Briefing Document for SAR Irene

This short briefing summarises the key themes and lessons to be learned following a Safeguarding Adults Review (SAR) undertaken by Salford Safeguarding Adults Board (SSAB).

Salford Safeguarding Adults Board

1. About the Adult

Irene, a white British woman, died in February 2020 in the home she shared with her husband Brian, a white British male.

'Irene' and 'Brian' are pseudonyms.

Irene was 71 years of age at the time of her death and had been diagnosed with Alzheimer's in 2017. She was diagnosed with aphasia in 2018 which affected her ability to communicate verbally.

2. What happened?

Following her death, the duty mortician at Hospital 1 raised concerns regarding extensive bruising found on Irene's body which were reported to the police.

A postmortem examination disclosed substantial injuries, only some of which could be accounted for by falls. The pathologist concluded that a significant proportion of her injuries were very likely to have been sustained as a result of physical assault. Irene's cause of death was given as Alzheimer's disease with Dementia with Lewy bodies.

The police investigated the injuries to Irene and interviewed Brian who provided no explanation for his wife's injuries other than that bruising occurred when he prevented her from falling. Brian has since died.

In the latter stages of Irene's life, she had contact with a number of professionals from a number of agencies following a hospital admission and also had a short stay in a rehabilitation unit. The review explored how these agencies worked together to safeguard Irene and the challenges in recognising her as a victim of domestic abuse.

During the review period, Irene had not attended (or been taken to) a number of appointments. On some occasions, her son had engaged with professionals or cancelled appointments on her behalf. Brian was sometimes difficult with professionals and was observed to be 'quite short' with Irene. His views on declining support became dominant. Communication challenges meant that sometimes there was an over reliance on family members to communicate, rather than finding a way to obtain and clarify Irene's views and wishes.

In the months prior to Irene's death, professionals requested that changes be made to the home environment to make this safer for Irene and enable her to be discharged from hospital. This included, removing items that could have made it difficult for Irene to get around and having a bed downstairs. Brian either refused to make the changes or agreed to it but then refused to see it through. Shortly before Irene's death, an attempt to discharge her home failed as the home environment was found to

be unsuitable. Irene was discharged home a few days later but there was still no bed downstairs and Brian was found to be hostile and uncooperative towards professionals. He reluctantly agreed to one call per day from a care agency, however this was subsequently cancelled due to non-engagement.

3. Reason for the Review

On 29th July 2021 Salford Safeguarding Adults Board agreed to conduct a mandatory Safeguarding Adults Review (SAR) following a referral from the Crown Prosecution Service (CPS) to whom the police had submitted the case file relating to their investigation of Irene's injuries.

The delay in arriving at the point at which a SAR could be considered was occasioned by the need for the police to obtain expert evidence in respect of Irene's injuries.

The period of time that the review covered was February 2019 until February 2020.
David Mellor was appointed as independent reviewer for the SAR. He is a retired chief officer of police and has ten years' experience of conducting statutory reviews. He has no connection to any agency in Salford.

4. What worked well

- It was appropriate for the Doctor at the Salford Memory Assessment Team Doctor to raise a safeguarding concern as a result of missed and incorrectly administered medication in September 2019.
- It was appropriate for the ambulance service to submit an ambulance welfare notification following their contact with Irene on 19th September 2019.
- The involvement of Speech and Language Therapy in supporting Irene during meetings and Mental Capacity Assessments.
- The duty mortician raised concerns in respect of bruises found on Irene's body following her death.

5. Key Learning from the Review

Making Safeguarding Personal: Ensuring the Voice of the Adult is Heard and Not Just Heard Through Family Members

- **Recommendation 1.1**
  That Salford Safeguarding Adults Board promote the National Aphasia Association (NAA) suggestions for improving communication with people with aphasia when the learning from this SAR is disseminated. (Speech and Language Therapy has been consulted and supports this recommendation)

- **Recommendation 1.2**
  That Salford Safeguarding Adults Board obtains assurance that relevant partner agencies have systems and processes in place which enable them to comply with a person's wish for correspondence relating to treatment, diagnosis, appointments to be sent to an address other than their home address.

- **Recommendation 1.3**
  That Salford Safeguarding Adults Board shares this SAR report with Salford Community Safety Partnership and requests the latter partnership to consider how a change in culture towards an 'all age' approach to domestic abuse can be achieved including the need for 'routine enquiry' in respect of older people to be addressed in domestic abuse training.
- **Recommendation 1.4**
  That Salford Safeguarding Adults Board requests all agencies involved in this SAR review their approach to making reasonable adjustments to the services they provide to people with communication difficulties in the light of the learning derived from this case.

- **Recommendation 1.5**
  That Salford Safeguarding Adults Board requests partner agencies to review their approach to discharging people from their service on the basis of the wishes expressed by a family member on behalf of the adult.

- **Recommendation 1.6**
  That Salford Safeguarding Adults Board consider adopting a 'was not brought' approach to missed appointments by adults who rely on others to attend appointments particularly where there is a context of safeguarding concerns.

- **Recommendation 1.7**
  That when Salford Safeguarding Adults Board disseminates the learning from this SAR, the importance of verifying information provided by family members where possible should be stressed, particularly where there are safeguarding concerns.

- **Recommendation 1.8**
  That when the learning from this SAR is disseminated, Salford Safeguarding Adults Board takes the opportunity to draw attention to the local community advocacy offer, seeks assurance that all agencies include reference to the local community advocacy offer within their safeguarding training and also seeks assurance that partner agencies make referrals to the local advocacy service.

Early Identification and Support for Informal Carers: Supporting Carers/Managing Carer Stress

- **Recommendation 2.1**
  That Salford Safeguarding Adults Board shares the learning from this SAR with the Carers Steering Group, in particular the learning in respect of finding appropriate language to discuss caring responsibilities and the need to not regard the declining of a carer's assessment as the end of the conversation.

Recognising the Signs of Domestic Abuse, Coercion, and Control in Older Adults

- **Recommendation 3.1**
  Salford Safeguarding Adults Board may wish to work with Salford Community Safety Partnership to enhance the knowledge, skills and awareness of domestic abuse, including coercion and control amongst the range of professionals who work with older adults. Disseminating the learning from this SAR would make a valuable contribution to this goal.

- **Recommendation 3.2**
  In particular, the Board and the Partnership may wish to obtain assurance that single and multi-agency training in this area is effective and up to date, given the professional knowledge about the ways in which coercion and control is manifested in different types of relationships.

- **Recommendation 3.3**
  The adapted Duluth Power and Control Wheel is part of a tool kit designed to address 'Domestic Abuse and the co-existence of dementia' which has been recently launched by Dewis Choice. The Board and the Partnership may wish to promote the use of the tool kit in response to the learning from this SAR.

- **Recommendation 3.4**
  The Board and the Partnership may wish to promote the use of the DASH risk assessment amongst a wide range of professionals. This would require training and support.

- **Recommendation 3.5**
  Undertaking a DASH risk assessment with victims who have communication challenges would not be a straightforward task. The Board may wish to invite Speech and Language Therapy to develop a DASH risk assessment adapted for use with victims with communication difficulties.

  It is understood that Irene's family didn't know where to go to get help, or what to do for the best in respect of the domestic abuse it is alleged that Irene suffered. There would be merit in raising awareness of domestic abuse in intimate relationships involving older people, the support that is

available to victims and with whom people who are worried about older victims of domestic abuse can share their concerns.

- **Recommendation 3.6**
  That Salford Safeguarding Adults Board may wish to work with Salford Community Safety Partnership to raise awareness of domestic abuse in intimate relationships involving older people, the support that is available to victims and with whom people who are worried about older victims of domestic abuse can share their concerns.

Application of Mental Capacity Act

- **Recommendation 4.1**
  That a case study based on the complex Mental Capacity issues which arose in this case is developed and used to enhance Mental Capacity training. The case study should include assessing the capacity of a person with communication challenges, considering the impact of undue pressure on capacity and recognising and addressing the tensions which may exist between the wishes of the person and her primary carer.

Discharge from Intermediate Care

- **Recommendation 5.1**
  That Salford Safeguarding Adults Board discusses the apparent tension between the charging regime for intermediate care and the need to ensure safe discharge in more complex cases with the commissioners of intermediate care.

- **Recommendation 5.2**
  That Salford Safeguarding Adults Board requests partner agencies to review their policies on discharging people from their service following non-engagement or difficulties in gaining access to the person's home and consider undertaking a risk assessment and also contacting other agencies involved in the person's care.

- **Recommendation 5.3**
  That Salford Safeguarding Adults Board should seek assurance from partner agencies that discharge planning should also include contingency planning where there is a risk that discharge arrangements may not succeed.

- **Recommendation 5.4**
  That Salford Safeguarding Adults Board should seek assurance from partner agencies that where discharge from a service appears to carry significant risks, the case should be escalated to management.

Effectiveness of the safeguarding policy and procedures/Missed opportunity to raise safeguarding concerns

- **Recommendation 6.1**
  That Salford Safeguarding Adults Board obtains assurance that enquiries in respect of safeguarding referrals fully considers any underlying issues in addition to the presenting issue or issues.

- **Recommendation 6.2**
  That Salford Safeguarding Adults Board obtains assurance that policy and training in respect of adult safeguarding includes a greater awareness of the dynamics of domestic abuse, particularly coercion and control, when considering safeguarding referrals.

- **Recommendation 6.3**
  That Salford Safeguarding Adults Board requests partner agencies to encourage and support their staff to take personal accountability for making a safeguarding referral irrespective of whether other professionals involved in the case might be considered to have greater safeguarding expertise.

Hoarding

- **Recommendation 7.1**

When the learning from this SAR is disseminated, Salford Safeguarding Adults Board takes the opportunity to highlight the presence of hoarding issues in this case and promotes the use of the GMFRS Hoarding Assessment Tool.

Think Family

- **Recommendation 8.1**

When the learning from this SAR is disseminated, Salford Safeguarding Adults Board takes the opportunity to highlight the benefits of adopting a 'think family' approach in the circumstances in which one of Irene and Brian's grandchildren was harmed whilst in their care.

Agencies working together and information sharing

- **Recommendation 9.1**

That Salford Safeguarding Adults Board request the Northern Care Alliance NHS Foundation Trust to add functionality to their EPR information system to enable safeguarding referrals to be flagged in order to enable professionals to become more readily aware of any safeguarding referrals.

6. What are we going to do?

- **A wider learning event was held on 24/11/2022** to share the learning with the workforce. The event was led by the Independent Author, David Mellor.

  The event will be recorded for those who are not able to attend on the day, if you wish to get access to the link or for any further information regarding this SAR, please contact **ssab@salford.gov.uk**

- The SSAB will develop an action plan and seek assurance on the questions the Independent Reviewer has asked to the SSAB to ensure there is learning and positive change from the review.

- Learning has been shared with all agencies which includes a robust action plan developed to address the key themes and learning which will be monitored on a regular basis.

- The SSAB will develop further mechanisms to disseminate learning for practitioners to raise the profile of lessons learned and areas of good practice from SAR Jayne and other SARs in the system in due course.

- The SSAB will feed this report into the work of the Community Safety Partnership including the Domestic Tackling Abuse Board (TDAB) to ensure the learning can be shared across the workforce of adults and children.

7. Signposting and Resources

If you are worried about an adult - you can report any concerns of abuse or neglect by telephone on 0161 206 0604 or online by using the 'Report a safeguarding concern form', please see the link which provides all the necessary information to report your concern.

Support and Services for Domestic Abuse

In 2022, Salford created the 'Safe in Salford' domestic abuse service which brings together a number of partners to deliver a range of services. Salford Foundation was commissioned as the Lead provider.

There are five elements to the partnership:

1. Crisis Service (Independent Domestic Violence Advocates, or IDVAs) for victims / survivors.
2. Advice and Support Services for Victims / Survivors
3. Specialist Support for GP's (known as IRIS)
4. Children and Young People's Support (Harbour)
5. Behaviour Change Programme for Perpetrators.

Please visit Salfordfoundation.org.uk/safeinsalford for further information regarding the support available to the public and professionals. The website also advises you of the referral pathway for the service.

Please visit the SSAB website Safeguarding Policy and Procedures and Tri-x has provided a list of useful and key National Contacts including **National Domestic Abuse Helpline which is 0808 2000 247.**

Recognising Domestic Abuse in Later Life

Researchers at Dewis Choice – a Welsh initiative combining a co-produced service with research on domestic abuse in later life – have adapted the Duluth Power and Control Wheel – which was developed by Pence, McDonnel and Paymar (1982) as a tool to explain the variety of ways perpetrators use power and control to manipulate and abuse victims.

The adapted version was informed by a six-year longitudinal study undertaken by Dewis Choice which captured the lived experience of 131 older victim-survivors of domestic abuse from intimate/ex-intimate partners and/or family members.

The adapted Duluth Power and Control wheel describes controlling behaviours under the domains:

- Using emotional abuse
- Using coercion and threats
- Using economic abuse
- Misuse of privilege
- Minimising, denying and blaming
- Limiting environmental mastery
- Using isolation
- Using intimidation

This tool is particularly helpful in considering Brian's observed behaviour towards Irene.

For more information, please see the Transforming the Response to Domestic Abuse in Later Life: Practitioner Guidance and Domestic Abuse and the co-existence of dementia.

Advocacy in Salford

An advocate is someone who make sure that other people and organisation listen to the adult and take their views into account. Mind in Salford is the independent charity that represents the voice of Salford. They meet individuals first and are committed to helping people get their voice heard.

To access the Advocacy Service whether it is a Care Act Advocate or IMCA the referral form can be found online at mindinsalford.org.uk

Making Safeguarding Personal

This is an important when working with adult with care and support needs and aims to develop an outcome focus to safeguarding work and supports people to improve or resolve their circumstances and ensuring their voice remains central.

Anyone Can Become a Carer

Quite often, people don't consider themselves as 'a carer', they are just looking after their family member or friend and doing what anyone else would do in the same situation. It is important that just because someone declines an assessment because they don't see themselves as a carer that support is still offered to enable them to care for their loved one. For further information about what support is available for carer, use this link – Information for carers.

For Professionals Only

- The **High-Risk Advisory Panel** has been introduced to support professionals who are working with adults who have complex needs and are at high risk of harm.

  The High-Risk Advisory Panel aims to offer support for professional by providing multi-agency risk enablement approach to offer advice and support for those who adults and multi-agency responses have not been able to reduce the level of risk, whilst empowering the adult and recognizing their human rights.

  If you are working with an adult who is at high risk, take a look at the SSAB website regarding the High-Risk Advisory Panel.

- **The DASH (Domestic Abuse, Stalking and Honour Based Violence)** is a commonly accepted risk assessment tool which was designed to help front line practitioners identify adults who are at high risk of domestic abuse, stalking and 'honour'-based violence and to decide which adults should be referred to the **Multi-Agency Risk Assessment Conference (MARAC)** and what other support might be required. The DASH Risk Assessment tool / MARAC referral can be accessed on the domestic abuse pages of the Salford City Council website.

8. Next Steps – we ask that you

- Share the briefing within your own organisation, across your teams and share with individuals who will benefit from the learning from this review.
- Make yourself familiar with the report and access the wider learning event.

For more information, visit our website https://safeguardingadults.salford.gov.uk/