

Salford Safeguarding Adults Board

Safeguarding Adults Review: Irene

Executive Summary

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1.0 Introduction

- 1.1 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. She 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. 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 post-mortem 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. However, Irene's cause of death was given as Alzheimer's disease with Dementia with Lewy bodies.
- 1.2 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.
- 1.3 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.
- 1.4 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. The process by which the SAR was conducted is shown in Appendix A.
- 1.5 An inquest may be held in due course.
- 1.6 Salford Safeguarding Adults Board wishes to express sincere condolences to the family and friends of Irene and Brian.

2.0 Terms of Reference

2.1 The medical and social history of Irene and Brian has been considered for the period of February 2019 until February 2020, but the review has also considered any other relevant information falling outside this time frame.

2.2 The following general terms of reference questions have been addressed:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support people that are experiencing domestic abuse, coercion and the other area of alleged abuse that has been identified.
- Identify what went well and examples of good practice.
- Identify clearly what those lessons are, both within and between agencies; how those lessons will be acted on, within what timescales and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Determine what agencies could have done differently that could have prevented harm or death and that might prevent similar harm in future.

2.3 The following case-specific themes will also be explored:

- Missed opportunity to raise safeguarding concerns
- Making Safeguarding Personal – ensuring the voice of the adult is heard and not just heard through family members.
- Early identification and support for informal carers
- Supporting carers/managing carers stress
- Risk Management
- Agencies working together
- Lack of personal curiosity
- Multi-agency and single agency escalation
- Recognising the signs of domestic abuse, coercion, and control in older adults
- Application of Mental Capacity Act.
- Effectiveness of the safeguarding policy and procedures

3.0 Glossary

Best Interests: If a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

Domestic Violence and Abuse: Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- economic
- emotional

Controlling Behaviour: A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive Behaviour: A continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Making Safeguarding Personal: A sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Multi-Agency Risk Assessment Conference (MARAC): A meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions

are life changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The presumption in the MCA is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability to understand the implications of their situation, to take action themselves to prevent abuse and to participate to the fullest extent possible in decision-making.

DASH (Domestic Abuse, Stalking and 'Honour'-based violence): A commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi-Agency Risk Assessment Conference (MARAC) and what other support might be required.

Section 42 Care Act 2014 - Enquiry by local authority: This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

4.0 Synopsis

4.1 Irene was born in Salford and educated locally. She married Brian and they lived together in the Salford Council area where they raised three children – one boy and two girls who were born the 1970s and early 1980s. Irene had one sibling – a sister who lived locally, with whom she appears to have had a close relationship. Irene appears to have retired from paid employment in her late fifties. Irene appears to have retained a close bond with her son who provided her with quite substantial support when she began to experience cognitive decline. It is unfortunate that it has not been possible to obtain a more rounded view of Irene's life. The SAR focusses on the final two years of her life during which Irene experienced challenges in communicating with professionals as a result of her aphasia and

her son often spoke to agencies on his mother's behalf. Irene's family were invited to contribute to this SAR but declined. There is no obligation on family members to engage with a SAR.

- 4.2 It is understood that Brian worked primarily as a steel erector and the nature of this work meant that he often worked away from home. He was also employed as a labourer and experienced periods of unemployment. which seems likely to have put a strain on the family did other work including. In later life Brian was diagnosed with type 2 diabetes and cirrhosis of the liver but was often reluctant to engage with health professionals. He seemed to have an interest in music as there were a number of guitars in the family home which was described by professionals as cluttered. There was some evidence that Brian may have become a hoarder. He was said to have struggled with mood and motivation following his retirement.
- 4.3 Irene was six years younger than Brian and would have been 19 when they married. They were together for over fifty years. It is difficult to get a balanced view of their relationship as the information shared with this SAR by partner agencies relates to the last two years of Irene's life, by which time she had experienced significant cognitive decline. The family GP observed that Brian was largely nocturnal and that prior to Irene's diagnosis of aphasia, they were largely leading separate lives within the family home. As her needs increased, Irene seemed reluctant to be reliant on care from Brian, preferring the support of her sister and son. During the last two years of her life there was repeated evidence of controlling behaviour by Brian, who appeared extremely reluctant to allow professionals into the family home even though this could have substantially reduced the burden of caring for Irene, which Brian appeared to assume complete responsibility for following her discharge from Intermediate Care in December 2019. Prior to that point their son had managed a substantial amount of Irene's contact with professionals as her health needs became more complex.

2018

- 4.4 In early February 2018 Irene – then 69 years of age - was seen by the Hospital 1 Neurology team and diagnosed with aphasia and referred to the Salford Memory Assessment Team (MAT) to obtain advice on treatment options and post-diagnostic support. (Aphasia is difficulty with language or speech and is usually caused by damage to the left side of the brain). Salford MAT subsequently confirmed her diagnosis and identified the medication she needed. She was referred to a Dementia advisor.
- 4.5 Irene disclosed some frustration with Brian as she said he had minimal insight into her condition and little interest in finding out more about it, although she had initially been reluctant for information about her diagnosis to be shared with him. A carer's assessment was declined by Brian.

2019

- 4.6 At the beginning of February 2019 Irene did not attend a Speech and Language (SALT) Appointment. Her son explained that she had been 'shaken' by a fall on ice a few days earlier in which she had bruised her hand. Her son said that although his mother's relationship with his father was 'strained', his father now understood the nature of her illness and was being more supportive. The son said that he felt that his parents wished to stay together in their own home. It was documented that Irene did not wish to attend any support groups offered by a local older adult inpatient facility but was now going shopping weekly with one of her daughters and liked this routine.
- 4.7 Later in February 2019 Irene saw her GP who found her speech difficult to understand and noted 'jerky' movements to her arms. The GP prescribed Valproate (prescribed primarily for epilepsy and bipolar disorder) for Dystonia (uncontrolled and sometimes painful muscle movements) on the advice of the Neurology team. The GP was also advised that Irene had been discharged by SALT who said that she had been reluctant to use 'low tech' written and picture communication.
- 4.8 Towards the end of February 2019 Irene, accompanied by her son, was seen by the Neurology team and noted to be stabilised on Rivastigmine but had now had four 'quite troublesome' myoclonic (sudden, involuntary) jerks (documented as 'falls' by the GP on receipt of a letter from Neurology) and had been referred to the 'falls team'. Irene's understanding of 'verbal material' was said to be 'really quite good' but she had 'severe expressive difficulties'. Communication by expression gesture was found to be good. She was able to stand up and walk unaided but with a shuffling gait.
- 4.9 In early March 2019 Irene's GP spoke to her son by phone. He said that his mother had a fall the previous week and pendent alarms and 'other options' were discussed.
- 4.10 Later in March 2019 the Northern Care Alliance (NCA) falls team triaged Irene's referral, noting that she had had four falls since December 2018 and that they planned to visit her. However, Irene was discharged from the falls team on 25th March 2019 after her son phoned to say that his mother didn't want the service at that time.
- 4.11 During late April 2019 the GP spoke to Irene's son by phone. He was concerned about his mother's weight loss (approximately 2 stones) over a period of only a few months as she was not eating during the day and ate very little of the meals he cooked for her in the evening. He added that communication was proving difficult as she could barely speak and didn't like using a 'point book' (for pointing at pictures). The son said that he had organised a care on call (mobile warden service) visit and for handrails to be fitted but Brian had cancelled the appointments as he didn't want anyone in the house.

- 4.12 The GP made a home visit the next day and spoke to Irene in the presence of Brian and their son. Brian was noted to be very keen for Irene to be admitted to hospital for a period of observation, but the GP explained that this would not be the usual response to Irene's weight loss. When asked about turning away support for his wife, Brian said that extra handrails were not needed and would actually be an inconvenience due to some cupboards at the top of the stairs. Irene had a healing injury to her little finger which Brian attributed to a fall. Brian said that Irene went out to shop at the supermarket on her own. Their son said that this was not the case. Brian said that one of their daughters had been taking money from Irene when she took her out shopping but Irene shook her head when he said this. The GP examined Irene and referred her to the community dietician and to the falls team for assessment for a walking aid. The GP noted that Irene did not appear to be coping well with her home environment and that Brian was often asleep during the day and had his own health needs. The GP later documented that if Brian obstructed services from assessing Irene, further action would be required, such as 'safeguarding'.
- 4.13 In late June 2019 NCA falls team received a referral in respect of Irene's recurrent falls but discharged her at the beginning of July 2019 'without intervention'. It appears that Brian may have declined the service on his wife's behalf.
- 4.14 At the beginning of July 2019 two of her young granddaughters were left in Irene's care by one of her daughters (the children's mother) whilst she went to work and one of the children fell and sustained a fractured skull whilst in the care of Irene. The children's social care department from the local authority area in which the daughter resided and the police became involved after the child was taken to Hospital 1. Both children were initially removed from their mother's care and temporarily placed with Irene's son. Enquiries conducted by the children's social care department later established that Irene had dropped her granddaughter, who sustained the injury as a result, but had denied doing so for several days 'because Brian had scared her, saying that she (Irene) would go to jail'. Children's social care ultimately reached the view that the child's injury was a 'tragic accident' and that Irene's daughter had struggled to accept her mother's dementia diagnosis and had greater confidence in Irene's ability to care for the children than was warranted. The children were later returned to the care of the daughter. A Child in Need plan commenced but this was closed after Irene's daughter declined to engage with children's social care and as no concerns were raised by any agency involved with the family.
- 4.15 Later in July 2019 Irene, accompanied by her son, attended a Salford Memory Assessment Team (MAT) appointment and concerns about her weight loss and a deterioration in her speech were noted. A further referral was made to SALT. There were also references to referrals to dietician, falls and telecare team. There is a reference to apologies being offered to Irene for the delay in her care plan being completed.

- 4.16 During August 2019 Irene's GP received a letter from Salford MAT which advised that Irene had not attended an appointment earlier in the month. The letter went on to state that due to concerns about Irene's mood and speech difficulties, she may benefit from a SALT assessment. A further Salford MAT appointment was arranged for the end of August 2019 but Irene again did not attend.
- 4.17 On 12th September 2019 Irene attended a Salford MAT appointment accompanied by Brian and her son. It was documented that Irene had missed her medications for six weeks 'one month ago' and that Brian had been changing her Rivastigmine patch incorrectly (every 12 hours instead of every 24 hours). It was also documented that there had been frequent falls but that 'Irene had refused to attend' an appointment with the falls team. The Salford MAT Doctor raised a safeguarding concern which was passed to the local Adult Social Care team who were assured by Irene's son that his mother's medications were now being administered correctly. It was decided that the circumstances did not meet the threshold for a Section 42 Safeguarding Enquiry and that further support would be offered to Irene and Brian, given the concern that Brian was struggling to care for Irene and had previously refused support. Both Irene and Brian were to be assessed. Salford MAT also planned to refer Irene to the community mental health team (CMHT) for care co-ordination due to increased risk of carer burden, neglect, vulnerability and the risk of unintentional overdose.
- 4.18 On 18th September 2019 Irene's son contacted the Salford MAT and told them that Irene had fallen and hit her head on the radiator. He said that he felt that his mother needed to go to hospital but his father disagreed. Salford MAT advised the son to take Irene to hospital.
- 4.19 The following day (19th September 2019) Irene's son contacted the Adult Social Care Contact Team and spoke to a duty occupational therapist and reported concerns about Irene's falls, including the recent fall in which she had hit her head on the radiator. He also mentioned her weight loss. The occupational therapist recommended an urgent priority occupational therapy visit to advise on moving and handling. The occupational therapist noted a risk of carer breakdown but was advised that a carer assessment was to take place, although there is no indication that this was, in fact, the case.
- 4.20 Later the same day Irene's son called the Out of Hours (OOH) GP who examined Irene and documented a gradual deterioration over the past three months in which there had been reduced oral intake, reduced mobility and a decline in her mood. She had declined further over the past three days and had also been incontinent. The OOH GP documented that offers of care and also adaptations had been declined. The 'last note' on the OOH records stated that Irene didn't want to live with Brian anymore and her son was going to arrange for her to stay with family for a few weeks. (It has not been possible to obtain any further information about the circumstances in which Irene made these comments, although it appears that one of her daughters may have invited her mother to come and stay with her

and her mother had been keen to do so). The OOH GP felt that Irene may benefit from skin assessment by district nurses given her reduced dietary intake.

- 4.21 An ambulance crew also attended due to Irene's dizziness and not eating or drinking. The ambulance crew noted bruising to her arms and back. One of the bruises on Irene's arm comprised of four dots suggesting four fingers. Brian was asked about the bruising which he said had been caused when he stopped her from falling. It was decided not to convey Irene to hospital and for her GP to follow up the next day. Irene was also documented to lack mental capacity to consent to care. Brian was documented to be unhappy that Irene was not taken to hospital by the ambulance crew. The ambulance service submitted an ambulance welfare notification.
- 4.22 On 20th September 2019 Irene's GP spoke to her son who confirmed that his mother had deteriorated over the past few weeks and that she was now incontinent and hallucinating. The GP later visited Irene at home and after receiving no reply to knocking or by phoning, entered the unlocked house. Irene and Brian were upstairs. Brian assisted his wife downstairs. The GP noted that Irene was 'covered in bruises', one on her face and 'all up her arms'. Brian said that the bruises were caused when he stopped Irene from falling. The GP felt that Irene had an underlying infection/malignancy and a poor swallow. The GP documented that Irene was 'not safe at home'. It is unclear whether this observation related to conditions in the house – described as very cluttered – and/or other factors. The GP arranged for Irene to be admitted to hospital the same day.
- 4.23 Irene was conveyed to Hospital 1 where the presenting issues were summarised as 'reduced oral intake, dehydration with possible infection, not coping at home'. Prescribed medication on admission was documented to be sodium valproate, rivastigmine patch and mirtazapine (antidepressant). Irene's son was able to provide the hospital with information about his mother's medical history. As well as her recent difficulty in swallowing, she also had a sore throat. Her son said that she had appeared more confused than normal and had hit her head after falling out of bed. She had also been getting out of bed and 'wandering'. The son said that the bruising on her arms and legs was currently 'worse' because of her low body weight and because Brian was having to take her to the toilet more frequently. Bruising was evident on Irene's arms and legs 'with no clear cause'. Significant weight loss and emaciation was noted. The differential diagnosis arrived at was that Irene likely had a urine infection given her increased confusion and incontinence and that her poor oral intake had resulted in dehydration and acute kidney injury, against a background of increased falls, worsening mobility and struggling to cope at home.
- 4.24 At the time of Irene's admission to Hospital 1, Irene was on a waiting list to be allocated a worker from the local Adult Social Care team 'as a priority' for the assessment referred to in Paragraph 4.17. Her admission to hospital led to the closure of her case by the local Adult Social Care team. The SAR has been advised that this practice has now changed and that the

Neighbourhood Adult Social Care team would now retain the case and complete the planned Care Act assessment.

- 4.25 On 21st September 2019 a hospital doctor spoke to Brian about his wife. Brian did not wish to accept a care package and appeared distrustful of professionals. The doctor noted that discharge planning may be difficult as a result and that Irene may require an advocate.
- 4.26 The ambulance welfare notification submitted by the ambulance service was treated as a safeguarding referral by the Adult Social Care integrated hospital discharge team. After information was gathered, including noting the earlier safeguarding referral it was decided, after consultation with management to manage the issues outside the Section 42 process. The rationale for this decision appeared to be that the carer (Brian) had not acknowledged that outside help was needed and had experienced carer stress.
- 4.27 On 23rd September 2019 Irene was assessed by the Hospital Mental Health Liaison Team (MHLT). The MHLT spoke with Brian who felt that his wife had improved since her admission to hospital. He expressed concern about Irene's weight loss although the MHLT doctor noted that an earlier dietician referral had been 'cancelled by the family'. The doctor discussed support for Irene following her return home with Brian who was opposed to this saying that it was 'dangerous' to have people round at their house and that social services would probably 'steal things'. The doctor documented that at the time of discharge professionals would need to think about Irene having her own advocate as she lacked capacity. It was decided to increase Mirtazapine to 30mg at night, prescribe Zopiclone to help with Irene's sleep and for her weight loss to be investigated. The doctor considered it to be probably wise for her to return home as this would be in her Best Interests and the least restrictive option. It was documented that Salford MAT planned for Irene to be supported by the community mental health team (CMHT) following her discharge home.
- 4.28 On 25th September 2019 an ASC advanced practitioner from the integrated hospital discharge team was allocated to complete a social care assessment of Irene and plan for her discharge. When the advanced practitioner spoke to Irene's son, he said that he did not believe his father was abusing his mother and explained that his parents had always been reluctant to allow others to enter their home. He said that he felt the bruising to his mother arose as a result of his father struggling to care for her, including the need to physically carry her upstairs on occasion. The son said that he was happy to be involved in discharge planning. The following day a DNACPR (do not attempt cardiopulmonary resuscitation) was put in place for Irene after consultation with her son.
- 4.29 On 28th September 2019 one of Irene's daughters expressed concern to nursing staff that Irene's husband and son were not acting in Irene's best interests and that she and her sister would like to be more involved in making decisions on Irene's behalf. The contact details of both daughters were obtained. The daughter's concerns were shared with the MHLT who

reviewed Irene's case on 30th September 2019 and appeared to be under the incorrect impression that a 'safeguarding investigation' was ongoing.

- 4.30 On 1st October 2019 the advanced practitioner and a SALT practitioner completed a Mental Capacity assessment of Irene and deemed her to lack capacity to make decisions in respect of her care needs. A professionals meeting was to be held to consider whether HomeSafe reablement or an intermediate care (IMC) placement was the most appropriate way forward for Irene. When these options were discussed with Irene's son the following day he disclosed that his mother may be reluctant to accept IMC as she had been affected by her own mother dying in hospital several years previously. He also elaborated on his father's longstanding reluctance to allow people into the family home for fear of being 'robbed' and said that as his father was a hoarder there would be insufficient room in the family home for care and treatment because of all the clutter. When discussing his father's difficulties in caring for Irene, the son observed that his father 'hadn't done anything at home for 40 years and all of a sudden he's doing everything'.
- 4.31 On 2nd October 2019 both the hospital and the MHLT were advised by 'social care' that safeguarding issues had been resolved as Irene's husband was willing to accept outside help in supporting her.
- 4.32 On 9th October 2019 a Best Interests meeting was held in respect of Irene and it was decided that transferring to a local residential intermediate care facility was in her Best Interests. The transfer took place on 16th October 2019 and the ASC advanced practitioner also transferred Irene's case to the intermediate care social care team. Thereafter Irene was an inpatient in the residential intermediate care facility until 15th December 2019.
- 4.33 On 19th and 20th October 2019 Irene had falls in her room, sustaining a small bruise to her right shoulder in the second fall.
- 4.34 On 25th October 2019 a community psychiatric nurse (CPN) from the CMHT made contact with Irene's son. He said that his father wanted Irene to return home but 'the family' felt that he (Brian) was unable to cope and meet Irene's needs.
- 4.35 At one of the two practitioner reflective learning events arranged to inform this SAR, the Speech and Language Therapist advised that she had supported the physiotherapist to assess Irene's capacity on 4th November 2019. There is no specific record of this mental capacity assessment in the agency chronologies submitted to this SAR and it is not completely clear what prompted this further capacity assessment. However, during the first attempt to discharge Irene home on 18th December 2019 the chronology refers to an undated assessment of Irene's mental capacity carried out in the residential intermediate care facility by physiotherapy and SALT which concluded that she had capacity around discharge planning.

- 4.36 On 6th November 2019 Brian's GP was contacted by the advanced nurse practitioner who was looking after Irene and asked whether Brian had a cognitive impairment. The GP's view was that Brian was 'eccentric' and doubted whether a Salford MAT referral would help the situation. The GP added that Brian could be hostile and 'unusual' in his behaviour.
- 4.37 On 7th November 2019 Irene's husband shouted at Irene and her sister who were seen to be crying. Staff advised him not to shout. During the same day Irene's son was twice advised not to take Irene up the stairs or to help her mobilise generally without using her walking frame. On both occasions he was seen assisting his mother to mobilise by linking his arm into hers. On the second occasion he appeared to be dragging her along. He was advised to speak to the physiotherapist but said that he couldn't do this as he worked during the day. The ward manager was advised of the concerns that had arisen but it is unclear what action was taken.
- 4.38 On 11th November 2019 the CMHT liaised with Irene's son to arrange an out patient's appointment. Her son said that he anticipated that his mother would be discharged from the residential intermediate care facility around Christmas 2019 and so the out patients appointment was scheduled for 21st February 2020.
- 4.39 On 17th November 2019 Irene had two further falls whilst in her room which did not require treatment although contact was made with the Out of Hours GP service.
- 4.40 On 20th November 2019 an intermediate care social worker was allocated Irene's case. She met Irene and explained the support provided by intermediate care but Irene was unable to communicate her needs at that time because of her aphasia. The social worker attempted to visit Brian but he appeared to refuse to acknowledge her when she tried to attract his attention by waving to him through the front window of his home. However, she subsequently met Brian and Irene's son and established that Brian was willing to accept carers twice daily at 11am and 1pm, willing to support Irene to use the nearby day centre and discussed the purchase or provision of a wheelchair to take her there, agreed to a bed downstairs if this proved necessary and was willing to accept a referral to care on call and telecare equipment linked to this. The social worker noted a concern about Brian's reluctance to heat the family home and his tendency to put Irene in bed to keep her warm. A home heating assessment was under consideration. The social worker, in discussion with an occupational therapist felt that it may not be appropriate for Irene to move directly to residential care without trying care at home in the first instance.
- 4.41 On 28th November 2019 a planning meeting took place involving the social worker, occupational therapist and Irene and Brian. Irene used a visual communications aid to answer questions by pointing to 'yes' or 'no' although she looked towards her husband - apparently to check for his reaction on occasion. When asked where she wanted to go from the residential intermediate care facility, Irene pointed to 'home'. During the meeting Brian

raised objections to some proposals such as having a bed downstairs and fitting a second stair rail. The outcome of the meeting was documented to be agreement by Irene and Brian to a care package involving two visits per day, a second stair rail assessment, Irene sleeping nearer the bedroom door, two commodes, a bath lift, toilet frame, care on call and additional heaters were to be purchased by their son. The social worker and a hospital technician were to meet Brian at the family home on 2nd December 2019 to confirm the above arrangements. The son was also going to be present to assist in moving a large wardrobe at the top of the stairs and removing items from the stairs.

- 4.42 The planned visit to the family home took place on 6th December 2019 when a different intermediate care social worker visited with the hospital technician. Brian was said to be unhappy with the equipment, adaptations and ‘intrusion’ by professionals.
- 4.43 On 8th December 2019 Irene suffered a witnessed seizure lasting approximately one minute. It appears that the OOH GP was consulted.
- 4.44 A joint assessment had been completed with Irene and Brian. Irene was assessed as being unable to manage and maintain nutrition, maintain personal hygiene, manage her toilet needs, dress herself, use her home safely, maintain a habitable home environment or make use of services in the local community. The assessment recognised Brian as Irene’s carer who was said to provide her with support at home for 24 hours daily. The assessment noted that Brian declined a separate carer’s assessment or a benefits check but that an outcome of the joint assessment would be a Carers Personal Budget. On 9th December 2019 the intermediate care social worker referred Irene to the Intermediate Home Support Service (IHSS) for a care package consisting of twice daily visits by a single carer to support Irene with personal care and support Brian in his main carer role. The IHSS facilitate up to six weeks of continuing rehabilitation and reablement for the service user. However, IHSS advised that their provider had no availability and so Irene was referred to an alternative provider. Irene and Brian had also agreed to a referral for Extra Care Housing for the management of Irene’s care needs in the future. The social worker advised Irene’s son of the IHSS referral and he said that his mother ‘didn’t want to spend another night’ in the residential intermediate care facility and had been tearful and distressed.
- 4.45 On 11th December 2019 Irene’s son emailed the intermediate care social worker to inform her that Brian had decided that there was no room for a bed downstairs and in any event his father didn’t want one down there. The son said that his father wanted Irene in bed with him so that he could keep an eye on her rather than having to go downstairs. The son went on to say that with a commode downstairs, his mother would only need to be supported to use the stairs twice daily. The planned discharge from the residential intermediate care facility was postponed as Irene needed to be supported to practice her mobility on stairs but her swollen ankles prevented this. IHSS advised that they would now be able to provide the care package for Irene from the new discharge date of 16th December 2019.

- 4.46 On 16th December 2019 Brian behaved in a hostile manner towards the occupational therapist when discussing home discharge arrangements. During the same day the occupational therapist found that Irene's mobility was improving.
- 4.47 On 17th December 2019 Irene became visibly upset when nursing staff discussed her return home. She said that she didn't want to go home but when asked where she would like to go, she shrugged her shoulders. Nursing staff expressed concern about Irene not wanting to go home to the social worker who is documented to have replied that this issue had been discussed with Irene on many occasions and she had consistently said that she wanted to go home.
- 4.48 On Wednesday 18th December 2019 the first attempt to discharge Irene home was unsuccessful and Irene returned to the residential intermediate care facility. The occupational therapist and a rehab technician went with Irene to the family home. On arrival Brian did not answer the door. After waiting for a few minutes the therapist and the technician and Irene waited in their taxi for a few more minutes before Brian eventually came out of the house, making no apology or offering any explanation. The professionals were unsure how this delay in answering the door would affect the home carer visits. Irene was unable to climb the stairs, which were very steep and lacked a hand rail for part of the left side and there were planks of wood running up the length of the stairs creating a trip hazard. It was not possible to manoeuvre Irene's walking frame past obstructions on the ground and first floor. Many floor surfaces were slippery. Irene needed her husband to help her with all moving and handling which left him out of breath and fatigued. On some occasions he went against Irene's wishes and persisted with situations she was uncomfortable with and was noted to be 'quite short' with her and become easily frustrated. When Brian objected to Irene sleeping downstairs because she had previously attempted to leave the house, Irene shook her head as if she disagreed with him. When asked if she agreed to return to the residential intermediate care facility, Irene appeared reluctant to answer and so Brian began lifting her hand and pointing to 'yes'. The therapist and technician repeated their recommendation that a bed was needed for Irene downstairs in view of her repeated difficulty in ascending the stairs with support, with which Brian now said he agreed. A referral was to be made for a bed sensor on the carer alert system. Brian suggested that Irene remain in the residential intermediate care facility for a further week but it was eventually agreed that discharge could be attempted the following day and that Brian and his son would arrange for a single bed to be placed downstairs and he would sleep downstairs on a sofa until the bed sensor was in place (scheduled for 23rd December 2019). The occupational therapist was to discuss a more substantial package of home care with the intermediate care social worker – who felt that this could be considered after the planned care package had been monitored for a time.
- 4.49 On 19th December 2019 Irene was reviewed by a consultant geriatrician. It was documented that Irene's social worker was to consider the use of an independent mental capacity

advocate (IMCA). It was now planned to discharge Irene home on Monday 23rd December 2019.

- 4.50 During the night of 22nd/23rd December 2019 Irene got up in the night on several occasions. An alarm alerted staff to her movement. On one occasion she was found in the corridor without her walking frame.
- 4.51 Irene was discharged home on Monday 23rd December 2019. She was accompanied by the same occupational therapist and rehab technician who had attempted to discharge her home the previous week. The IHSS co-ordinator arrived at the same time. No bed had been put in place downstairs despite an assurance from Irene's son that a bed would be put in place over the preceding weekend. When this was discussed with Brian he quickly became agitated and asked Irene - who was becoming distressed - if she wanted to return to the residential intermediate care facility. When she said 'no' she didn't want to return, Brian told the professionals to 'piss off' and 'get out'. Both the rehab technician and the IHSS co-ordinator consulted their managers by phone. Brian continued to behave in a hostile and uncooperative manner and initially wouldn't allow the professionals to use the communication aids to ask Irene if she wished to stay at home but eventually relented. Irene indicated that she wished to stay at home but the IHSS co-ordinator documented that she felt that Brian had coerced her into making this decision. The occupational therapist documented that Irene had requested to stay at home 'to please Brian'. Brian wouldn't allow the IHSS co-ordinator to complete the necessary paperwork to enable the home care package to commence. Attempts to ring Irene's son were unsuccessful. The occupational therapist was to speak to Irene's intermediate care social worker and a safeguarding referral was to be discussed with management.
- 4.52 The intermediate care social worker visited Irene and Brian at home later the same day. They were sitting in the lounge drinking Bacardi and coke and were about to watch a film on TV. The social worker checked Irene's medication and arranged for missing medication to be sent by taxi that evening. Brian thanked the social worker. The social worker arranged to visit again the following day to check how they managed overnight and to offer the home care package again and to offer respite care until such time as a flat in Extra Care sheltered housing became available. The son was also to visit his parents that evening and feed back to the social worker.
- 4.53 On 24th December 2019 the social worker visited Irene along with a representative from IHSS. Brian reluctantly agreed to one call per day from IHSS, starting on 30th December 2019. Brian asked the social worker to repeat information she had given him about Irene's medication the previous day and he seemed to have difficulty in recalling who had visited him on that day. The social worker wondered whether this was stress related, due to memory loss or his alcohol intake. Irene was noted to be passive most of the time, making

eye contact, smiling and attempting to talk. She was wearing new pyjamas bought for her by one of her daughters.

- 4.54 On 27th December 2019 Irene's social worker discussed simplifying her medication regime with the GP as the family were getting 'muddled'.
- 4.55 On 30th December 2019 a carer from Care Agency 1 – the provider of the rehabilitation/reablement home care facilitated by IHSS - was unable to gain access to Irene's home address for the first care package visit.
- 4.56 On 31st December 2019 the community dietetics team assessed Irene via a telephone call with her son. The son said he thought the GP planned to prescribe Ensure Compact (a nutritional supplement) which the dietician thought would be satisfactory for three months by which time Irene may be able to attend a clinic appointment. On the same date the intermediate care supported discharge team visited Irene at home to conduct a stairs assessment. Irene was asleep on the sofa downstairs and Brian struggled to wake her. She appeared reluctant to mobilise and it was not possible to conduct the assessment. A physiotherapy – and possibly an occupational therapy assessment – were to be arranged. On the same date a Care Agency 1 carer appeared to have been able to gain access and deliver care.
- 4.57 On 1st January 2020 the Care Agency 1 carer was unable to get a reply and after ringing Irene's son, the visit was cancelled. Care Agency 1 carers were unable to obtain a reply to any further daily visits despite scheduling them for later in the day in case Brian and Irene were still in bed. On 9th January 2020 the care package was cancelled.
- 4.58 On 9th January 2020 the social worker and an IHSS professional visited Irene at 3.30pm and were unable to obtain a reply despite knocking loudly several times. The social worker arranged to meet the son at Irene and Brian's address on 23rd January 2020.
- 4.59 On 16th January 2020 the intermediate care supported discharge team made a home visit with a physiotherapist which had been arranged with the son but were unable to obtain any reply despite knocking very loudly. A phone call to the son went unanswered. A note was put through the door asking Irene to contact the office if an appointment was required. The note also stated that if no contact was received in two weeks, Irene would be discharged from the service. The letter was copied to Irene's GP.
- 4.60 On 22nd January 2020 the community dietetic service were unable to obtain a reply from Irene's son when they attempted to phone him to find out whether the GP had, in fact, prescribed oral nutritional supplements to Irene.
- 4.61 At 4pm on 23rd January 2020 the intermediate care social worker visited Irene and Brian at home. The son sent an apology for not attending the meeting as arranged as he said he had

recently been arguing with his father and didn't want to create any further arguments. The social worker initially spoke to Brian as Irene was asleep in her bed upstairs. He said that he was managing his wife's care and didn't want any outside help. He declined a referral for Extra Care sheltered housing. The social worker went upstairs and saw Irene who was resting in bed with her eyes closed. The social worker asked her a number of "yes/no" questions, initially about the fish and chips she and her husband were planning to eat later. The social worker was able to understand her responses. When the social worker moved on to ask her if she was 'OK' and happy to stay with Brian, she answered 'yes'. The social worker noted that Irene was smiling during the conversation.

- 4.62 On 29th January 2020 the GP received a letter from intermediate care to advise that Irene had been discharged from their care. Irene's intermediate care social worker was later informed of this.
- 4.63 On 8th February 2020 Irene's son rang NHS 111 on his father's behalf. An NHS 111 health advisor then phoned Brian who said that Irene was not breathing. He said that he had left her on the toilet to go and get something to change her into and when he returned he found her lying head-first in the bath. The ambulance service attended and found that Irene had died. They contacted the police at 6.20pm the same day. The police attended and were told by Brian that Irene had soiled herself whilst downstairs and he had helped her upstairs to the toilet and sat her on the toilet whilst he went downstairs to fetch clean clothes. On his return he saw her leaning over the bath and realised that she was no longer breathing. He then cleaned her up, dressed her, put her in bed and rang his son. When later advised to take Irene out of bed and place her on the floor to facilitate CPR he had followed this instruction. The police concluded there were no suspicious circumstances. (Irene's GP practice later received a notification of the incident from NHS 111 and recorded that Brian had left Irene in the bathroom to go to the shop).
- 4.64 On 9th February 2020 concerns were raised by the duty mortician at Hospital 1 in respect of injuries found on Irene's body. On 12th February 2021 a Home Office post mortem examination found bruising and scratching to Irene's face, heavy to the right and left side and into both ears which appeared fresh. Also found was a small cluster of brown bruising to her lower neck, a bruise to her chest above the heart area which was red in colour, bruising to her right arm, extensive bruising to her left arm, scratch marks and bruises on the back of both hands, brown bruising to each hip, extensive heavy and dark bruising to the front of both legs, bruising on the top of both feet, a broken nose, four broken ribs, and a subdural hematoma. Pooling of blood along the length of her body and down each leg was also noted. There was a healed scratch on her lower back.
- 4.65 On 13th February 2020 Brian was interviewed by the police and stated that any marks on his wife's arms were from when he stopped her falling. He provided no explanation for any other injuries nor did he offer any explanation for not obtaining medical attention for his

wife. Following the interview the police created a Concern for Welfare notification in relation to concerns in respect of his address and the apparent lack of adequate heating (broken boiler and two small heaters in the front room and one in the bedroom).

4.66 On 6th October 2020 a statement was obtained from the pathologist who carried out the post mortem examination from which Irene's cause of death was given as Alzheimer's disease with Dementia with Lewy bodies. The statement noted that Irene had numerous bruises, some of which were accounted for by falls. However, because of the multiplicity of the bruising and its symmetrical nature, the pathologist found it difficult to escape the conclusion that a significant proportion of her injuries were very likely to have been sustained as a result of physical assault. Despite this, none of her injuries, from a pathological perspective, had contributed to her death.

4.67 Brian has since died.

5.0 Contact with Irene's family

5.1 Irene's son and two daughters and her sister were invited to contribute to this review but declined to do so. As previously stated, there is no obligation on family members to contribute to a SAR.

6.0 Analysis

6.1 In this section of the report each of the terms of reference questions will be addressed in turn.

Making Safeguarding Personal: Ensuring the voice of the adult is heard and not just heard through family members.

6.2 The SAR focusses on the period between Irene's diagnosis with aphasia in February 2018 and her death two years later. Irene's aphasia severely affected her ability to communicate verbally but her understanding of information communicated to her by others was judged to be 'really quite good' and her ability to communicate through expressions and gestures was also considered to be 'good'.

6.3 Professionals were often able to ascertain her wishes by asking her closed questions which required a 'yes' or 'no' answer. SALT found her to initially be reluctant to use 'low tech' written and picture communication but she appeared to become more confident in using this method of communication, particularly during her admission to the residential intermediate care facility between October and December 2019.

6.4 However, professionals increasingly turned to Irene's son to speak for his mother and he appears to have been generally regarded as a reliable source of information about Irene's

day to day life, her relationship with her husband Brian, the state of her physical and mental health and her family history. Brian also spoke to professionals on behalf of his wife and when important decisions about Irene began to be made from the time of her admission to the Hospital 1 from September 2019 onwards, Brian's preferences over issues such as accepting or declining support following Irene's discharge became increasingly dominant. Irene's son's interventions on behalf of his mother gradually diminished as his father asserted his preferences more persistently and aggressively and by the time Irene was discharged home just before Christmas 2019, her son appeared to have backed away almost completely. This changed dynamic proved challenging for professionals as they generally appeared to have regarded Irene's son as an ally who was helping them to moderate Brian's influence. The SAR Panel questioned whether all professionals involved in Irene's care were sufficiently attuned to the changing dynamic in the way in which Irene's family members were engaging with professionals.

- 6.5 Irene appeared to largely acquiesce to her husband's wishes, sometimes being observed to check for Brian's reaction before answering a question. On other occasions Brian intervened to influence his wife's response to a question, lifting her hand to point to 'yes' on the communication aid when Irene appeared reluctant to return to the residential intermediate care facility after the first attempt to discharge her home was unsuccessful. However, she was seen to register disagreement with Brian on occasions by shaking her head in response to something he said. For example when Brian objected to her sleeping downstairs because he said that she had previously attempted to leave the house, Irene shook her head. This suggested that one of the objections advanced by Brian for disagreeing with the recommendation that Irene should sleep downstairs may have been false. Irene generally expressed a wish to be discharged home from the residential intermediate care facility although this was not consistent. For example, on 17th December 2019 Irene became visibly upset when nursing staff discussed her return home. She said that she didn't want to go home but when asked where she would like to go she shrugged her shoulders. At an earlier stage Irene appears to have said that she didn't want to live with Brian anymore and that her son was going to arrange for her to stay with family for a few weeks. The extent to which Irene was able to freely express her wishes will be considered in the section of this report on 'coercion and control'.
- 6.6 There were occasions on which professionals could have attempted to communicate more meaningfully with Irene in an effort to better understand her wishes and feelings, such as the MHLT assessment of Irene and when enquiring into the safeguarding referral raised by the ambulance service when her husband and then her son respectively appeared to be the primary sources of information on which professionals relied.
- 6.7 The National Aphasia Association offers the following helpful suggestions to assist in communicating with a person with aphasia (1):

1. Make sure you have the person's attention before you start.
2. Minimise or eliminate background noise (TV, radio, other people).
3. Keep your own voice at a normal level, unless the person has indicated otherwise.
4. Keep communication simple, but adult. Simplify your own sentence structure and reduce your rate of speech. Emphasize key words. Don't 'talk down' to the person with aphasia.
5. Give them time to speak. Resist the urge to finish sentences or offer words.
6. Communicate with drawings, gestures, writing and facial expressions in addition to speech.
7. Confirm that you are communicating successfully with 'yes' and 'no' questions.
8. Praise all attempts to speak and downplay any errors. Avoid insisting that each word be produced perfectly.
9. Engage in normal activities whenever possible. Do not shield people with aphasia from family or ignore them in a group conversation. Rather, try to involve them in family decision-making as much as possible. Keep them informed of events but avoid burdening them with day-to-day details.
10. Encourage independence and avoid being overprotective.

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)

6.8 When Irene was first diagnosed with aphasia, she requested that all correspondence relating to the diagnosis be sent to her sister's address by the Hospital 1 Neurology team. It appears that Irene's request may not have been complied with as Hospital 1 did not have contact details for Irene's sister. When Irene reiterated her request to Salford MAT the following month, she was accompanied by her sister. In the witness statements made by Irene's son, he said that correspondence relating to his mother's medical appointments was sent to himself and Irene's sister until such time as Brian was told about his wife's diagnosis. Complying with an adult's wishes in respect of the person to whom letters relating to treatment, diagnosis, appointments etc. should be sent - where the adult has capacity to make such a request - appears to be quite an important issue in safeguarding adults from abuse or neglect.

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.

6.9 However, fully complying with Irene's wishes carried the risk that Brian would be unaware of his wife's diagnosis and less able to support her as a result. As a minimum the reasons why Irene requested that correspondence be sent to her sister should have been explored and documented. Such a conversation could also have enabled 'routine enquiry' - i.e. automatically asking people if they are experiencing domestic abuse with every initial/new contact with a service, if safe to do so. If Irene's reasons for wishing the correspondence to be sent to her sister had been explored it is possible that she may have disclosed any fears she might have had over her husband's response to this information might be. The extent to which controlling partners may use their partner's mental health diagnosis against them is explored later in this report. It is generally regarded as good practice to make 'routine enquiry' at antenatal and post-natal checks, contraceptive review, treatment of sexually transmitted infections, unplanned pregnancies and when the person presents with medical symptoms that cannot be explained. It has been noted in other reviews that the majority of points when 'routine enquiry' takes place relate to the earlier years of an adult's life. There do not appear to be the same number of recognised opportunities to apply 'routine enquiry' to an older person. Irene's two requests for correspondence relating to her diagnosis to be sent to her sister represented opportunities for 'routine enquiry'. The SAR Panel felt that 'routine enquiry' is more challenging to embed in professional practice in busy working environments although the Panel acknowledged that in Irene's case there were many, many opportunities for 'routine enquiry' which appear to have been overlooked. The Panel felt that a factor in the missed opportunities in this case was that routine enquiry for older people is a significant gap in current domestic abuse training and that there needed to be a change in culture towards an 'all age' approach to domestic abuse.

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.

6.10 Irene's family members declined services on Irene's behalf. This was particularly apparent at the time of Irene's discharge home from intermediate care and during the following weeks when Brian refusal to make changes to the family home to facilitate the safe care of Irene in her home environment and did not answer the door to professionals who attempted to visit

Irene in the weeks following her discharge home. Irene's son also declined services on his mother's behalf, advising the NCA falls team didn't want their service at that time. There is no indication that the falls team attempted to communicate with Irene herself and discharged her from their service despite noting that she had suffered 4 falls at home between December 2018 and March 2019. It would have been very difficult for the falls team to ascertain Irene's wishes by telephone, given the impact of aphasia on her ability to communicate verbally. In these circumstances the falls team could have considered making a 'reasonable adjustment' and arranging to obtain her views through face to face communication by arranging a home visit.

- 6.11 All public authorities have a legal duty to make 'reasonable adjustments' to the way they make their services available to people with a disability, to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff training and service delivery to ensure they work equally well for people with a disability (2).

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.

- 6.12 Many agencies which provide services to children have stopped categorising missed appointments as 'did not attend' and refer to them instead as 'was not brought' to reflect the fact that children usually need to be brought to appointments by parents or carers. Such 'was not brought' policies recognise that missed appointments may be an indicator of neglect which could raise safeguarding concerns and that these missed appointments should be rigorously followed up on, particularly if the child is subject to child protection or child in need planning. Adult health and social care services in some areas of the UK have adopted a similar approach in respect of adults who are reliant on another person to get to an appointment. The non-attendance of the adult is coded as 'was not brought' and professionals are asked to consider what the impact of the missed appointment on the welfare of the adult could be and whether there are any other concerns within the family in deciding whether further action is required.

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.

6.13 As stated Irene's son began to play a diminishing role in supporting his mother as her discharge home from intermediate care approached. Professionals appear to have become alive to this dynamic only at the time that Irene was about to be discharged home. There were earlier indications that the son may not have been acting in his mother's best interests at all times which do not appear to have been picked up on including declining services on his mother's behalf and not following instructions when helping his mother to mobilise. Additionally, one of Irene's daughters expressed concern to nursing staff that Irene's husband and son were not acting in Irene's best interests and that she and her sister– would like to be more involved in making decisions on Irene's behalf. With the benefit of hindsight, this may have been quite an important intervention by the daughter which merited more detailed exploration and consideration than it received at the time.

6.14 In the witness statement Irene's son made to the police following his mother's death he disclosed that he had witnessed his mother being hit by his father. He had not disclosed this to professionals when providing details of Irene's history. There may have been many reasons why her son did not disclose the alleged domestic abuse whilst his mother was alive. However, the fact that he did not make any disclosures of physical domestic abuse of his mother by his father emphasises the importance of professionals treating information from family members on behalf of the service user with an appropriate degree of caution. The SAR Panel expressed the view that verifying information provided by family members could be quite challenging for professionals working in busy environments and stressed the importance of pre-planning so that a person could be asked who she/he wishes to be their representative whilst they retain the capacity to make this decision. However, in this case, it seems likely that Irene would have wanted her sister and/or her son to be her representative and both appeared reluctant to discuss alleged domestic abuse of Irene whilst she was alive.

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.

6.15 Professionals recognised that Irene may require an advocate in respect of discharge planning and shortly before she was discharged home from intermediate care the NCA consultant documented that Irene's social worker was to consider the use of an independent mental capacity advocate (IMCA). It is unclear why no referral for advocacy

was made. It seems possible that until the point at which Irene was discharged home on 23rd December 2019, professionals continued to place a high degree of trust in Irene's son to advocate for her. Salford has a non-statutory community advocacy offer so practitioners did not need to be concerned about whether Irene met the criteria for an IMCA or not. Whilst it is unclear why no referral for advocacy was made in Irene's case, a factor may have been lack of professional awareness of the local community advocacy offer. In February 2022 Salford Safeguarding Adults Board and Mind provided a 'bitesize briefing' on advocacy. The recording of this session can be requested by contacting ssabtraining@salford.gov.uk.

This is a valuable and informative resource which would benefit from being promoted as widely as possible.

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 carers stress

- 6.16 Brian initially declined a carer's assessment and appeared to have a long held reluctance to engage with health and care professionals and admit them to his home. The joint assessment of Irene and Brian recognised Brian as Irene's carer who was said to provide her with support at home for 24 hours daily. The assessment noted that Brian declined a separate carer's assessment or benefits check but that an outcome of the joint assessment would be a Carers Personal Budget, although this did not appear to have been progressed prior to Irene's death. The SAR Panel felt that the joint assessment should pick up on the needs of the carer, albeit not in as much depth as a stand-alone Carer's Assessment. The joint assessment acknowledged the risk of carer stress if Brian continued providing a high level of support for Irene. The joint assessment anticipated that the provision of home care and day care would address the risk of carer stress. The intermediate care social worker had worked very hard to engage Brian in planning for the support he and Irene needed. However, after Brian's resistance to accepting support appeared to have been overcome, he subsequently disengaged from the support arranged for Irene following her discharge home, which exposed Irene to considerable risk but also increased the risk of carer stress highlighted in the joint assessment.
- 6.17 The SAR Panel questioned whether the declining of a carer's assessment should be the end of the conversation. Brian may not have perceived himself to be a carer so professionals need to exercise care in using the carer 'label' and find ways of discussing the issue in a way

which is sensitive to the informal carer. Should a carer's assessment be declined, as in this case, professionals should consider alternative approaches to encouraging the informal carer to consider accepting support. In this case, if Brian declined support as an informal carer it would almost certainly have an adverse effect on the person he was caring for – Irene.

- 6.18 Additionally, Brian had health needs and there was evidence of self-neglect in terms of declining health interventions, hoarding behaviour, a struggle with mood and motivation since his retirement and some evidence of alcohol misuse although his GP has advised this review that his cirrhosis of the liver was not alcohol related. The burden of caring seemed likely to impact on Brian's self-care.
- 6.19 The adoption of the role of primary carer for his wife appeared to entail a substantial reversal of roles within their relationship. His son observed that his father 'hadn't done anything at home for 40 years and all of a sudden he's doing everything'. The GP noted that Brian was largely nocturnal and that prior to Irene's diagnosis of aphasia, they had been leading largely separate lives within the family home they shared. From agency records Brian comes across as very inflexible in terms of his approach to life with a strong tendency to give priority to maintaining his lifestyle without interruption or interference. The risk of carer stress and breakdown in this case appeared quite high.
- 6.20 Salford's All Age Carer's Strategy 2019-2024 has been shared with this SAR. There may be value in sharing the learning from this SAR report with the Carers Steering Group which oversees the strategy.

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.

- 6.21 The Safeguarding Adults Board, supported by Gaddum – an advocacy charity, has recently produced a 7-minute briefing in respect of carers. This has been updated and a bite size briefing was produced in support of Carer's Week in June 2022. This information was also included in a recent Safeguarding Adult Board newsletter which has a very wide reach. The links are below:

<https://safeguardingadults.salford.gov.uk/professionals/multi-agency-training-and-learning-opportunities/>

<https://safeguardingadults.salford.gov.uk/media/1295/7-min-briefing-carers-mar-2022.pdf>

<https://safeguardingadults.salford.gov.uk/for-the-public/information-for-carers/>

Recognising the signs of domestic abuse, coercion, and control in older adults

6.22 As stated 'domestic violence and abuse' is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- economic
- emotional

6.23 The post mortem which took place following Irene's death disclosed substantial injuries. The pathologist who conducted the post mortem concluded that some of the bruises on Irene's body were accounted for by falls, but because of the multiplicity of the bruising and their symmetrical nature, the pathologist found it difficult to escape the conclusion that a significant proportion of Irene's injuries were very likely to have been sustained as a result of physical assault. When interviewed by police Brian stated that any marks on his wife's arms were from when he stopped her falling. He provided no explanation for any other injuries nor did he offer any explanation for not obtaining medical attention for his wife.

6.24 From September 2019 professionals began noticing bruising on Irene's body. The ambulance crew who saw Irene on 19th September 2019 noted bruising to her arms and back. One of the bruises on Irene's arm comprised of four dots suggesting four fingers. The following day the GP noted that Irene was 'covered in bruises', one on her face and 'all up her arms'. On both occasions Brian said that the bruising had been caused when he stopped his wife from falling, which was the same explanation he gave the police for all the injuries found during the post mortem.

6.25 Bruising was also evident on Irene's arms and legs 'with no clear cause' when admitted to Hospital 1 on 20th September 2019 although her son's explanation that the bruising on her arms and legs was currently 'worse' because of her low body weight and because Brian was having to take her to the toilet more frequently was documented. Irene's son provided a similar explanation to the ASC advanced practitioner on 25th September 2019, who documented that the son felt the bruising to his mother arose as a result of his father struggling to care for her, including the need to physically carry her upstairs on occasion.

6.26 There were plausible explanations for Irene's bruising in addition to the one's put forward by her husband and her son. Irene was known to be at risk of falls and she also experienced

myoclonic (sudden, involuntary) jerks. However, there is little indication that the range of professionals who documented bruising to Irene considered whether they could have been caused by domestic abuse. The ambulance crew appeared to regard the pattern of four dot-like bruises as suspicious but if their suspicions were included in the ambulance welfare notification, they do not appear to have been regarded as an indication of domestic abuse as the Adult Social Care integrated hospital discharge team decided to manage the issues disclosed in the ambulance welfare notification outside the Section 42 process after gathering information. The rationale for this decision appeared to be that the carer (Brian) had not acknowledged that outside help was needed and had experienced carer stress.

The GP documented that Irene was 'not safe at home' but it is unclear whether this observation related to Brian's difficulties in safely supporting Irene to mobilise, the conditions in the house – described as 'very cluttered' – or other factors such as domestic abuse.

- 6.27 Overall, the bruising to Irene does not appear to have been considered in the context of other aspects of Brian's observed behaviour towards his wife such as going against Irene's wishes and persisting with situations she was uncomfortable with and being seen to be 'quite short' with her and become easily frustrated and the many indications of controlling and coercive behaviour. This is concerning. There seemed to be a readiness to treat bruising as accidental. It is acknowledged that exploring whether Irene's bruising was non-accidental would have involved professionals in potentially uncomfortable conversations with Irene and her family members. It is common to ascribe the lack of exploration of Irene's bruising to a lack of professional curiosity, but the underlying issue may be professional discomfort.
- 6.28 'Controlling behaviour' is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
- 6.29 'Coercive behaviour' is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
- 6.30 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, McDonnell 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' and 'Using

intimidation' (3). This tool is particularly helpful in considering Brian's observed behaviour towards Irene. The domain headings from the adapted Power and Control Wheel are shown in bold whilst the abusive behaviour sub-headings which allegedly apply to Irene are shown in italics with the evidence recorded in normal type.

Using intimidation:

Being rude and intimidating to your guest to discourage future contact – when Irene was discharged home on 23rd December 2019, Brian behaved in a hostile and unco-operative manner towards the professionals involved, telling them to 'piss off' and 'get out'. The occupational therapist documented that Irene requested to stay at home 'to please Brian' and elaborated on this at one of the practitioner learning events saying that Irene appeared embarrassed and distressed by her husband's behaviour which may have been a factor in her acquiescing to his wishes.

Misuse of privilege:

Limiting personal space in your own home – Brian insisted on Irene sleeping in the double bed in their upstairs bedroom rather than having a single bed downstairs, which was considered a safer option given the risks involved in ascending and descending the stairs on which there were trip hazards. Brian's hoarding behaviour restricted Irene's space to safely mobilise within the house. Brian's 'reluctance' to heat the family home resulted in her spending a great deal of time in bed in order to keep warm.

Giving you no choice over daily activities – the risks entailed in Irene attempting to mobilise in the home and the lack of heating which meant that she spent long periods in bed to keep warm left her with limited choice over her daily activities.

Minimising and denying and blaming:

Blaming you for their abusive behaviour

Perpetrator using caregiver stress as an excuse for the abuse

Arguably Brian's frequently repeated explanation that Irene's bruising was caused by him stopping her from falling is evidence of Brian attributing responsibility for his wife's injuries to her risk of falling – for which support had twice previously been declined on Irene's behalf.

Limiting environmental mastery:

Restricting your access to, or knowledge of services - professionals had limited success in obtaining a reply to home visits to Irene during the period from her discharge home on 23rd December 2019 and her death on 8th February 2020. Of 14 home visits attempted, 5 were

successful despite professionals knocking very loudly several times and altering the times of visits to the afternoon given that Brian was known to sleep in during the mornings. Prior to Irene's discharge professionals documented Brian's unwillingness to answer the door or acknowledge their presence.

Denying you access to support that promotes your independence - it was documented that Irene did not wish to attend any support groups offered by the Woodlands - an older adult inpatient facility - although this information appeared to have been provided by her son, rather than being a choice exercised by Irene.

Using isolation:

Preventing you having contact with other people' – Brian said that their daughter had been taking money from Irene when she took her out shopping but Irene shook her head when he said this. Brian's comments could have been construed as attempting to prevent or dissuade Irene from being taken out shopping by her daughter. It is understood that Irene had no independent means of communication and that because Brian did not answer the house phone, telephone contact was invariably with Irene's son.

Restrict your mobility through hoarding behaviour and limiting your personal space – Irene's son said that his father was a hoarder and that there would be insufficient room in the family home for care and treatment because of all the clutter. When the first attempt was made to discharge Irene home on 18th December 2019, the stairs – which were noted to be very steep – lacked a hand rail for part of the left side and there were planks of wood running up the length of the stairs creating a trip hazard. Nor was it possible to manoeuvre Irene's walking frame past obstructions on the ground and first floor. Many floor surfaces were slippery.

- 6.31 Some of the indicators of coercion and control illustrated by the adapted Duluth Power and Control Wheel are quite subtle. Others are far less subtle and were recognised to an extent by professionals. For example the IHSS co-ordinator documented that she felt that Brian had 'coerced' Irene into making her decision to stay at home during the second attempt to discharge her. However, at no stage did any professional consider completing a DASH risk assessment or consider a referral to any service providing support to victims of domestic abuse.
- 6.32 The use of language by professionals in contact with Irene, Brian and their son may have inadvertently minimised the evidence of possible domestic abuse. Irene was documented 'not to be coping well with her home environment' and 'struggling to cope at home'. This use of language was not inaccurate but moving onto to spell out why she was 'not coping well/struggling' could have drawn attention to alleged abuse. Additionally, Brian's behaviour was sometimes described as 'eccentric' or 'unusual', language which may have deflected attention away from behaviour which appears to have been abusive and controlling.

6.33 However, it is recognised that there are other quite deep seated reasons why domestic abuse in older people is often overlooked. Research shows that older victims of domestic abuse are likely to have lived with the abuse for prolonged periods before seeking help (4), and they may perceive there to be more at stake after a lifetime of shared history and possessions, financial issues which over time have become interlinked and a fear of any change to long term family dynamics. Over many decades the victim may have internalised the abuse and concluded that ‘this is just the way it has always been’. The SAR Panel felt that practitioner may also subconsciously attach less significance to indications of abuse in relationships between older couples. Older victims are likely to have grown up during a time when the home was regarded as a private domain and it would have been socially unacceptable to discuss matters which occurred behind closed doors.

Additionally, research by Dr. Hannah Bows has found that domestic abuse in older victims is not infrequently subsumed under ‘elder abuse’ discourses and policies because of ageist stereotypes and narrow understanding of domestic abuse (4).

Furthermore awareness raising campaigns have consistently focussed on younger victims and perpetrators, inadvertently reinforcing a false assumption that domestic abuse ceased to exist beyond a certain age (5).

6.34 It is worthy of note that the use of the adapted Duluth Power and Control Wheel to analyse agency contact with Irene, indicates that her son may have contributed to his father’s controlling behaviour, specifically in denying her access to support from services such as Woodlands and the falls team which could have promoted greater independence and helped to safeguard her.

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.

- 6.35 As previously stated, Irene's sister advised the SAR that the family didn't know where to go to get help, or what to do for the best in respect of the domestic abuse she alleged that Irene suffered at the hands of Brian. Although this alleged domestic abuse does not appear to have been limited to Irene's later life, 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

- 6.36 Irene's capacity did not appear to have been actively considered by professionals until shortly before her admission to Hospital 1 in September 2019. She was documented by the ambulance service to lack mental capacity to consent to care, although the next day her GP documented Irene to be hallucinating and to have an underlying malignancy which could have been causing confusion. During her subsequent admission to Hospital 1 the ASC advanced practitioner and a SALT practitioner completed a Mental Capacity assessment of Irene and deemed her to lack capacity to make decisions in respect of her care needs and a Best Interests meeting was held on 9th October 2019 at which a decision was taken to transfer her from the hospital to intermediate care in the residential care facility.
- 6.37 The SAR has been advised that a joint physiotherapy/SALT assessment of Irene's capacity during her admission to the residential intermediate care facility concluded that she had

capacity around discharge planning. Irene was specifically regarded as having capacity to decide to be discharged home from the residential intermediate care facility and professional confidence in her continuing capacity to decide to be discharged home was influential in proceeding with the discharge on 23rd December 2019 in circumstances which raised concerns about her safety in the family home. However, her decision to return home appeared conditional on support being in place. During the discharge planning meeting on 28th November 2019. She was asked “where do you want to go from here?” and pointed to “home” on the visual communication cards. She was then asked “do you need additional support at home?” and pointed to “yes”. She was then asked whether she would accept support and again pointed to “yes”. She went on to answer “yes” to a number of follow up questions relating to the specific support she would need and the specific preparations which would need to be made before she returned home. She wasn’t asked “where she would like to go from here if no support was available to her at home” other than family support during the discharge planning meeting or during the process of discharging her home. The SAR Panel felt that informed consent depended on having all available options explained to Irene and the Panel was not convinced that all options had been fully explained and explored with Irene.

- 6.38 When the social worker saw Irene at home on 23rd January 2020 she spoke to Irene alone and she replied “yes” to the questions “are you OK?” and “are you happy staying at home with Brian” and replied “no” to “is there anything that I can do for you?”. Irene was documented to be smiling as she responded to these questions. The social worker was satisfied that Irene understood the questions and did not doubt her capacity to decide to remain at home with Brian.
- 6.39 Arguably, Irene’s decision to be discharged home on 23rd December 2019 could have been considered by professionals to be unwise as could her decision to remain at home on 23rd January 2020. The Mental Capacity Act (MCA) sets out five statutory principles which underpin the legal requirements of the Act, one of which is that a person is not to be treated as unable to make a decision merely because they make an unwise decision. However, the MCA Code of Practice states that ‘there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character’. The Code of Practice adds that ‘these things do not necessarily mean that somebody lacks capacity...but there might be need for further investigation, taking into account the person’s past decisions and choices’. The Code of Practice suggests issues worthy of further investigation might include whether the person is ‘easily influenced by undue pressure’ (6).
- 6.40 In Irene’s circumstances, professionals do not appear to have considered whether Irene’s arguably unwise decisions were worthy of further investigation given the evidence that she may have made those decisions under undue pressure from Brian. On the contrary,

professionals involved in her discharge home appear to have regarded Irene's wish to be discharged home as an unassailable decision which required them to respect it.

- 6.41 There is no indication that any professional questioned Brian's mental capacity in respect of any decision. Brian's wishes appeared to be that Irene should be discharged home and, ultimately, that they should then be left alone by professionals. His resistance to care and support being provided to Irene in the home they shared appeared to have been overcome for a time, but with the benefit of hindsight, Brian's stated willingness to accept home care may not have been genuine. There was a tension between Irene's stated wish – to return home with support – and Brian's apparent wish – that Irene return home without support.
- 6.42 Recommendations without number have been made about the application of the Mental Capacity Act in SARs. 'Attention to Mental Capacity' was the most frequently mentioned 'direct practice' issue found in the National SAR Analysis Report (7). The learning from this SAR in respect of mental capacity could be a valuable case study to consider some of the complex issues which may arise when attempting to assess the capacity of a person with communication challenges who may also be under duress.

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

- 6.43 Discharge planning proceeded on the basis of a number of key assumptions:
- That Brian, supported by the son, would make changes in the family home which would make it a safer environment for Irene.
 - That Brian's reluctance to allow professionals to enter the family home had been overcome.
 - That Irene and Brian's son would remain fully engaged in the discharge process which would help to mitigate concerns about Brian's commitment to that which had been agreed to ensure a safe discharge.
- 6.44 Professionals clearly did not have complete confidence in all of these assumptions but, in the event, all of these assumptions proved unfounded and the decision to abandon the first attempt at discharge Irene home on 18th December 2019 was entirely appropriate. However, it is difficult to see what had materially improved by the time of the second attempt to discharge Irene home on 23rd December 2019, which went ahead. The only changes were that the son had provided some heaters to mitigate the fact that the central

heating in the family home did not function and had not been repaired and in the period following the first attempt at discharge Irene had been supported to practice her mobility on stairs, although this had been hampered by her swollen ankles.

- 6.45 Discharge planning did not involve the SALT – to facilitate communication with Irene – as originally intended or professionals who would be involved in supporting Irene following her discharge home, particularly her GP who knew both her and Brian well. However, it is apparent that there were additional pressures to complete a timely discharge home which may have had an adverse effect on the effectiveness and inclusivity of discharge planning. The first six weeks of intermediate care are free of charge but are then changed at around £142 per week. Irene’s initial six week period in the residential intermediate care facility expired on 4th December 2019, from which point charges would be payable. An additional pressure was the need to discharge Irene prior to the pre-Christmas date on which care providers would no longer accept new referrals, having finalised care staff rotas for the Christmas and New Year holiday period.
- 6.46 There appears to be a tension between the charging regime for intermediate care and ensuring the safest possible discharge from intermediate care in more complex cases. This appears to be an issue which needs to be taken up with commissioners.

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.

Post-discharge

- 6.47 Professionals involved in discharge planning harboured concerns about the extent to which care providers would be able to gain access to Irene’s home. The visits by the social worker later on the day of discharge and on the following day (Christmas Eve) provided a degree of reassurance that Irene had settled back into the home environment and Brian had agreed to daily home care visits, albeit with some reluctance.
- 6.48 Thereafter, the plans for supporting Irene post-discharge almost completely broke down. Care Agency 1 - the provider of the rehabilitation/reablement home care facilitated by IHSS – were repeatedly unable to gain access, despite varying the time of day of their visits to correspond with Brian’s nocturnal lifestyle and the service was cancelled on 9th January 2020. The intermediate care supported discharge team were initially able to gain access but were unable to conduct a stairs assessment as Irene was sleepy and reluctant to mobilise. After a subsequent visit when they were unable to obtain a reply, the intermediate care supported discharge team discharged Irene from their care after putting a note through the

front door asking Irene to contact their office if support was required. The community dietetics team were also unable to engage directly with Irene. As previously stated the social worker was able to gain access to the family home and communicate with Irene on 23rd January 2020, having previously been unable to obtain a reply despite knocking loudly several times. The period of time between the two social worker visits (9th- 23rd January 2020) appears to have been quite lengthy given the level of concern.

- 6.49 By 23rd January 2020 all specialist services had effectively withdrawn from engagement with Irene. Brian had succeeded in preventing professionals gaining admittance to the family home. There is no indication that any risk assessment was completed by any of the professionals who discharged Irene from their care. There is no indication that any of the professionals involved considered a multi-agency discussion. There is no indication that any contingency plan was considered to address the risk that Irene would be unable to access support following discharge because of her husband's obstruction. Irene's GP was notified when decisions to discharge her were made.

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

- 6.50 Two safeguarding referrals were made in this case.
- 6.51 The first safeguarding referral was made by a Salford MAT Doctor on 12th September 2019 after it was discovered that Irene had 'missed her medications for six weeks one month ago' and that Brian had been changing her Rivastigmine patch incorrectly (every 12 hours instead

of every 24 hours). This was passed to the local Adult Social Care team who were assured by Irene's son that his mother's medications were now being administered correctly. It was decided that the circumstances did not meet the threshold for a Section 42 Safeguarding Enquiry and that further support would be offered to Irene and Brian, including assessment. However, the local Adult Social Care team closed Irene's case following her admission to the Hospital 1 on 20th September 2019. At that time Irene was on a waiting list for assessment by the local Adult Social Care team.

- 6.52 The second safeguarding referral was made by the ambulance service in the form of an ambulance welfare notification. This was treated as a safeguarding referral by the Adult Social Care integrated hospital discharge team. After information was gathered, including noting the first safeguarding referral, it was decided to manage the issues outside the Section 42 process. It appears that a key factor in resolving this second safeguarding concern was Brian's apparent willingness to accept outside help in supporting her.
- 6.53 In both cases assurance provided by, or on behalf of, family members appeared to be quite influential in assuaging concerns. In the first case it appears that only the presenting issue – medication management by family members – was considered and that there may have been insufficient exploration of underlying issues. In the second case, it is unclear why the suspicious bruising noted by the ambulance crew did not give rise to greater concern.
- 6.54 A safeguarding referral was to be discussed with management by the occupational therapist involved in Irene's discharge home on 23rd December 2019 but it is not known what the outcome of any discussion was. There was a strong case for making a safeguarding referral at that time and a safeguarding referral could also have been actively considered when it became clear that planned post-discharge interventions were being obstructed by lack of access to Irene's home.
- 6.55 At the practitioner learning events, attendees appeared to accept the view that safeguarding referrals could have been justified but there appeared to be a reluctance to do so. Unfounded optimism appeared to be a factor as was a tendency to defer to the judgement of the social worker on behalf of some professionals.

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

6.56 Evidence began to accumulate that Brian may have an issue with hoarding. This was noted by the family GP and whilst Irene was receiving intermediate care, their son advised professionals that as Brian was a hoarder there would be insufficient room in the family home for care and treatment because of all the clutter. When professionals attempted to discharge Irene home they recognised by professionals as the cluttered state of the family home was in conflict with safe discharge planning for Irene. However, 'hoarding' was not named as an issue other than by Brian's son. Had 'hoarding' been named, there would have been an opportunity to apply the GMFRS Hoarding Assessment Tool which facilitates the rating of clutter in levels 1, 2 and 3. Level 1 is defined as 'no specialised assistance is needed. If the resident would like some assistance with general housework or feels they are declining towards a higher clutter scale, appropriate referrals can be made'. Level 2 is defined as 'household environment requires professional assistance to resolve the clutter and the maintenance issues in the property'. Level 3 is defined as 'household environment will require intervention with a collaborative multi agency approach with involvement from a wide range of professionals. This level of hoarding constitutes a Safeguarding alert due to the significant risk to health of the householders, surrounding properties and residents'.

6.57 On the basis of the information shared with this SAR, the property shared by Irene and Brian most closely accorded with level 2.

6.58 The risks that Brian's hoarding potentially exposed Irene to are described in Paragraph 4.59. It seemed clear to professionals that without changes being made, Irene would find it extremely difficult to move around parts of the house and use the stairs which would place even greater responsibility on Brian for moving and handling and thus increase the risk of carer stress.

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

6.59 The serious injury to one of Irene's granddaughters whilst in her care led to the involvement of Hospital 1, the children's social care department from the local authority area in which the granddaughters resided with their mother and the police. The children's social care department conducted a Section 47 Enquiry which eventually concluded that the child's injury was the result of a 'tragic accident'. Whilst there was an understandable focus on the action required to safeguard the children involved, there may have been an opportunity for the children's social care department to check whether Irene and Brian were known to services in Salford and share information about the incident. Irene appears to have not been truthful about her role in the incident in which the child was injured whilst under a degree of duress from Brian. Had contact been made with services in Salford, Irene's support needs could have been considered of further considered. Whilst it is accepted that the involvement of agencies from different local authority areas complicated matters, an opportunity to adopt a 'think family' approach appears to have been overlooked.

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

6.60 There is a point to make here about the frequency with which a person with fairly complex needs moves through different services and the opportunity to get to know them and their context may be challenging for the series of professionals they come into contact with. This 'journey' through different services also increases the risk that key information may not always be shared. For example, intermediate care professionals at the residential intermediate care facility advised one of the reflective sessions for practitioners arranged to inform this SAR that were not aware of the two safeguarding referrals made in respect of Irene in September 2019. The SAR Panel has been advised that the electronic patient record (EPR) used by both Hospital 1 and Intermediate Care has no facility to flag key pieces of information – such as safeguarding referrals. Professionals accessing the EPR can use the search facility to look for details of safeguarding referrals in the notes recorded on the system. The Panel was also advised that the Northern Care Alliance NHS Foundation Trust has established a project development team to

'streamline' the use of the EPR across the Trust and that there may be an opportunity for the project development team to explore the addition of a flagging system for safeguarding referrals. It is therefore recommended that the Safeguarding Board requests the Trust to consider this matter.

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.

6.61 However, there remains the risk that key information may be overlooked when a person is making their 'journey' through the hands of several services. An example is the concern expressed by Irene's daughters that Brian and his son were not always acting in Irene's best interests. At the first reflective session arranged to inform this SAR, the intermediate care social worker who assessed Irene to inform the arrangements for discharge and post-discharge care said that she was unaware of this information. Currently, there appears to be no system for avoiding this risk and so the onus appears to be on professionals carrying out assessments to trawl through relevant information systems as comprehensively as possible.

Risk Management

6.62 The risks to Irene arising from domestic abuse, hoarding, falls, discharge from intermediate care and discharge from services are addressed elsewhere in this report.

Multi-agency and single agency escalation

6.63 Escalation to management has been addressed through Recommendation 6.4

Good practice

- It was appropriate for the Salford MAT Doctor raised 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.

7.0 List of Recommendations

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.

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.

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.

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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.

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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.

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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.

- 6.34 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.

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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.

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.

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.

8.0 References

- (1) Retrieved from <https://www.aphasia.org/aphasia-resources/communication-tips/>
- (2) "The Essential Guide to the Public Sector Equality Duty" (2014) Equality and Human Rights Commission retrieved from: http://www.equalityhumanrights.com/sites/default/files/publication_pdf/PSED%20Essential%20Guide%20-%20Guidance%20for%20English%20Public%20Bodies.pdf
- (3) Retrieved from https://dewischoice.org.uk/wp-content/uploads/2022/02/Dewis-Choice-Dementia-and-DA_COMPRESSED.pdf
- (4) Retrieved from <https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf>
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- (6) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf
- (7) <https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019>

9.0 Appendix A

Process by which Safeguarding Adults Review (SAR) Was Conducted

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach

supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Membership of the SAR Panel

- Assistant Director: Integrated Commissioning, Salford City Council/NHS Salford Clinical Commissioning Group (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care).
- Principal Policy Officer: Salford City Council (and representative of Salford Community Safety Partnership).
- Business Manager: Salford Safeguarding Adults Board
- Head of Service/ Principal Social Worker: Adult Social Care/Salford Royal NHS Foundation Trust
- Named Practitioner Safeguarding Adults: Northern Care Alliance.
- Principal Manager for Safeguarding: Salford Royal NHS Foundation Trust /Adult Social Care
- Professional Lead for Social Care: Greater Manchester Mental Health NHS Trust
- Administrator: Salford City Council
- Training and Development Officer: Salford Safeguarding Adults Board
- Named GP for Adult Safeguarding; NHS Salford Clinical Commissioning Group (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care).
- Independent Reviewer
- Specialist Nurse Safeguarding Families: NHS Salford Clinical Commissioning Group (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care)
- Solicitor: Salford City Council Legal Services
- Designated Nurse Safeguarding Adults: NHS Salford Clinical Commissioning Group (The CCG's functions have now been taken over by NHS Greater Manchester Integrated Care)
- Assistant Director:Adult Safeguarding, Northern Care Alliance

Chronologies which described and analysed relevant contacts with Irene were completed by all agencies which had had relevant contact with Irene.

The chronologies were analysed and issues were identified to explore with practitioners at two reflective events facilitated by the lead reviewer.

As stated earlier in the report, Irene's husband Brian died prior to the SAR being commissioned. Irene's adult children decided not to contribute to the SAR. Irene's sister also decided not to contribute to the SAR.

The independent reviewer developed a draft report which reflected the chronologies and the contributions of practitioners.

The report was further developed into a final version and will be presented to Salford Safeguarding Adults Board. This report is an executive summary of the final report.