Trafford Strategic Safeguarding Board

SAFEGUARDING ADULT REVIEW

SUSAN AND ANNE

May 2018

Independent Chair: David Hunter

Independent Author: Ged McManus

NHS Trafford Clinical Commissioning Group

TRAFFORD COUNCIL

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1 INTRODUCTION

1.1 This Safeguarding Adult Review, hereinafter referred to as the Review, is about Susan aged 95 years and Anne aged 61 years. Susan was Anne's mother and the two of them lived together in social housing in Trafford. Susan and Anne are pseudonyms chosen by the review panel.

1.2 Susan had two children, Anne and an older sibling. The family lived in Greater Manchester and both children were brought up locally and attended local schools. As adults both of Susan's children lived independent lives although the family stayed in touch and all of them lived locally. Anne was a store supervisor for a national retail chain and lived together with her partner for many years.

1.3 Susan had lived in the same house since January 1982 and following the sudden death of Anne's partner around fifteen years ago, Anne moved in with her mother. Approximately ten years ago Anne gave up work. The exact reasons for this are not known but it is believed that she had been suffering from sciatica and had struggled to manage back pain for many years.

1.4 In the last few years of her life Susan's health declined significantly, and she became very dependent on Anne. Anne developed depression and anxiety which combined with her back pain limited her ability to live an active life. She went out rarely and shopped online, with groceries being delivered regularly. During conversations with her older sibling, Anne did not want to discuss looking for outside help to care for her mother and refused to discuss the issue further.

1.5 Their rent was paid by housing benefit and other than for routine repairs and maintenance they were little known to the landlord. Their house and garden were kept clean and tidy and as a result of the good conduct of their tenancy the local housing office had little contact with them. The last landlord annual gas safety check before the deaths was done on 17 August 2016.

1.6 On 24 February 2017, following a concern being reported by a neighbour, police and ambulance service attended Susan and Anne's home. After gaining entry they found Anne deceased in a decomposed state lying on the sofa in the lounge of the property. Susan was alive in bed upstairs but in a severely dehydrated state. She was taken to hospital and received treatment to stabilise her condition.

1.7 Susan's overall physical condition was said to be good given her recent experience. She received treatment for her medical conditions and briefly left hospital to stay in an intermediate care centre. However, her condition deteriorated and she returned to hospital where she passed away on 18 April 2017, from natural causes.

1.8 A post mortem was unable to establish the cause of Anne's death. HM Senior Coroner for Manchester South, Ms Mutch, has set the inquest for June 2018.

2 ESTABLISHING THE SAFEGUARDING ADULT REVIEW

2.1 Decision to Hold a Safeguarding Adult Review

Section 44 Care Act 2014 Safeguarding Adults Reviews says:

(1) A SAB[1] must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if-

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) Condition 1 or 2 is met

(2) Condition 1 is met if-

the adult has died, and

the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

2.1.1 On the 12 April 2017, the Chair of Trafford Safeguarding Adult determined that the circumstances of Susan and Anne's deaths met the criteria for a safeguarding adult review.

2.1.2 On 22 June 2017 David Hunter was appointed as the chair for the Review and was supported by Ged McManus who wrote the report. Neither has worked for any of the agencies contributing to the review and they were judged by the Chair of Trafford Safeguarding Adults Board to have the experience necessary to conduct an independent and thorough enquiry. The first meeting of the Safeguarding Adult Review panel took place on 15 December 2017.

[1] Safeguarding Adult Board

2.2 Panel Members

Name	Position	Agency
Morgan Adams	Administrator	Trafford Metropolitan Borough Council
Karen Ahmed	Director of all age commissioning	Trafford Metropolitan Borough Council
Mark Albiston	Strategic Lead Central Neighbourhood and Lead Professional Adult Social Care.	Trafford Metropolitan Borough Council
Nikki Brown	Named nurse for safeguarding families	Pennine Care NHS Foundation Trust
Jacquie Coulton	Designated Nurse Safeguarding Adults	Trafford Clinical Commissioning Group
Ann Marie Jones	Chief Executive	Age UK Trafford
Sally Kass	Clinical lead continuing health care	Trafford Clinical Commissioning Group
Andy Latham	Chief Officer	Healthwatch Trafford
Sarah Owen	Named Nurse Adult Safeguarding	Manchester University NHS Foundation Trust
Alison Troisi	Detective Sgt	Greater Manchester Police
Debbie Ward	Head of nursing - safeguarding	Manchester University NHS Foundation Trust
Ged McManus	Author	Independent
David Hunter	Chair	Independent

2.3 Agencies Contributing Information to the Review

H.M. Senior Coroner Manchester South
Trafford Metropolitan Borough Council Adult Social Care
Department of Work and Pensions Trafford Partnership Unit
Greater Manchester Mental Health NHS Foundation Trust
University Hospital South Manchester NHS Foundation Trust [now Manchester University NHS Foundation Trust]
Trafford Housing Trust
Greater Manchester Police
North West Ambulance Service
General Practitioner

3. TERMS OF REFERENCE

3.1 General

3.1.1 The Safeguarding Adult Review needs to determine whether any learning can be gained from the way the agencies worked together prior to Susan and Anne's deaths and how effective such working was.

3.2 Specific Terms

1. Which professionals, including medics, had contact with Susan and Anne?
    a. The time and date of the contact
    b. The nature of the contact
2. Did professionals have any concern with regard to the welfare and care or support needs of either of the subjects of the review?
3. What indicators of abuse or neglect, including self-neglect, did the professional(s) identify?
4. Were there any opportunities missed to raise a safeguarding alert and hold a strategy meeting?
5. What information about Susan and Anne's circumstances was shared, who was it shared with and for what purpose?
6. What, if any, risk assessments were done on Susan and Anne and what risk assessment tool was used?
7. What consideration was given to the financial circumstances of Susan and Anne and did either have a formal carer's role for the other?
8. What carer's assessments were completed on any identified carer?
9. What mental capacity assessment(s) were completed and what assessment tool was used?

3.3 Time Period under Review

3.3.1 From 01 December 2016 to 31 March 2017

4. NOTABLE EVENTS

Set out in the following table are brief details of the notable events identified by the review panel. They are listed without commentary. The analysis of the events appears in Section 5.

Notable Events

Date	Time 24 hour clock	Event
16.11.16.	Not known	A practice nurse from the GP surgery visited Susan and Anne at home to administer influenza inoculations. She observed that the house was clean and tidy and that Susan and Anne appeared to have a close bond.
27.1.17.	Not recorded	Anne contacted the GP surgery on the telephone complaining about severe back pain. She was given advice by a doctor on how to manage the condition and made an appointment to attend the surgery on 30.1.17.
30.1.17.	Not recorded	Anne contacted the GP surgery by telephone as she was unable to get to the surgery due to her back pain. The doctor who had spoken to her on the telephone on 27 January 2017, visited her at home. Anne was tearful and said that she was unable to do housework. It was diagnosed that she was suffering from lumbago with sciatica. She was given advice on how to manage the condition and prescribed appropriate medication.
14.2.17.	16.42	Police received a call from a neighbour expressing concern as Susan and Anne had not been seen for some time.
14.2.17.	17.15	A police officer attended Susan and Anne's address. After knocking at the door Susan appeared at an upstairs window and after ten minutes or so came downstairs to open the door. Anne could be heard inside shouting to Susan not to open the door. The police officer spoke primarily to Anne as Susan was quite deaf and communication was difficult. Anne told the police officer that she was the primary carer for Susan and had been since she gave up work about eighteen months ago to look after Susan. Anne said that she had hurt her back about eighteen months ago lifting Susan and had since been suffering from depression, anxiety and agoraphobia. Neither Susan nor Anne had been out of the house since July 2015. Anne said that the house phone and her mobile were switched off because she did not want to speak to anyone or answer the door. Anne said that her GP visited her at home every two weeks. The police officer observed that both ladies were dressed in clean clothes and there was fresh food in the fridge. The house was dirty with food, hair and dust on the floor and several bags of rubbish in the kitchen. On looking in Susan's bedroom it was observed that the bedsheets were soiled and the room smelled of urine. Anne said that she had been unable to change the sheets for two weeks due to her back pain. The police officer contacted a relative who was unable to help and also contacted the local mental health triage team who said that their last contact with Anne was several years ago and she was not currently receiving treatment. The police officer risk assessed the incident as high risk indicating: High - Person in need of immediate protection from significant harm. (Greater Manchester Police Guidance says: - Consider PPO[2], 136 MH act, re-housing, emergency duty team **and** consult with PPIU (Public Protection Investigation Unit), CID and S/V.

[2] PPO is an abbreviation for Police Protection Order and is thought to refer to section 46 Children Act 1989: Removal and accommodation of children by police in cases of emergency. Section 46 bestows

		E.g., Physical or sexual assault or serious neglect has occurred or is likely to occur or person is likely to be abducted etc.) This caused the incident to be automatically sent to the Trafford Partnership Team (a joint police and council team) Anne declined consent for information to be shared with other agencies.
15.02.17.	08.55	The visit to Susan and Anne the previous day and the high risk assessment was reviewed by an officer in the Trafford Partnership Team and allocated to a supervisor.
15.02.17.	17.46	The supervisor created a referral to Initial Assessment Team (IAT) and sent it to Adult Social Care at Trafford Council.
15.02.17	17.50	The referral was received by Trafford Council's Screening Team.
16.02.17	Not specified	Referral placed on Trafford's Councils Liquid Logic; a system used for recording such matters. There is no recorded evidence to show how the referral was prioritised.
21.2.17	09.48	Trafford Council Adult Social Care actioned the referral. Telephone enquiries were made and Susan and Anne's GP surgery was contacted. A visit to them by the GP was requested and agreed. The case was allocated to a duty social work team.
21.2.17.	14.00 – 17.00	The duty social work team attempted to contact Anne by telephone and text message. Susan's son was contacted. A social worker visited the address at 16.00 but got no answer.
21.2.17.	Not recorded	A doctor from Susan and Anne's GP surgery visited their home and was unable to obtain an answer to knocking. The doctor spoke to a neighbour and posted a note through the letter box.
22.2.17	16.00	The duty social work team spoke to Susan and Anne's GP surgery and ascertained that they had not been seen the previous day. A telephone call was made to the telephone number given on the police referral and when no reply was received a message was left. The intention of the call was to arrange a joint Adult Social Care and police visit.
23.2.17.	Not recorded	The social worker allocated to the case made three telephone calls to the telephone number given on the police referral. The telephone was not answered and messages were left.
24.2.17.	23.31	The ambulance service were called by a neighbour who was concerned about Anne. Ambulance service and police attended and entry was forced into the house. Anne was found deceased on the sofa in the lounge. Susan was upstairs in bed, confused and dehydrated.
25.2.17	00.53	Susan was admitted to hospital and nursed on a ward until her condition had improved sufficiently to be transferred to an intermediate care centre.
01.3.17	03.49	An urgent and standard deprivation of liberty safeguards (DOLS) application was made. This included a Mental Capacity Assessment relating to Susan's ability to consent to the admission.
06.3.17	13.08	Susan was transferred to an intermediate care centre.
13.3.17	22.34	Following a deterioration in her medical condition Susan was readmitted to hospital.
15.4.17	Not recorded	Decision made to stop treating Susan and concentrate on keeping her comfortable.
18.4.17	21.26	Susan passed away.

a 'power' on a constable to act and is erroneously known and referred to by some officers as making an 'order'. It cannot be applied to adults.

5. ANALYSIS OF NOTABLE EVENTS

5.1 Which professionals, including medics had contact with Susan and Anne?

a. The time and date of the contact.
b. The nature of the contact.

5.1.1 While outside of the review period the following contacts are included for additional context.

5.1.2 There is an incomplete assessment for Susan recorded on the Adult Social care computer system - Liquid Logic on 31March 2015. This assessment was not concluded as Susan withdrew, there are no recorded issues with regards to Susan not having Mental Capacity or experiencing abuse or neglect. This decision was recorded on Liquid Logic the day before the Care Act 2014, was implemented on 1st April 2015. At the time this decision was made the duty of assessment was set out in Section 47 of the NHS and Community Care Act 1990. The decision to close the assessment at the client's request was in keeping with practice at the time.

5.1.3 On 17 August 2016, Trafford Housing Trust undertook a landlord gas safety check at Susan and Anne's home. The gas engineers are direct employees of the Trafford Housing Trust and have received training to recognise the signs of adult and child abuse or neglect and how to report it to the Trust's safeguarding officer. The gas appliances passed the safety check and no signs of adult abuse or neglect were recorded.

5.1.4 On 16 November 2016, Susan and Anne were visited at home by a practice nurse from their GP surgery. The purpose of the visit was to administer influenza inoculations to both women. This had been the pattern for several years. The practice nurse was trained to identify adult safeguarding issues and how to escalate them.

5.1.5 The Housing Officer had limited contact with the family. Their home and garden were tidy and no complaints were received from them or against them.

5.1.6 From the above information it is reasonable to say that those professionals who had contact with Susan and Anne in their home between August 2016 and November 2016 did not identify any care or support needs for the family. Staff knew how to respond to such needs.

5.1.7 Other significant professional contacts in the context of the review are recorded in section 3 – notable events.

5.2 Did professionals have any concern with regard to the welfare and care or support needs of either of the subjects of the review?

5.2.1 The GP's visit on 30 January 2017, focussed on Anne's distress due to her back pain. The doctor who visited Anne had spoken to her on the telephone on 27 January 2017 and was therefore already aware of her condition. Anne was tearful and said that she was unable to do housework, she was prescribed appropriate medication and given advice on how to manage her condition. The doctor had no concerns in relation to Anne's mental capacity and observed that the home was clean and tidy.

5.2.2 Whilst Susan and Anne had been cared for by the same GP surgery for many years, they were both completely unknown to the doctor who visited Anne on 30 January 2017. The doctor did not know of Susan and was unaware that she was present in the house whilst treating Anne. Had the doctor known that Anne was a carer for a person of Susan's age and needs, she had the training to know that a referral to Adult Social Care would have been necessary and how to make it.

5.2.3 When the police attended Susan and Anne's home on 14 February 2017, the officer attending recorded that there were concerns about Susan and Anne's care and support needs. During the visit the officer noted that there was fresh food in the house and Susan was wearing clean clothes and looked clean, the kitchen and lounge were dirty and untidy with bags of rubbish accumulating in the kitchen. Susan's bed sheets were soiled and the bedroom smelled of urine. Susan appeared to be confused and Anne shouted at her a number of times. In March 2017 a mental health professional noted that Anne was 'hard of hearing'. However, the officer felt that Anne was short tempered with her mother. Anne appeared to be unable to cope and told the officer that she had been unable to change bedsheets due to her bad back.

The officer documented those concerns as:

A) State of the house

B) Filthy bed sheets

C) Susan has not been out of the house for 2 years

D) Whilst I was there Anne shouted at Susan and stated she needed 5 minutes peace and quiet she shouted at Susan 3 or 4 times ordering her to sit down and to sit still. I am concerned about emotional abuse due to Anne's poor Mental Health.

E) Anne is clearly mentally ill. She is scared of answering the door or the telephone and cannot leave the address. She has been throwing up for 2 weeks but has not contacted her doctor and states she has pain all over her body. She refused to be seen by a paramedic but agreed to an appointment with her doctor.

F) Anne clearly can no longer cope mentally with caring for her mother and the stress is adding to her mental instability.

The officer also risk assessed the incident as High, which by definition of Great Manchester Police Operation Quest[3] states:

Person in need of immediate protection from significant harm.

5.2.4 The review panel felt Anne's shouting was probably greater than that needed to overcome her mother's hearing impairment. It could have been a sign of the pressures faced by Anne's or as the officer thought, emotional abuse. In any event being short tempered in those circumstances was something that needed addressing and formed part of the officer's rationale for determining it was a high risk case, a decision the review panel agreed with. The routing of the referral is looked at later.

[3] Operation Quest was a review of Greater Manchester Police's response to calls for service.

5.3 What indicators of abuse or neglect, including self-neglect, did the professional(s) identify?

5.3.1 Only Greater Manchester Police identified any issues. The attending police officer recognised that Susan may be being physically neglected. The house was dirty and untidy, her bed was soiled, the bedroom smelled of urine and there were urine stains on the carpet. The officer also witnessed Anne shouting at Susan on several occasions and thought that this might amount to emotional abuse.

5.3.2 The officer also noted potential self-neglect in relation to Anne, who stated that she "had been throwing up for two weeks" but had not sought medical treatment. Anne told the officer that she was suffering from anxiety and depression and the officer formed the opinion that Anne was 'clearly' suffering from a mental illness.

5.4 Were there any opportunities missed to raise a safeguarding alert and hold a strategy meeting?

5.4.1 The Trafford Safeguarding Adults Board Multi-Agency Safeguarding Adults Policy and Procedures (January 2017) states:

A safeguarding adult concern is any worry about an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs); and
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

This reflects the statutory position set out in Section 42 of the Care Act 2014.

5.4.2 The GP's visit to Anne of 30 January 2017, focussed on Anne's back pain. The doctor had not previously seen Susan or Anne and did not know Susan was in the house. Patient records are not directly linked on the GP surgery computer system and therefore there was nothing to prompt the doctor to be aware of Susan's needs. Within the computer system is a dropdown box which if checked would show details of any other known members of the household. The doctor did not check this as she had no specific reason to check it for the purpose of the visit to Anne. The Review Panel felt that where a patient's condition limits their ability to carry out day to day tasks, GP's should make a routine enquiry about the patient's social circumstances and caring responsibilities. This forms a recommendation.

5.4.3 The police officer who attended on 14 February 2017, clearly recognised that Susan and Anne had care and support needs and were experiencing or were at risk of abuse or neglect. The officer assessed the risk as high, which automatically prompted a notification to the Trafford Partnership Team. This team reviewed the high risk notification at 8.55 AM the following day and the reviewing officer forwarded the notification to a supervisor who created a referral to Adult Social Care at 5.46 PM the same day. The high risk referral was

received by Trafford Council's Screening Team four minutes later and because it came after normal working hours was not entered onto its Liquid Logic recording system until the following day. There is no recorded evidence as to how it was prioritised until it was actioned on 21 February 2017.

5.4.4 Greater Manchester Police Operation Quest provides guidance to officers when assessing a safeguarding risk as high.

High - Person in need of immediate protection from significant harm.

Consider PPO, 136 MH act, re-housing, emergency duty team and consult with PPIU, CID and S/V.

E.g., Physical or sexual assault or serious neglect has occurred or is likely to occur or person is likely to be abducted etc.

The officer did not contact the emergency duty team which would have given Adult Social Care the opportunity to assess the risks to Susan and Anne on 14 February 2017. The rationale for this was that Susan and Anne were in a warm secure house and their immediate needs in terms of food were met. The officer did not think that the emergency duty team would respond. Even if an immediate response was not possible or had not been considered necessary a telephone call to them could have prompted a review of the case. The officer could have contacted the emergency duty team to inform them of the concerns and discuss the case. This would in effect have been a strategy discussion. This was a missed opportunity and is a learning point.

5.4.5 The attending officer's rationale for grading the risk as high was to ensure that the Trafford Partnership Team would refer the matter to Adult Social Care. The officer contacted the partnership team supervisor on 15 February 2017, to ensure that the referral would be made.

5.4.6 The officer concluded that Susan was an adult in need of immediate protection from significant harm but with due consideration decided it was safe to leave her in a house where she was familiar with her surroundings, warm and appropriately dressed and fed. The officer believed that grading the risk as high would cause the case to be prioritised by others and receive help sooner than if a lower grading had been applied.

5.4.7 There is no mention in the police paper work whether the officer, or those subsequently scrutinising the incident, considered whether Susan or Anne had capacity to make the decisions they did. This is a learning point and is discussed further at 5.9.4

5.4.8 On receipt of the information about Susan and Anne from the attending officer the Trafford Partnership Team could have called a strategy meeting. They did not do so and chose to send a referral. This process of itself took from 8.55 AM until 5.46 PM the same day. Taking into consideration that this case had been assessed by the attending officer as high risk the referral was not treated with the right degree of urgency. This is a learning point. The review panel is aware that the Trafford Partnership Team had a further twelve incidents coded for the attention of the partnership unit to deal with from the previous day and in total 94 historic incidents for review, but it is unclear if this had an impact on this case.

5.4.9 The decision to make the referral to Adult Social Care overrode Anne's refusal to consent to a referral. Whilst a rationale was not recorded for this, it was clearly an appropriate decision

taking into account the attending officer's observations and the fact that the officer thought Anne's behaviour in shouting at Susan may amount to emotional abuse.

5.4.10 The Trafford Adult Social Care Screening Team received the referral on Wednesday 15 February 2017 'out of hours' and assessed it on Thursday 16 February 2017. The body of the referral stated the attending police officer felt that the case was high risk. The Screening Team was unable to action the referral on either Thursday 16 or Friday 17 February 2017 because of '…various urgent referrals in relation to other cases…' There is no recorded evidence as to how this referral for Susan and Anne was prioritised or of any discussion about action to safeguard Susan and Anne over the weekend [18 and 19 February 2017] as the ASC screening team works Monday to Friday.

5.4.11 The referral was actioned on Tuesday 21 February 2017, by a Senior Practitioner from the Screening Team who then dealt with the case urgently.

5.4.12 The panel noted that the screening team had received a number of urgent referrals. This is not uncommon for the adult screening team which acts as the front door for all adult safeguarding concerns. Whilst the panel did not have any evidence as to how the referral for Susan and Anne was prioritised they felt that the five days between receiving and actioning, a high risk referral was too long. The panel was made aware of the fact that the screening team was working with significantly reduced staffing during this period, but there is no specific evidence as to how that affected the referral for Susan and Anne.

5.4.13 This suggests that prior to the 21 February 2017, there was no effective screening of the referral by the Screening Team, otherwise it would have been identified as urgent. There was no new information added to the original referral before it was treated as urgent by the senior practitioner on 21 February 2017.

5.4.14 On 21 February 2017 the senior practitioner contacted Trafford Mental Health Services and discovered neither Susan or Anne was known to them. The senior practitioner contacted the family's GP surgery who advised they had last seen Anne in January 2017. The senior practitioner informed the medical centre that the police had visited on the 14 February 2017 and requested a GP visit the family. She then tried unsuccessfully to contact Anne by telephone. Thereafter it was agreed between the senior practitioner and a manager that the case should be referred to a Community Social Work Team. The review panel thought that was an appropriate decision.

5.4.15 The allocated social worker who attempted to contact Anne by telephone call and text, spoke to Anne's sibling on the telephone who said he had no concerns about his mother and sister, would support them and was unable to visit that day. The social worker arranged for a fellow social worker to visit the house at 4PM that day. The fellow social worker called as agreed and was unable to gain access. There is no recorded evidence that the social worker sought advice from a manager and this was a missed opportunity to escalate the concerns.

5.4.16 Having been treated as urgent on 21 February 2017, momentum was quickly lost. The next action taken by Adult Social Care was a telephone call to the GP surgery at 4PM on 22 February 2017, this elicited the information that a doctor had visited the house on 21 February 2017, but that there had been no answer to knocking and neither Susan or Anne had been seen. The social worker telephoned the Trafford Partnership Team and when there was no answer left a message asking for someone to return the call.

5.4.17 The review panel felt that social work activity of 21 February 2017, reflected the urgency they first attached to the case on that date. The activity would have been enhanced had the

Screening Team or Community Social Work Team tried to contact the police on the 21 February 2017, rather than agreeing to do so the next day. The 21 February 2017, would have been another opportunity to talk about the need for a strategy meeting.

5.4.18 On 21 February 2017, a GP visited Susan and Anne's home and was unable to gain access and left a note through the letterbox. Liaison between the GP, the GP surgery and the social worker established that a doctor had a telephone consultation with Anne on 27 January 2017 and a home visit on 30 January 2017. The social worker left an unanswered message on an answerphone in the Trafford Partnership Team office and made an unannounced and unanswered visit to Susan and Anne's home. The social worker spoke to a neighbour who reported that Susan was deaf and neither occupant answered the door. The neighbour said she felt they were 'were okay' as she and her son were able to hear them.

5.4.19 The social worker's unannounced visit was at 4.40 PM on 22 February 2017. It is not known to the review panel when the neighbours last heard signs of life from the house. It can be inferred from the information in the Adult Social Care papers seen by the review panel that the neighbour's statement that the family, 'are okay' meant that shouting was heard on 22 February 2017, albeit that is conjecture. What is known is that on a previous occasion [14 February 2017] a different neighbour called the police when they had not seen or heard the family for two days.

5.4.20 On 23 February 2017, the social worker telephoned the Trafford Partnership Team three times and sent an e-mail. These were followed by a further call on 24 February 2017. The intention of the calls to the Trafford Partnership Team was to arrange a joint social work and police visit in order to establish contact with the two women. This would have provided another opportunity to discuss the need for a strategy meeting. A voicemail message was left on each occasion asking for the officer named on the referral to contact the social worker. The officer was off duty and the messages were not responded to. Although the social worker made a number of unanswered phone calls there is no recorded evidence that advice was sought from their line manager about how to respond to the safeguarding concerns that were now 10 days old. This would have led to a discussion around other actions the social worker could undertake to progress this matter.

5.4.21 Nevertheless, it was inappropriate and unprofessional for the messages left on the Trafford Partnership Team's office number not to be responded to. This is the case whether the intended recipient is at work or, as in this case, not at work. The panel did not know the partnership office routine for the voice mail. For example, is there written guidance on how often the voice mail should be checked, who should check it and what should happen to messages left for people who are not at work? This is a learning point for the review and forms a recommendation.

5.4.22 Adult Social Care could have considered other legal powers in order to gain access to Susan and Anne's home, for example a warrant under section 135 Mental Health Act 1983. [Although the mental health issues displayed in this case may not have resulted in a warrant being granted]. The police may also have had a power to enter under Section 17 of The Police and Criminal Evidence Act 1984 to preserve life. [This power was in fact used to enter the property in relation to the neighbour's concerns on 24 February 2017]. Whichever power was most appropriate could have been discussed and decided had any agency initiated a strategy meeting or discussion. The non-response from the Trafford Partnership Team meant that Adult Social Care acted without them.

5.4.23 There is limited evidence to support how the agencies worked together as required by

Section 6 of the Care Act 2014 to Safeguard Adults. [Duty for partners to cooperate in protecting adults with needs for care and support who are experiencing, or are at risk of, abuse or neglect]. This would have led to a shared understanding of the risks and exploration of the potential remedies required to safeguard Susan and Anne.

5.5 What information about Susan and Anne's circumstances was shared, who was it shared with and for what purpose?

5.5.1 Susan and Anne lived a quiet and private life, they did not routinely come to the attention of agencies other than for medical appointments with their GP and relatively little was known about them.

5.5.2 The agency with most knowledge was the GP practice, although this was limited. In the twelve months prior to Susan and Anne's deaths they had been visited at home three times by staff from the practice. No information was shared with other agencies. Had the doctor who visited Anne on 30 January 2017, known of Susan's presence and care needs, a referral to Adult Social Care should have been made given that Anne, her designated carer, was struggling with her own health, probably to the detriment of being able to properly care for her mother. Sadly, the doctor was unaware of Susan, or that Anne was her carer.

5.5.3 Having attended at Susan and Anne's home on 14 February 2017, the police decision to share information with Adult Social Care was appropriate in responding to the concerns raised. However, given that the attending officer had graded the risk as high the information was not shared with any urgency. It took from 8.55 AM on 15 February 2017 when the Trafford partnership team reviewed the information until 5.46 PM the same day for the referral to be created.

5.5.4 Having submitted the referral on 15 February 2017, the police assessed that no further police response was required and therefore a lack of contact from Adult Social Care did not alert them to the fact that the referral had not been actioned.

5.5.5 A police officer considered contacting Trafford Council's Emergency Duty Team because the case was high risk, but felt that as Susan was warm, appropriately dressed and had access to food that a referral the following day was appropriate. Social workers were unable to get a response from multiple telephone calls and one e-mail. Why those points existed needs further analysis. The review panel felt that Trafford Safeguarding Adult Board should seek assurance from Greater Manchester Police and Trafford Adult Social Care that they have resolved the communication difficulties evidenced in this review. This forms a recommendation.

5.6 What, if any, risk assessments were done on Susan and Anne and what risk assessment tool was used?

5.6.1 The only recorded risk assessment that the review has seen evidence of was that of the attending police officer on 14 February 2017.

5.6.2 The Greater Manchester Police Integrated Computer System generates a Force Wide Incident Number [FWIN] for each incident created. This is an auditable document. Any incident coded

as “G16 Concern for welfare adult aged 18 or over” requires the attending officer to update the FWIN with the following details as per Greater Manchester Police Operation Quest.

1. Name of the child(ren), Adults, DOB, Address, School, GP.

. Parent/ Carer/Next of kin details. Address(es), where live separately, Contact details, Occupation, relationship to vulnerable person, whether private fostering arrangements are in place. Cultural issues/isolation?

. Parties present and relationship to child(ren), or vulnerable person. Include perpetrator details, name, DOB, Address, Occupation.

. Circumstances of incident/occurrence. Include injuries, plus any actions/measures taken to protect or prevent further harm. Is this a repeat either reported or not? Any escalation

. Powers used. Offences, Crime report, Police Protection, section 136, any orders in force i.e. Injunction or Non-molestation orders, forced marriage protection orders, restraining orders etc.

. Risk assessment

• Low - minor concerns, no offences, family may have additional needs, which may benefit from the support of other services (Child Assessment Framework).

E.g., truanting, minor anti-social behaviour, shabby appearance, advice of specialist, unsupervised vulnerable person etc.

• Medium - child/adult currently safe but further support and assessment needed. Ensure PPIU aware for follow up and referral to Social Care/Health.

E.g., An allegation of abuse from another family member who does not pose an immediate threat to the vulnerable person, and there are no immediate forensic/care issues.

E.g., Investigation involving violent /drug/ firearm offences by parents or carers, and children may be suffering as a result.

• High - Person in need of immediate protection from significant harm. Consider PPO, 136 MH act, re-housing, emergency duty team **and** consult with PPIU, CID and S/V.

E.g., Physical or sexual assault or serious neglect has occurred or is likely to occur or person is likely to be abducted etc

7. Consent to share information with other agencies. This should be sought in all cases, unless to do so would place a person/child at risk of significant harm. It is particularly useful in low risk cases where an assessment can be put in place to address additional needs before they become critical.

8. Ask for appropriate coding. Ensure supervision, PPIU and CID are made aware if appropriate. Inform duty social worker when appropriate.

5.6.3 The incident of 14 February 2017, was appropriately coded and assessed as high risk by the

attending officer. The closing code of the FWIN automatically generated a notification to the Trafford Partnership Team who created the referral to Adult Social Care. The panel noted there was no structured safeguarding adult guidance to assist officers reach a decision. Such determinations seem to rely on each officer's unstructured professional judgements against the narrative description for each risk level. This is a learning point.

5.7 What consideration was given to the financial circumstances of Susan and Anne and did either have a formal carer's role for the other?

5.7.1 Susan received Pension Credit from April 2015 to April 2017; Attendance Allowance from April 2008 to April 2017 and State Pension from April 2015 to April 2017.

5.7.2 Anne received Carers Allowance from 2014 to 2017 and Housing Benefits from Trafford Local Authority.

5.7.3 There is no direct evidence of any consideration being given to Susan and Anne's financial circumstances. The police officer attending the incident on 14 February 2017, noted that both were appropriately dressed and there was sufficient fresh food in the house. Anne is known to have shopped on line and had groceries delivered.

5.7.4 The rent was up-to-date and without arrears. Anne paid Trafford Housing Trust for small 'handyman' type works at the address; plumbing in a new washer/decorating. The last paid for work was in June 2016.

5.7.5 All the evidence points to Susan and Anne being financially stable and free from financial hardship.

5.7.6 The only other contact with Susan and/or Anne came before the review period in March 2015. Anne contacted Trafford Council Adult Social Care to express a concern about her mother. Whilst records are unclear on the issue that was being assessed, the assessment was not concluded as Susan withdrew, there are no recorded issues with regards to Susan not having Mental Capacity or experiencing abuse or neglect. Therefore, Adult Social Care was not under a duty to complete an assessment as set out in Section 11 of the Care Act 2014.

5.8 What carer's assessments were completed on any identified carer?

5.8.1 There were no carer's assessments completed within the review period.

5.9 What mental capacity assessment(s) were completed and what assessment tool was used?

5.9.1 Under the provisions set out in the Mental Capacity Act 2005, in order to decide whether an individual has the capacity to make a particular decision two questions must be answered.

Stage 1. Is there an impairment of or disturbance in the functioning of a person's mind or

brain?

If so, **Stage 2**. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision? The Mental Capacity Act says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- understand information given to them
- retain that information long enough to be able to make the decision
- weigh up the information available to make the decision
- communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand

5.9.2 There is no evidence of any mental capacity assessment of Anne during the review period. There were two opportunities for Anne's mental capacity to be assessed. The GP visit of 30 January 2017, did not give rise to any cause for concern in relation to Anne's mental health or mental capacity. The Mental Capacity Act 2005 (Principle 1) is clear that capacity should be assumed unless there are indicators to the contrary and therefore it was appropriate that a mental capacity assessment was not conducted.

5.9.3 The police attendance of 14 February 2017, did give rise for a cause for concern about Anne's mental health and it would have been appropriate for Anne's mental capacity to be considered at that point. The police individual management review author noted that the officer considered placing Susan in police protection. While that was not lawfully possible in the circumstances, it was an indication of the level of the officer's concerns.

5.9.4 The Mental Capacity Act 2005, is little understood across policing in the United Kingdom and few patrol officers have received any training in its application. The attending officer was therefore not equipped with the knowledge or skills to complete a mental capacity assessment, or to know that one was required. This may have been progressed if the officer had contacted the emergency duty team to discuss the case.

5.9.5 After being found in a dehydrated and confused state on 24 February 2017, Susan was taken by ambulance to Wythenshawe Hospital (now Manchester University Hospitals NHS Foundation Trust). Records show that Susan was confused. There is no evidence of a Mental Capacity assessment in relation to her care and medical needs being conducted. A Deprivation of Liberty Safeguards[4] application and an associated Mental Capacity Assessment was made at 0349 hours 1 March 2017, by a ward sister, which was appropriate in the circumstances. The application was not prioritised by Adult Social Care and was not authorised during Susan's time in hospital.

5.9.6 On 16 March 2017, during an assessment by a frailty nurse it was recognised that a Mental Capacity Assessment was required and that it may be necessary to obtain the services of an Independent Mental Capacity Advocate[5]. Despite this recognition there is no evidence that a

[4] The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. They provide legal protection for those vulnerable people who are, or may become deprived of their liberty within the meaning of Article 5 of the European Convention on Human Rights, in hospital or care home, whether placed under public or private arrangements.

[5] The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

mental capacity assessment was considered or completed during Susan's time in hospital and a referral was not made to obtain the services of an Independent Mental Capacity Advocate.

5.9.7 A 'best interests' telephone discussion took place between hospital staff and Susan's son on 27 March 2017. It is possible that due to Susan's medical condition, professionals had reasonable belief that she did not have capacity or that a mental capacity assessment was conducted but not recorded. The policies of the Trust were not followed.

6 LESSONS IDENTIFIED

6.1 Introduction

6.1.2 The panel noted that agencies identified some minor lessons and dealt with them in their recommendations which will appear in an action plan prior to the report going to the Trafford Safeguarding Adult Board.

6.2 The Panels Lessons

6.2.1 **Narrative**
The GP who visited Anne was unaware of the fact that she lived with her mother Susan or that Anne was Susan's carer.

Learning
The GP would have had an opportunity to refer Susan and Anne to Adult Social Care as people in need of a care and support assessment, if the doctor had been aware of Susan and her care and support needs.

6.2.2 **Narrative**
Anne was thought by a police officer to be suffering from a mental illness which in part limited her ability to care for Susan. Later, in hospital there is no evidence that a Mental Capacity Assessment for Susan was considered when it was clearly appropriate to do so.

Learning
The Mental Capacity Act 2005 was not always considered when professionals dealt with Susan and Anne.

6.2.3 **Narrative**
Greater Manchester Police sent a referral to Trafford Adult Social Care. Trafford Adult Social Care were unable to contact the referrer to follow up on the case.

Learning
Communication between Greater Manchester Police and Trafford Council Adult Social Care was not effective.

6.2.4 **Narrative**
There is limited evidence of how agencies cooperated in protecting Susan and Anne, who were almost certainly adults with needs for care and support who were experiencing, or were at risk of, abuse or neglect.

Learning
This case would have benefitted from a strategy meeting or strategy discussion.

6.2.5 **Narrative**
The police officer who attended Susan and Anne's home coded and assessed the risks as high. The panel noted there was no structured safeguarding adult guidance to assist officers reach a risk grading.

Learning

Greater Manchester Police may benefit from having a guidance document for adult safeguarding, that would assist officers to gather the necessary information to ensure that high quality referrals are made.

7 NOTABLE GOOD PRACTICE

7.1 Whilst the panel did not identify any innovative or outstanding work it recognised that many professionals who had contact with Susan and Anne carried out their duties with diligence and compassion.

8 CONCLUSIONS

8.1 Susan and Anne had lived together for around ten years. Both women were known to their GP surgery, where staff thought the relationship was very supportive. Trafford Housing Trust knew a little; other agencies were unsighted.

8.2 Anne was in receipt of carers allowance in respect of the care that she provided to Susan. From the information provided to the review it seems that she had stopped working and willingly taken on that role. Despite Susan's apparent dementia and increasing care needs, Anne was reluctant to accept help.

8.3 In December 2016, a practice nurse who knew Susan and Anne visited them at home. She saw that the house was clean and tidy and the two women appeared to be well. This is consistent with other contemporaneous information.

8.4 Until January 2017, Anne appeared to manage the situation well. Their house was well kept, rent was paid, repairs and maintenance were arranged and paid for as necessary. The review has learnt that Anne had become reluctant to leave the house, but she arranged for groceries to be delivered by on line shopping and continued to care for her mother. In essence they were private people. Weekly visits by Susan's son did not identify any problems.

8.5 The turning point appears to have come when Anne suffered a deterioration in a long standing back condition which caused her to contact her GP surgery on 27 January 2017. A doctor visited Anne at home on 30 January 2017 and prescribed medication for her condition. The two women were not known to the doctor and Susan was not seen during the visit, the doctor was not aware of her presence in the house. Anne told the GP that she was unable to do housework and she would also therefore have been restricted in providing care for Susan. If the doctor had been aware of Susan she should have considered the impact of Anne's back condition on her ability to care for Susan. This should have prompted contact with Adult Social Care to arrange an assessment.

8.6 By 14 February 2017, neighbours had become so concerned for the welfare of the two women that the police were called. The attending officer was eventually allowed into the house by Susan despite Anne's reluctance. The officer spent some time at the house and saw that Anne was not coping well with her back injury and caring responsibilities. The officer thought that there was a high risk of harm occurring and the response was to make sure that a referral was made to Adult Social Care.

8.7 The officer could have contacted the Adult Social Care Emergency Duty Team. Even if an immediate response was not possible or thought necessary a call to the Emergency Duty Team would have prompted a review of the case and a visit by Adult Social Care.

8.8 The information provided by the attending officer was sent to the Trafford Partnership Team. It then took a full working day for a referral to be created which was then sent to Trafford Council Screening Team.

8.9 It was not effectively assessed until a senior practitioner saw it on 21 February 2017 and determined it needed urgent attention. The police had assessed that no further police response was required and therefore a lack of contact from Adult Social Care did not alert them to the fact that the referral had not been actioned.

8.10 Once actioned there was a flurry of appropriate information gathering to aid assessment including an unanswered home visit to Susan and Anne and a request for a GP to visit. Later that day the case was passed to a Community Social Care Team.

8.11 Events on Wednesday 22, Thursday 23, and Friday 24 February 2017 included: the GP informing Adult Social Care that the visit had been unsuccessful. The social worker made several calls to the police, left answerphone messages and sent an e-mail, all of which were not responded to. The officer to whom the telephone messages were left for was off duty. Other means of contacting the police were not explored, nor was the matter escalated. [Lesson 3]

8.12 Late in the evening of 24 February 2017 following a concern expressed by a neighbour police officers forced entry to Susan and Anne's home. Anne's was found deceased on the sofa in a decomposed state. Susan was alive and was taken to hospital.

8.13 Sometime between the police visits to Susan and Anne's home on 14 February 2017 and 24 February 2017, Anne died. The pathologist had two descriptions of Anne's body. One said, 'The body showed signs of moderately advanced decomposition'. At the conclusion of the report the pathologist recorded, 'Histology was not taken due to the severe decomposition'. The review panel did not know if there was a practical difference between the descriptions in terms of estimating the time of death.

8.14 The review panel was unable to say for two reasons whether opportunities to prevent Anne's death were missed. Firstly, the cause of death has not been established and secondly there are simply too many variables between the police making the referral on 15 February 2017 and the discovery of Anne's body on 24 February 2017. These variables include a lack of a professional opinion by the pathologist and the dehydration of Susan. It is known that Susan was dehydrated peripherally cyanosed[6] when she was found in her home, but it is not known when she last drank or how accessible water or other liquid was to her.

6 Causes of cyanosis: Blue hands, feet, limbs (peripheral cyanosis) The limbs will also usually feel cold. It happens when blood circulation is poor because of: Raynaud's phenomenon – where the blood supply to the fingers and toes becomes temporarily reduced, an artery problem that affects the blood supply to the legs, beta-blockers, a medicine used to treat high blood pressure, a blood clot that stops the blood supply to or from a limb. Sometimes it can also be caused by: being in cold air or water, being at high altitude.www.nhs.co.uk

9 RECOMMENDATIONS

The Review Panel

1. A. Trafford Clinical Commissioning Group to ensure that General Practitioners ICT systems highlight adults in need of care and support, including linked records to members of households.

   B. Trafford Safeguarding Adult Board should ensure workforce development with General Practitioners to provide assurance that they are aware of referral pathways to Trafford Adult Social Care.

   C. Where a patient's condition limits their ability to carry out day to day tasks, GP's should make a routine enquiry about the patient's social circumstances and caring responsibilities. [The CCG should work with GP's to ensure that where a patient's condition limits their ability to carry out day to day tasks, GP's make a routine enquiry about the patient's social circumstances and caring responsibilities. A record of the enquiry should be made in the patients notes and a referral to Adult Social Care should be made where it is suspected that a carer is restricted in their ability to continue providing support to a named third party]
   [Lesson 1]

2. That Trafford Safeguarding Adults Board provides Mental Capacity Act workforce development to ensure partner agencies are aware of the Act. [Lesson 2]

3. That Trafford Safeguarding Adults Board seeks assurance from Greater Manchester Police and Trafford Council Adult Social Care that both organisations have effective communication processes in place for dealing with adults in need of care and support. [Lesson3]

4. That Trafford Safeguarding Adults Board provides workforce development on Trafford Adult Safeguarding Policy on strategy discussions or meetings. [Lesson 4]

5. That Trafford Safeguarding Adults Board considers whether Greater Manchester Police, and other constituent agencies would benefit from having a guidance document that would assist them to gather the necessary information to ensure that high quality referrals are made. If it is considered necessary a guidance document should be implemented [Lesson 5]

End