the Multi-Agency Risk Management [MARM] process as a means of mitigating the risks to Betsy in respect of self-neglect, even if it was believed that she had capacity to decline support.

3.41. National analysis identifies that often a focus on specific need or behaviour obscures recognition of foreseeable risk, reporting that:

> *"even when self-neglect was recognised, it was little understood and poorly explored, lacking detailed personal history and exploration of the person's home conditions or health management routines. Refusal of services was not explored or understood. Professional curiosity was not exercised. Assessment, particularly in the hospital context, relied heavily on self-reporting, with home circumstances not observed. In some cases, assurances about actions the individual would take were accepted at face value, despite evidence to the contrary."*[15]

3.42. Although it was appropriate for DNS to continue to make referrals over time as new safeguarding concerns arose, a more robust approach may have been to challenge the local authority Safeguarding Team's decisions at the time these were made. It is important that frontline practitioners understand local escalation procedures and feel the confidence to use these, supported by generous leadership. There is a common misperception that escalation equates to a complaint, and practitioners may not want to be seen to complain about other professionals, particularly when the issues sit in the other professional's area of expertise. However, the purpose of escalation is to ensure that there is a shared understanding of the risks in the case, the legal options open to each agency and to seek resolution of any areas of professional disagreement, to secure the best outcome for the individual.

Systems finding

3.43. The concepts of mental capacity and a person's ability to protect themselves as a consequence of their care and support needs can be inappropriately conflated when triaging safeguarding referrals against the s42 criteria for a safeguarding enquiry. While the principles of Making

[15] National Sar Analysis. ADASS/LGA, Michael Preston Shoot, 2020 {p101] available at: https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

Safeguarding Personal should be appropriately applied when determining what action to take to mitigate the risk of future abuse, neglect or self-neglect (including through the MARM process where appropriate), artificially excluding cases, either at the point of referral or the point of triage creates a barrier to exploring the risks with the individual, building a full picture of the risk matrix, or identifying when a more assertive safeguarding response is necessary to prevent serious abuse. This is particularly important when repeated safeguarding referrals evidence that the individual has been unable to protect themselves over time even if they assert that they can do so, or harm is cumulative or escalating. The frontline practitioners – in particular district nurses - who had made the referrals were not consulted as part of the safeguarding triaging or enquiry, but when decisions were taken not to take further action, they and the GP surgery were left to manage the risks without the support of the wider professional network and unaware of processes available to escalate or challenge these decisions.

Recommendation 5: *Adult Social Care should provide clear advice for partners and social workers in the Safeguarding Adult team about application of the 'unable to protect' test under s42(1)(c) of the Care Act 2014, its interface with the Mental Capacity Act and principles of Making Safeguarding Personal and the need to consider other factors such as frailty, coercion or insight in respect of risk.*

Recommendation 6: *CPSAPB and partners should consider how to raise the profile of medical self-neglect as a safeguarding matter and review the Partnership's Self-Neglect policy to ensure this gives due weight to this issue.*

Recommendation 7: *ASC should review its s42 processes to ensure that in cases where multiple safeguarding referrals are received from the professional network, a multi-agency strategy meeting is convened to explore the reasons for those concerns and options for safety planning before closing the referral.*

Recommendation 8: *ASC should ensure that clear feedback loops are available to safeguarding referrers to enable ongoing concerns to be escalated where necessary. CPSAPB should review how the inter-agency escalation policy is being used, including by front-line staff, and whether this is resulting in timely resolution on areas of dispute between agencies.*

Hospital discharge and care package restart processes

3.44. Effective communication and a shared understanding of proper procedures between agencies was essential to keep Betsy safe. When Betsy attended the Emergency Department in late October 2023, one of the district nurses called the hospital to check whether she would require a visit that day, and was told that she was still in the emergency department, so was waiting for a restart message before resuming her visits. Betsy was treated and once her blood glucose had stabilised, a decision was taken that she could return home without formal admission to hospital. The Emergency Department called the DNS administrator to advise that Betsy was returning home (which was excellent practice), but the DNS ICT system recorded that Betsy's regular visits were already scheduled to take place that day, so no further action was taken. When DNS explored the reasons for this, they found that because Betsy required two nurses to attend each visit due to the concerns about her son, it could be challenging to reinstate this package once stopped, due to pressures on local resources. As a consequence, district nurses had not formally stopped her package when she attended the Emergency Department, to ensure there would not be any difficulty restarting this if she only had a short admission. This was a commendably person-centric approach, taken with Betsy's best interests at heart. Tragically this meant that when the administrator reviewed Betsy's records, there was no way for her to know that the district nurses were waiting to hear from the hospital to resume visits. The administrator therefore confirmed to QEH staff that the package of visits would take place.

3.45. Practitioners from the hospital explained that it could be challenging to follow the correct discharge notification processes, because they worked across the footprint of multiple community nursing teams, local authorities and independent care providers, each of which had its own discharge notification process. This was further complicated by QEH being outside the region of Cambridgeshire and Peterborough. In particular, they noted that at the time of Betsy's discharge, staff were required to send notifications to other NHS providers using their secure NHS.net email addresses, rather than their hospital email. This mean that they would have to log into a separate email system to send the email, and then, if they wanted to check whether an acknowledgement had been sent, would have to log back on again. This could be particularly problematic in the context of a busy emergency department, where staff may be dealing with dozens of different patients across the course of a shift, or when a member of staff sent an email late in their shift, as other members of staff would not be able to check for a response once they had left for the day.

3.46. Finally, practitioners noted that there could be significant problems with referral forms, which were hard copies filled in by hand for the convenience of staff (as these were often completed on the ward with patients, when the only computers available are in the nurses' station), but had to then be manually scanned and emailed to providers. This created a systemic vulnerability as the forms were double-sided and important information such as contact details for the referrer were on the back of the form. This meant that if these were not scanned on both sides, and the recipient did not discover this until after the person sending the referral's shift ended, this error could be difficult to resolve in a timely way. Staff therefore often felt more confident making a telephone call (where this was possible with the specific provider) to ensure that the health or care provider had definitely received notification that the patient's support package needed to commence. This was particularly common in the emergency department for the reasons outlined above. These challenges are consistent with those found in other SARs nationally, such as a thematic SAR by Havering SAB[16] which looked at five failed discharges, noting "…*well-planned discharges… are hard to ensure, because of the pressure of discharges, changes in, and lack of staffing, confusions about discharge pathways, methods of communication and ways to escalate concerns."*

3.47. Leaders noted that since 2023, efforts had been made to introduce more consistency and safeguards into the discharge referral process. The security on QEH's internal email addresses had been strengthened so that staff no longer had to log on separately to their NHS.net account, and sent from a central ward email address rather than those of individual staff members. The emergency department now follows the same process as other wards, by emailing the restart message rather than circumventing this by making a telephone call (although there may be cases where a telephone call is made in addition to the electronic referral). From the perspective of the DNS, a formal system had been ratified and rolled out that in every case where someone with an existing visiting package attended hospital, the package would be suspended on their system, so that there was no inconsistency in respect of whether a restart notice was required.

3.48. Although not relevant to this case, ASC confirmed that they had a similar process for restarting packages of care and support that were arranged by the local authority, with a generic email address for hospitals to contact. Leaders explained that it was the responsibility of the hospital to contact the patient's family or private care providers where appropriate. Both ASC and DNS noted that staff would regularly contact the wards for updates on patients' progress, although the DNS was making enquiries to determine whether they could access the ICT systems of local hospital to check directly whether a patient was still in hospital, which can facilitate forward planning and act as a safeguard. However, it is neither realistic nor safe for this to be a routine

[16] Havering Safeguarding Adult Board Themed SAR re Discharges from Hospitals and Care Homes 2024

method of establishing whether a patient has been discharged, and in every case, the correct restart processes must be followed.

3.49. On the afternoon Betsy left hospital, the GP visited Betsy at home in response to the request from the DNS for a referral to be made to the Memory Clinic for an assessment, and found that she was disoriented after returning from hospital, so took the view that it was not an appropriate time to assess her memory. He asked the practice nurse to visit, and when she spoke with Betsy, discovered that she had not received her insulin, so arranged for the emergency Out of Hours community nursing service to visit to give Betsy her insulin injection. The GP surgery also called the Out of Hours Service before leaving for the day, to ensure that they had received the referral, and the first thing the next morning, checked to ensure that the visit had taken place. This proactive approach was thoughtful and highly commendable. However, it was the surgery's understanding that the Out of Hours Service would handover to the DNS to ensure that Betsy's regular daily visits would resume and that, in any event, they would receive a notification of the visit from the Out of Hours Service. It is unclear why this did not happen, but it is possible that again, the Out of Hours Service checked the DNS ICT system and saw that Betsy's regular visits were scheduled to take place.

3.50. There is no criticism of the GP Surgery, whose practice throughout this case was exemplary, demonstrating a truly caring ethos. However, leaders acknowledged that as a 'belts and braces' approach, given that there had already been an identifiable failure in respect of standard restart processes when Betsy left hospital, copying the DNS into the request for an Out of Hours visit would have added an additional layer of safety for her. Establishing the reason that district nurses were unaware of Betsy's discharge would have created an opportunity to ensure that this did not recur subsequently.

Systems finding

3.51. Given the potentially dire consequences of a failure to restart care or health support plans when patients leave hospital, it is essential that health and care providers have robust systems in place to ensure that packages of support always resume when they receive notification that a patient has returned home from hospital, including when no formal admission has taken place. When agencies have identified a failure in respect of a safe discharge/return home, in addition to emergency referrals to meet any immediate health or care need, urgent steps should be taken to notify both the hospital and the health or care provider, to ensure that any systemic failures can be addressed without delay.

Recommendation 9: *Partners should explore with providers across the regional footprint (liaising with neighbouring SABS where appropriate), whether greater consistency can be introduced in respect of discharge and care package restart referrals to simplify processes for hospitals and reduce the risk of human error arising from the existing inconsistencies.*

Recommendation 10: *Health and care partners should review existing discharge/return home policies to ensure that these clearly set out responsibilities for notifications about unsafe discharges or the failure to restart care or health support plans, and that these are socialised across relevant partner agencies.*

4. Glossary

AMTS	Abbreviated Mental Test Score
CCC	Cambridgeshire County Council
CDN	Community diabetic nurse
CMHT	Community Mental Health Team
CPFT	Cambridgeshire and Peterborough Foundation Trust
CPSAPB	Cambridgeshire & Peterborough Safeguarding Adults Partnership
DKA	Diabetic Keto Acidosis
DoLS	Deprivation of Liberty Safeguards
DNS	District Nursing Service
ECHR	European Convention on Human Rights
GDPR	General Data Protection Regulation
ICB	Integrated Care Board
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
MHLT	Mental Health Liaison Team
OT	Occupational therapist
QEH	The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
SAR	Safeguarding Adult Review