Trafford Strategic Safeguarding Partnership

Trafford Strategic Safeguarding Partnership Safeguarding Adult Review

SAR 'Susan and Anne'

Introduction

This summary/briefing is aimed at managers and practitioners working with vulnerable adults in Trafford. The key learning emerging from the Safeguarding Adults review and recommendations are presented.

Overview of report

This Safeguarding Adult 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 had lived in the same house since January 1982 and around 15 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.

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.

In January 2017 Anne contacted her GP complaining of severe back pain, she was unable to attend a subsequent appointment because of her pain, she received a visit at home by her GP who was unaware of Anne's caring status for Susan.

Police received a call from a concerned neighbour on the 14th February 2017 because Anne had not been seen. Police attended and made contact with Susan and Anne, the officer was concerned that they were isolated, that there were some obvious signs of neglect and potentially Anne was behaving in an emotionally abusive manner towards Susan, critically also the officer had concerns that Anne could not deliver the care and support that Susan required because of Anne's declining physical and mental health, and upon which Susan was entirely dependent . The officer assessed the risk as high which indicates an individual in need of immediate protection from significant harm. This in effect created a referral to the Adult Initial Assessment Team at the Council, having been reviewed by an intermediate police team. Some 8 days later on the 21st February the case was allocated to a duty team, face to face contact was attempted by a social worker and at the request of Social Care by the GP. Both visits failed to get a response from the address. On the 24th February the ambulance service were contacted by a neighbour concerned that she had not seen Anne. Police attended along with the ambulance, gained entry to the house and found Anne deceased. Anne had clearly been dead for some time. Susan was severely dehydrated but still alive. She was taken to hospital for recovery where she initially recovered but died some weeks later.

Legislative Authority for Review:

S44 (1) of the Care Act 2014: A SAB 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)

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Good Practice:

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.

What Happened

Up until January 2017, Anne appeared to manage the care she provided to Susan 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.

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.

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. 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.

A series of delays followed the making of the police referral, initially 24 hours in police systems before it was sent over to The Local Authority Initial Assessment Team (IAT), then within IAT when the referral was not actioned until the 21st February when a senior practitioner determined it needed urgent attention. The police had in the meantime taken the view that the situation did not require further police intervention because it had been referred to IAT so were not sighted on the fact that there had been no progression of the case within Adult Social Care.

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. 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.

The visit to Anne and Susan's home address did not result from this activity and they were eventually visited on the 24th February by the Ambulance service and Police

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What Happened *(continued)* following a second call from a neighbour expressing concern.

What the Independent Review Found

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

- 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.

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

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

- 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. 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.

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What needs to be done now to prevent similar incidents

- 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.
- Trafford Strategic Safeguarding Partnership should ensure workforce development with General Practitioners to provide assurance that they are aware of referral pathways to Trafford Adult Social Care.
- 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]
- That Trafford Strategic Safeguarding Partnership provides Mental Capacity Act workforce development to ensure partner agencies are aware of the Act.
- That Trafford Strategic Safeguarding Partnership 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.
- That Trafford Strategic Safeguarding Partnership provides workforce development on Trafford Adult Safeguarding Policy on strategy discussions or meetings.
- That Trafford Strategic Safeguarding Partnership 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.

What needs to be done now to prevent similar incidents *(continued)*

Further Information

- The SAR overview report on the 'Susan and Anne' SAR review and this briefing is available at:

http://www.tssb.uk/Docs/Safeguarding-adults/TSSB-Safeguarding-Adult-Review-Susan-and-Anne.pdf

- TSSP multi-agency safeguarding procedures are available at:

https://greatermanchesterscb.proceduresonline.com/chapters/contents.html

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