Salford Safeguarding Adults Board

Discretionary Safeguarding Adult Review (SAR)
In respect of Adult ET

Overview Statement

Family have requested that the initials are used, as referenced throughout the report.

1. Introduction – Reason for the Safeguarding Adult Review (SAR)

1.1 The Care Act 2014 Section 44[1] states that a Safeguarding Adult Board (SAB) **must** arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

1.2 Safeguarding Adult Boards (SABs) **may** arrange for a SAR in any other situation involving an adult in its area with needs for care and support.

1.3 The purpose of a Safeguarding Adult Review (SAR) is therefore to establish whether lessons can be learnt from the circumstances of the adult and to identify areas where there may be a need to improve practice or strengthen the way in which agencies and professionals work together to safeguard adults. The review will also share what worked well and examples of good practice.

1.4 The focus of the review is to ensure a culture of learning **and not blame.**

1.5 Salford Safeguarding Adult Board (SSAB) considers and screens all requests for a Safeguarding Adult Reviews (SAR).

1.6 The Salford Safeguarding Adult Board (SSAB) became aware of ET when a SAR referral was received on 13/10/2021; the Board has had no direct involvement with ET prior to this. The role and responsibility of the Salford Safeguarding Adult Board (SSAB) has been to undertake the review following ET's death and to identify areas of learning.

1.7 Upon receipt of the referral, the Salford Safeguarding Adult Board (SSAB) made arrangements to gather information from agencies involved with ET which supports the SAR Panel to make a decision to determine whether or not the criteria and the conditions for a Safeguarding Adult Review (SAR)[1] was met.

1.8 The SAR panel met 15/12/2021 to consider the circumstances of ET, at that stage the panel felt further information was needed. Additional information was presented to the January 2022 and at the February SAR Panel a decision was made that there was no evidence that ET's death was a result of abuse or neglect

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but there needed to be more understanding in how partners worked together to safeguard ET.

1.9 It was acknowledged there was an ongoing police investigation regarding the laceration to ET's leg and consideration was needed to whether there was evidence of wilful neglect. As a result, the panel agreed that the criteria for a review had been met but the Safeguarding Adult Review (SAR) wouldn't commence until the outcome of the police investigation as this may mean if there was wilful neglect than the criteria was met for a mandatory SAR[2] .

1.10 Following communication from the police who advised there would be no further action with the criminal investigation due to lack of evidence, a **discretionary Safeguarding Adult Review (SAR) was commenced**.

1.11 The review commenced on 27/04/2022 and the final report was completed in February 2023.

1.12 The SSAB would like to acknowledge that the Care and Support Statutory Guidance suggests that SAB should aim to complete the Safeguarding Adult Reviews within 6 months, this has not been possible on this occasion due to a number of due delays which have been caused by a change in management at the care home and pressures within the system that has resulted in delays being able to obtain additional information from single agencies.

2. Methodology/Process of the review

- Decision was made for a discretionary SAR.
- The Independent Chairs of the SSAB were in agreement with this decision.
- A multi-agency combined chronology was pulled together.
- A multi-agency review group was identified
- Terms of reference was written and agreed by multi-agency review group
- Planning meeting was held to plan for the multi-agency discussion – single agency to review their own involvement and identify any learning.
- Meeting was arranged with family and the care home
- 10/05/2022 - Multi-agency meeting was held for single agencies contributions.
- Further enquiries will be made to obtain and gather information and evidence
- The author of the report and a member of the GM NHS Integrated Care (Salford Locality Team) visited the residential care home to review the internal documentation.
- Draft report has been written that highlights areas of expected/good practice and areas of learning which has been shared with the multi-agency review group for acceptance
- Draft report has been shared with ET's family for comments and confirmation of accuracy
- Action plan to be created

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- Final report will be taken to SAR Panel for acceptance and sign off.

Period of time under review was 01/06/2021 until 07/10/2021.

(For the purpose of the review, the scoping period for the review, the United Kingdom was still in the pandemic of Covid 19. In July 2021, the government had started to plan the roadmap out of lockdown, most legal restrictions were in the planning to be removed including social distancing and social contact restrictions. Access to care homes and hospital settings were still restricted and the vaccine programme was underway.)

3. Partner agencies who provided information for the multi-agency review

- Greater Manchester Police (GMP)
- Northern Care Alliance (NCA) including Salford Community District Nurse Service (SRFT)
- Norther Care Alliance – Adult Social Care
- Greater Manchester NHS Integrated Care – Salford Locality (GP services)
- The Care Home where ET resided in the latter stages of her life.
- North West Ambulance Service (NWAS)
- Greater Manchester Mental Heal (GMMH)

Salford Safeguarding Adult Board (SSAB) led on the review.

Jane Bowmer, Business Manager for the SSAB was the lead author of the report.

4. Who was ET?

4.1 ET sadly died on 07/10/2021, aged 81 yrs.

4.2 For the purpose of the review the adult will be referred to as ET. *(The family have been asked what name they wish to use for ET throughout the SAR process)*

4.3 The following information has been gathered from ET's family.

4.4 ET was described as an outgoing lady who loved spending time with her children, she loved to sing, her favourite artist was Tom Jones which she loved to have a little dance to. She enjoyed her food and had a good appetite which then changed at the latter stages of her life.

4.5 At 16 yrs. of age, ET became a nurse cadet.

4.6 She met her husband and father of their children in the hospital, where they both worked. He worked as a porter, they married and had two daughters and one son. Unfortunately, the relationship broke down and she was a single parent for many years.

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4.7 For many years ET worked nights in the hospital, at the age of 54, ET returned to college and completed her nursing training. She worked for Bupa doing bank work for 8 weeks and then she was then offered a permanent contract.

4.8 From 2001, she started work (part time) in Orthopaedic Outpatients at the local hospital to where she lived and remained in that department until she retired in 2011 (aged 70)

4.9 ET had a very supportive family, and she was adored by all, including her extended family of nieces, nephews, grandchildren and great grandchildren.

4.10 ET was diagnosed in 2017 with Alzheimer's, family described it as a slow decline. Family supported ET for many years. ET's daughter was made redundant in 2021 and started to spend more time with her, it was during this time, the family started to realise that ET was struggling with some daily living tasks.

4.11 Even though ET lived alone in her own home, family visited her throughout the day (morning, lunch and tea/evening), they shared the caring role between them. When ET's daughter found new employment, the family approached Adult Social Care to request an assessment with a view of getting some formal support in place.

4.12 Unfortunately, a package of support couldn't be commissioned in time, and emergency respite was offered. The respite was initially going to be for 2 weeks but due to an unwitnessed fall within 24 hrs of being in respite, it resulted in ET staying in the care home for a longer period.

4.13 Sadly, ET was never able to return home and passed away with her family around her in the care home.

4.14 ET stayed at the residential care home from 24/07/2021 until she sadly passed away on 07/10/2021.

5. What happened?

5.1 ET was referred to the SSAB for consideration for a Safeguarding Adult Review (SAR) on 13/10/2021.

5.2 ET sadly passed away on 07/10/2021 after a short stay in a residential care home in Salford.

5.3 Prior to the admission into care home, ET was supported by family in her own home.

5.4 In June 2021, ET's family contacted Adult Social Care and requested a social care assessment with a view of getting a formal support package. At the time of the referral, ET's daughter advised that she was starting a new job and support would need to be in place by the end of the July 2021, unfortunately this deadline wasn't able to be met due to the local care agencies not having the capacity to deliver the

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requested support plan, due to care not being able to be commissioned emergency respite was offered. The family didn't feel they had any other option and agreed to the short stay. It was felt at that time that ET had capacity but its important to note that this was not formally assessed.

5.5 ET moved into the care home on 24/07/2021

5.6 Within 24 hrs of admission into the care home, ET had an unwitnessed fall (25/07/2021). This resulted in her being admitted into the local hospital, on admission it was confirmed that she had suffered a hip fracture and shortly after the operation (surgery was on 26/07/2021) suffered from delirium which subsequently led to a significant deterioration in her mental health and ability to engage in rehabilitation.

5.7 On 14/08/2021, ET was discharged back to residential care home.

5.8 Shortly after being discharged from hospital back to the residential care home, there were two alleged sexual assaults by the same resident to ET (two separate incidents, 1 month apart). Immediate action was taken by the care home. Safeguarding procedures were initiated. Police became involved.

5.9 ET also suffered an unexplained injury which was a severe laceration to her leg.

5.10 Care staff were interviewed by the police. A Criminal prosecution was considered, however, there was insufficient evidence to meet the threshold for charge, so the police took no further action.

5.11 Around 04/09/2021, ET's health then started to deteriorate and shortly after, ET sadly passed away – the initial cause of death was given as Pulmonary Embolism. ET was referred to the Coroner's Office for the cause of death to be determined.

5.12 The Coroner Inquest was held on 6th July 2022, and the conclusion was: ET's death was caused by natural disease processes and it was contributed to by an accidental injury. No Regulation 28[4] was issued.

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6. Views of the family/friend/representative

6.1 As part of the SAR process, contact was made with ET's family to ask whether they wish to be involved in the review process. Family agreed.

6.2 A meeting was arranged with ET's two daughters and granddaughter. An initial meeting was held on 25/04/2022 to obtain their initial views.

6.3 This section of the report reflects some of the key events that happened before the scoping period of the review which is 01/06/2021 until 07/10/2021.

6.4 Family spoke about ET being a happy, outgoing person. ET managed well with the Alzheimer's diagnosis and the family shared the caring responsibilities which enabled ET to continue to live independently.

6.5 The formal diagnosis was given through the Memory and Assessment Team, family described the condition as ET having a slow decline of her cognitive functioning over the years.

6.6 In 2020 – during the pandemic of covid – ET started to need a little more support to enable her to remain in her own home, family and friends provided this support by visiting morning, lunch and tea with additional time being given to support ET to manage general household tasks i.e., shopping, cleaning and managing correspondence etc.

6.7 In April 2021 – ET's daughter personal circumstances changed, and she made a decision to apply for redundancy, this resulted in ET's daughter having a 12 week break from employment, it was during this time ET's daughter was able to spend more time with her mum and it became apparent quite quickly that ET was needing more support than she was being given.

6.8 Consideration was given to whether ET could go to a day centre, the family sought lots of advice independently from Age UK.

6.9 The family found it challenging to manage ET's personal care because she had developed a fear of the shower and water falling on her, it was especially difficult washing her hair.

6.10 Around the beginning of June 2021, the family noticed that ET's physical health started to decline quite quickly, medical attention was sought through her GP, bloods were taken, then the following week she went 'off her legs' and she couldn't move off her chair. ET's niece came and managed to get her upstairs. ET then started to stay in her bedroom where she felt safe. Over time, ET was becoming a very anxious person living with her condition. This was the point VY contact Adult Social Care for some additional support.

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6.11 It was around this time that VY had found new employment, they contacted Adult Social Care with 3 weeks' notice before VY needed to return to work and request an assessment with a view of getting some formal support in place to enable ET to remain in her own home, they were requesting 4x visits per day. VY's start date for her new employment was given. VY advised that there was little communication from Adult Social Care, and she had to chase them to get updates. Despite several attempts the GP then sent an email to support the request for additional support.

6.12 VY advised that Adult Social Care couldn't commission a support package, so the family were offered emergency respite.

6.13 It was felt by professionals and the family that ET's needs could be managed at home, the emergency respite was only commissioned due to a lack of availability in the care market. The respite should have only been for 2 weeks and then ET would return home with a package of support.

6.14 Sadly, ET was never able to return home.

6.15 ET moved into the residential care home on 24/07/2021. The family were unable to visit ET as often as they would have liked, this was due to the restrictions on face-to-face visits that were in place at the time due to the pandemic. However, it was acknowledged by the family that they were allowed window visits and arrangements were made for them to stay with ET when she was at the end of her life.

6.16 Family rang on the day she went into the residential care home to check how ET was and the feedback from the care staff is that ET was fine and settled.

6.17 On the morning of the 25/07/2021 – Family were contacted to be told that ET had an unwitnessed fall, it was believed that she had fallen out of bed, an ambulance was called but it took 6 hrs to arrive.

6.18 The ambulance arrived at 4.15pm, took her to the local hospital. ET was described as being in 'agony'. VY went to Accident and Emergency Department and ended up staying with her, the hospital environment was described as chaotic there was no private rooms and at one point, VY had to hold a drip due to the lack of stands in the department.

6.19 VY started her new employment on Monday 26/07/2021 which is the same day that ET had her hip surgery.

6.20 Family advised from the medics in hospital that ET didn't really engage with therapy and wasn't eating very well. At that stage ET wasn't really talking much but could express her needs.

6.21 ET had a catheter put in and this remained in until she died.

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6.22 The Discharge 2 Assess (D2A)[3] process was implemented and they were arranging for ET to have rehabilitation in a community setting with the long-term plan being for ET to return home with equipment and support.

6.23 ET was discharged from hospital on 14/08/2021, she returned to the residential care home with the plan for ET to have therapeutic support through Intermediate Care Services.

6.24 At the time of discharge, only one family member could visit ET in the care home. When family visited, family supported ET with her meals because her appetite had reduced and ET needed support and encouragement with her nutritional and fluid intake. Family would also sit with her and look at her memory book because this was a way to engage her in a conversation, as the book often prompted memories from the past. She also loved Tom Jones and reacted well to music.

6.25 VY or any other family members didn't really feel they were involved in the discharge planning. VY advised she was contacted by the discharge co-ordinator who explained that ET needed to be discharged to a 24-hour setting to enable further rehabilitation, the family were asked if they had a preference. VY explained it was during this conversation that VY mentioned that ET had come from a care home, it was at that point she felt the conversation was focused on getting her back there rather than exploring in greater detail identifying a home that could meet her needs and provide the best possible post-surgery care. VY said that she just wanted her mum to have the best care and somewhere that could meet her needs.

6.26 ET was discharged back to the residential care home on 14th August 2021 with a view to therapy services going in to her with post op care for the hip surgery and provide some therapeutic rehabilitation.

6.27 From 14/08/2021, ET needed to have 2 weeks isolation, which was the covid measures that were in place at the time which resulted in the family only being able to have window visits.

6.28 Following discharge, the family had no contact from the therapists and the family were concerned that ET would lose any motivation to get back on her feet.

7. Key episodes which have been considered during the review

7.1 The reason for admission into 24-hour care

7.1.1 ET had a formal diagnosis of dementia and despite ET managing well over the years, in 2021, the family notice a declined in ET's cognitive functioning and recognised that more formal support was needed. In June 2021, ET's family contacted Adult Social Care for a social care assessment with a view to requesting support to be in place by end of July 2021 to enable VY to start her new employment.

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7.1.2 Family initially contact Adult Social Care to request an assessment some time in June 2021, the electronic records have been reviewed and due to the change of system and information being migrated across its unclear of the exact date when the initial referral was made.

7.1.3 The social care assessment was completed over the telephone on 06/07/2021, the outcome from the assessment is that a formal care package was required to enable VY to return to work and ET had the support at home. It's not clear from the information provided from Adult Social Care whether VY was offered a carer assessment. However, the needs of the carer have been taken into account within the social care assessment which would have been determined as a 'joint assessment'.

7.1.4 It was felt by professionals and family that ET's needs could be managed at home, unfortunately due to a lack of availability in the care market, towards the end of July 2021 when VY was returning to work there was still no support in place so emergency respite was offered.

7.1.5 Adult Social Care advised that the support plan was sent to a number of agencies on several occasions, which is the expected practice but unfortunately an agency could not be secured due to challenges at the time with staffing capacity, sickness and recruitment. These challenges faced were related to the ongoing difficulties caused by the Covid-19 pandemic.

7.1.6 For the purpose of the review, at this time the United Kingdom was leaving a further period of 'lockdown' and the four-step plan, known as the roadmap out of lockdown, intended to "cautiously but irreversibly" ease lockdown restrictions. Instead of a return to the tiered system, the Government said it planned to lift restrictions in all areas at the same time, as the level of infection was broadly similar across England.

7.1.7 Adult Social Care has been approached to seek assurance that all options were explored before 24 hour care was considered. Adult Social Care explained that the demand and capacity within the home care market can fluctuate on a daily basis. There can be pressures in specific areas of the city which can affect the ability to source homecare in a timely way. Since the pandemic the market management team have seen the number of packages of care reduce significantly but recognised the pandemic did cause a lot of issues with staff sickness and there are still problems with recruiting and retaining staff which can also cause delays to commissioning support.

7.1.8 Adult Social Care have established a care finding list to try to deal with any issues that may be affecting a home care provider picking up which has helped.

7.1.9 It appears from feedback from family and the review of the electronic records that there was minimal communication between Adult Social Care and ET's family and the family often had to chase to get updates. **(SSAB to seek assurance from Adult**

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Social Care on what learning has taken place since this review regarding ensuring family are kept up to date and informed)

7.1.10 Respite was discussed with family, no formal capacity assessment appears to have been completed to determine whether ET had capacity to consent or to consider her wishes and feelings. It doesn't appear there was any face to face or telephone discussion with ET, all communication went through her daughter. (It was noted that VY and granddaughter did have Lasting Power of Attorney but there was no evidence on the electronic records that this had been requested to confirm the legal status of the documentation)

7.1.11 It has been noted in the Adult Social Care support plan regarding mental capacity that it's been 'assumed that ET had capacity however it's not been formally assessed'. Considering the principles of Making Safeguarding Personal and considering capacity is decision specific, it is unclear and cannot be evidenced how ET's wishes and feelings were considered? **(SSAB to seek assurance from Adult Social Care)**

7.1.12 ET moved into the residential care home on 24/07/2021 for a 2 weeks respite stay whilst care in the community could be commissioned.

7.2 Unwitnessed fall in the Care Home

7.2.1 Within 24 hours of admission into the care home (25/07/2021), ET had an unwitnessed fall and was found to be in pain and was non weight bearing, it was suggested that she fell out of bed. Medical attention was sought (**expected practice**) and 999 was called at 09:44 hrs to request an ambulance.

7.2.2 The review was advised that it took 6 hours for the ambulance to arrive to provide care and treatment to ET.

7.2.3 Further information has been provided by North West Ambulance Service (NWAS) who advised a call was made, the call handler was advised that ET had an un-witnessed fall approx. 10 minutes prior. ET had got herself back into bed but was complaining of pain to her hip. She was awake, breathing and alert at the time of the call and there was no bleeding.

7.2.4 The carer making the call, was advised by the call handler that NWAS was incredibly busy and will send an ambulance as soon as possible but with the current demand it could take up to 7.5 hrs. Carers were advised to return the call if ET's health condition changed.

7.2.5 ET remained in bed, with care staff checking on her between 30-45 mins, personal care was provided, food and fluids were offered throughout the day. However it was acknowledged that ET was complaining of pain.

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7.2.6 The ambulance crew arrived at the care home at 15:49 hrs. ET was assessed, pain relief given and she was transported to the local Accident and Emergency Department.

7.2.7 On arrival, standard observations were completed on ET and it was apparent that she was experiencing pain and struggling to move her left leg.

7.2.8 The care home contacted the family so they were made aware of the fall and also when ET was leaving the home to be taken to hospital.

7.2.9 The review acknowledges that the length of time ET was waiting for an ambulance was lengthy but this is a national concern due to a number of factors including increase demand, poor patient flow within the health system, lack of social care capacity which means its taking longer for patients to be discharged from hospital which is impacting on the bed capacity within the hospital which then results in ambulances having to wait outside hospital.

7.2.10 On admission to Salford Royal Hospital, it was confirmed that ET had a left fracture to the neck of femur.

7.3 Hospital admission/discharge

7.3.1 On admission (25/07/2021), the assessment and care plan reflected that ET was previously independently mobile and often went for short walks but on admission to the Orthopaedic Ward, she was suffering hypoactive delirium on background of the dementia and required a catheter due to being in urinary retention.

7.3.2 ET remained in hospital until 14/08/2021.

7.3.3 ET was discharged fully hoisted and with a catheter. ET was being discharge back to the care home.

7.3.4 On the ward, the Deprivation of Liberty Safeguards [5] were implemented. An authorisation was put in place at time of the admission. It was noted on the hospital records that daughter and niece had power of attorney for health/wellbeing and finances. There appear to be regular discussion held with family regarding planning for the future. Family also agreed with the suggestion that a DNAR should be put in place.

7.3.5 Feedback from family is that following the surgery where she had a partial hip replacement. The ward staff kept family informed of her progress and they were advised ET wasn't communicating or eating much. **(This is acknowledged to be expected/good practice).** The geriatrician told the family that following surgery this was quite common behaviour including having delirium. ET was allowed one visitor at that time due to the covid -19 restrictions that were in place.

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7.3.6 The Discharge 2 Assess Process was implemented. This is a process that was brought in at the start of the Covid 19 pandemic which aims to streamline and speed up the discharge process and reduce the risk of infections whilst people remained in hospital.

7.3.7 The process includes a Discharge Pathway Manager to complete an assessment document, liaise with family and co-ordinate the discharge.

7.3.8 At the time of the discharge, the care home manager was not able to visit ET on the ward due to the covid restrictions that were in place at the time. The care home received the document from the hospital, and the care home was reliant on the information provided on the Discharge 2 Assessment document to be a true reflection of ET's needs. Prior to the pandemic, the standard process would be for the care home to visit the adult on ward to ensure the provider could meets the person's needs. This enables the care home manager to assess the level of need and risks and consider the level of dependency of all the residents within the home.

7.3.9 The care home manager advised that in their opinion, the Discharge 2 Assess document suggested that her needs could have been met but when ET arrived back at the home her actual level of need was very different from what was presented in the documentation.

7.3.10 The care home manager at the time when ET was a resident there, advised the review that if she would have assessed her in person they would have advised that her needs could not have been met and recommended that nursing care was considered. It unclear from the information provided whether nursing care was considered by the ward staff.

7.3.11 The Discharge 2 Assessment document has been reviewed. Initially it was unclear to the reviewer about what aspect of ET's care wasn't assessed accurately other than being discharged from hospital with a catheter in situ.

The new care manager who has since reviewed the documentation has reported that there are differences between information provided on the Discharge 2 Assess Documentation and how ET presented when she returned to the care home, please chart below.

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Area of need on the Discharge 2 Assessment	Answer on the document (information provided by the Discharge Co-ordinator	Actual need on return to the care home (view of the care home manager)
Glasses	Nil	ET did wear glasses
Hearing Aids	Nil	ET wore two hearing aids wearing them on admission to the home
Toileting	Incontinent Urine – ticked Incontinent – Faeces – ticked and will sometimes request to use the toilet and stated doubly incontinent, wear pads and pants.	On admission ET could only communicate 'yes' or 'no'
Catheter	Left unanswered	Returned to care home and ET had been catheterised

7.3.12 The care home felt that ET was discharged back to them, she presented very differently and ET appeared to them 'like she had given up', which they thought was understandable due to the experience of the hip fracture and she was in low mood. The care home reported that ET wasn't engaging with daily activities anymore. Her communication had deteriorated since her first admission to basic 'yes' and 'no' answers. ET had poor intake for food and fluids and a problematic catheter requiring regular District Nurse visits.

7.3.13 At the time this review was completed many of the restrictions that were in place had now been lifted but assurance is needed from the local hospital to understand if the Discharge 2 Assess process was still in place and what assurance they can give that assessments undertaken are a true reflection of a person's needed to support safe discharges. (**SSAB to seek assurance)**

7.3.14 The family were contacted by the care home prior to discharge to ask whether they were comfortable in ET returning to their care despite the fall she had. The family discussed this and agreed that the Discharge 2 Assess co-ordinator would not suggest for ET to return to the care home if there were any concerns regarding her fall so the family agreed for ET to return.

7.3.15 Despite the family having contact with some professionals, they felt that were detached from the discharge process and this was due to all conversations regarding

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discharge planning taking place via telephone call and there wasn't an opportunity to sit together with professionals to get a multi-agency view to what care and support their mother needed. ET's daughter confirmed that she was contacted by the discharge co-ordinator and care home as mentioned but VY did feel that in respect of the discharge the moment VY mentioned ET had come from the care home, the focus was on ET going back there rather than where could best meet her needs.

7.3.16 ET was discharged back to the care home, she had to have a period of isolation which resulted in no family members being able to visit. Window visits were allowed and ET always smiled when she saw them. The family also recognised which carers ET had a good relationship with, due to her body language and how she interacted with them. **(This is being acknowledged as positive feedback from family)**

7.3.17 After returning to the care home, there was a slight improvement in her appetite and ET would try to communicate with family and the care staff but this was minimal.

7.3.18 There was no evidence during the review period that a referral to the Speech and Language Team was considered to support with communication needs. (**area of learning from the review)**

7.4 Therapeutic support/rehabilitation

7.4.1 When ET was discharged back to the residential care home, a programme of therapy was needed to give ET every opportunity to regain her mobility, there were referrals made to the falls clinic due to the initial incident **(this is being acknowledged as expected/good practice).**

7.4.2 Concerns have been raised by family that there was a delay in ET receiving therapeutic support, and then when ET was seen there was concerns raised that she was discharged from the service quickly which then resulted in ET being fully hoisted and impacted on her ability to return home.

7.4.3 From the multi-agency discussion, Northern Care Alliance (NCA) provided information and advised, prior to discharge on the 13/08/2021, the therapist on the ward who as working with ET made a referral to the community therapy team. There was no specific date stated on the referral to when ET had to be seen by but it was submitted as a priority.

7.4.4 The community therapy team triaged the referral on 17/08/2021 and ET was placed on the 'urgent' waiting list. Northern Care Alliance (NCA) advised that there were no suggestions of a delay in triaging the referral. ET was put on a waiting list among other patients.

7.4.5 The community therapy team booked the initial assessment to take place on the 26/08/21. During that visit two therapists visited ET to complete an assessment. ET

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was unable to follow instructions and required maximal assistance for all transfers. ET did not show any initiation moving lower limbs on the bed when asked. ET was unable to use a mini-lift as she did not seen to be able to engage in lower limbs upon standing and was anxious about using the stand aid equipment.

7.4.6 There appears to be some inconsistency with the information provided from the Northern Care Alliance (Salford) electronic records and the information provided by the family. During the visit to the family, they advised that on 23/08/2021, there had been no contact from the Therapist Team and both the family and the care home were chasing to when ET would have her initial assessment.

7.4.7 The family then reported on 27/08/2021, there has been no input from the therapist but from the electronic records it was advised that the assessment took place on 26/08/2021.

7.4.8 When the family spoke to the therapist, they were advised that the outcome from the assessment is that ET did not have any rehab potential as she was unable to follow instructions and she did not have any engagement of her lower limbs when attempting to stand. As a result, it was deemed that ET's new baseline was therefore a full body hoist.

7.4.9 ET's daughter expressed concerns that she felt her mother was being discharged too early from the service and she wasn't given enough opportunity to engage in the therapy. The therapist agreed to discuss her concerns with the Multi-Disciplinary Team (MDT) and if appropriate they would re-refer ET back to the service and assess with daughter present.

7.4.10 The information from the hospital supported that ET was not engaging with the therapy sessions, despite the further offer and attempts made by referring to the community team to re-assess on discharge.

7.4.11 The MDT meeting was held on the 01/09/2021 where ET was discussed. The outcome of the discussion was for ET to have a GP review and she would be placed back on the therapy waiting list. It was acknowledged that ET's daughter had concerns the delirium was impacting her ability to engage with therapy.

7.4.12 By the 08/09/2021 ET was medically optimised. The therapist explained to ET's daughter, ET would be re-assessed but considering the trauma ET had experienced this may impact on her ability to engage with therapy.

7.4.13 ET's daughter was given the offer to be present at the next assessment. The therapist involved was on annual leave, however arrangements were made to re-assess ET on the 10/09/2021.

7.4.14 ET had a medical review and was re-assessed on the 10/09/2021.

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7.4.15 ET was unable to stand on the 'molift' (the 'molift' is a piece of equipment which is designed to safely move a person from a sitting to standing position whilst maintaining the best possible ergonomic moving and handling conditions for the caregiver). ET had difficulty following instructions. ET was distracted whilst therapists demonstrated how to use the molift. ET managed to lift her bottom up from wheelchair on sit to stand without aids but was not able to repeat. ET appeared upset and anxious during session as she was leaning back in the chair and trying to hold onto the therapists and her daughter. ET's daughter asked for a home exercise programme to practice with her, the therapist agreed and prescribed some exercises although they were unsure if ET would be able to follow instructions to complete. The therapist informed ET's daughter, there would be a further review in approximately 2 weeks, however if ET does not engage/follow instructions she will have to be discharged from physiotherapy.

7.4.16 On the 24/09/2021, there was a telephone conversation with a staff member the care home and the therapist arranged an appointment for 30/09/2021 for ET to be reviewed. Care staff agreed to inform ET's daughter of the appointment and the date and time, when she visited over the weekend

7.4.17 The review took place as planned (30/09/2021), ET was unable to place feet on footplates and unable to follow instructions to complete sit to stand. ET started to become distressed and therefore therapy discontinued. It was advised from the therapist that ET was to remain hoist transferred by staff. The staff at the care home were made aware and happy to continue hoisting. ET was therefore discharged from community rehabilitation services (VY was present at this visit). Staff at the care home had been using the hoist prior to the review and the records did not indicate if the prescribed therapy programme which daughter was assisting with was consistently applied.

7.4.18 In respect of catheter care, ET was discharge from hospital back to the care home with the catheter, the health records suggested that the catheter was short term only. The care home raised concerns regarding the catheter being in situ and their ability to manage it. A specialised nursing assessment was requested because the care home felt that ET's care needs were too great for the care home and she needed to be in a nursing environment.

7.4.19 There was a number of occasions when the catheter became problematic due to ET not being able to pass urine and the catheter was blocked which required visits from the District Nurses.

7.4.20 The review has not been able to confirm from the care home records nor the District Nurse records, the date in which the nursing assessment was requested, however there is an entry seen in the care home records on the 29/09/2021 that states there was a telephone call from the District Nurse, asking whether ET's daughter wanted to be involved and present at the assessment. The care home contacted the

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daughter who confirmed that she would like to be present. The way in which the entry was written suggests that the referral for the nursing assessment had already been made. It has been confirmed that the nursing assessment was completed on 01/10/2021 which confirmed that ET met the criteria for nursing care.

7.4.21 Family started to look for placement, a nursing home was identified and arrangements were made for ET to move but she became too unwell to move and passed away in the residential care home on 07/10/2021.

7.5 Safeguarding

Sexual Assaults

7.5.1 On the 23/08/2021 – the care home reported an incident where ET was inappropriately touch by a male resident at the home. A safeguarding was raised to adult social care, family were informed and the incident was reported to the police. **(this is being acknowledged as expected/good practice)**

7.5.2 There was a further incident, 2nd sexual assault by the same male on the 17/09/2021, again the care home took appropriate action and reported it to Adult Social Care and the Police via the online reporting method **(this is being acknowledge as expected/good practice)** and contact was made with the family to advise them of the incident**.** Within the multi-agency discussion, it was recognised that reporting the incident online was the best way to report this incident and this should be encouraged as it is a proportionate and correct way to report an incident of this nature given that safeguarding measures had been put in place.

7.5.3 There has been concern raised how the second incident could have happened given that ET was already under increased monitoring, it has been suggested that the 2nd incident happened because the member of staff allocated to supervise ET was also asked to supervise another resident who needed to go to the smoking area. Whilst the carers eyes were averted away from ET, the male took the opportunity to act very quickly. The male was described as being very agile.

7.5.4 On reflection, there was an opportunity to consider whether ET needed 1-1 support, more so whilst risk assessment and protection plans were being arranged and implemented, however it was felt that this action would have only put a level of protection in for ET rather than all the female residents. Therefore it was felt more of a proportionate response for the male to have been given 1-1 support to reduce the risk of further incidents and a proportionate response that enabled all the residents in the home to have a level of protection. This was eventually arranged but it was felt that this could have been arranged earlier. (Sexual offending is not necessarily gender specific, it is about power and control and therefore should this say all residents. This may have left male residents at risk of being sexually assaulted.)

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7.5.5 The male was known to Community Mental Health Services and Adult Social Care contacted the relevant team on 03/09/2021 to request a review of the male and provide an assessment to consider his risks to all residents. The care home was requested to monitor the male at all times. Telecare equipment was put in place but the male was quite agile and he would often remove the sensor and equipment that was put in place to alert staff if he left his room.

7.5.6 It was towards the end of September 2021, that ET's family started to notice her mood was starting to change, and she wasn't really engaging with anyone including family. ET appeared sad and low in mood.

7.5.7 It was explored within the review process if ET's emotional health and wellbeing was considered following the 2 incidents which must have caused some distress to her. Adult Social Care advised that the police were contacted to see if there were any specialist victim support services but the social worker was informed that were no services available for people with dementia. **(this is being acknowledged as expected/good practice)**

7.5.8 The social worker asked the care staff to monitor ET and asked to report to the social worker should there be signs of distress or any changes in behaviour etc.

The social worker ensured that when she visited ET, if family wasn't present then ET was supported by one of the carers who she had a strong relationship with (ET's face would light up when particular carers attended to her) and tried to speak to her to ascertain how she was feeling. At this stage, ET's communication was restricted to non-verbal (ET often responded through her facial expressions etc). The care home informed the social worker they would accommodate any visits needed by her daughter and would keep her updated/informed. **(this is being acknowledged as expected/good practice)**

7.5.9 There has been no evidence presented to the review that non-verbal methods to communicate were considered or explored, including a referral to the Speech and Language Team for additional support with communication.

7.5.10 This aspect of the review highlights the importance of 'emotional wellbeing' being at the forefront of practice. ET should have only been in that care home for a couple of weeks but certain factors prevented her from being able to return home which included lack of capacity in the home care market and the unwitnessed fall. It was difficult to evidence throughout the scoping period what discussions were held with ET and/or family regarding her wishes and feeling, and whether she was happy to stay in the care home.

7.5.11 This reflects back to the well documented debate of 'risk v's happiness' with the comment quote, 'what good is it making someone safer if it merely makes them miserable' which is a quote from Judge Mumby (as he then was) in **Local Authority x v MM & Anor (No 1) (2007)**

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7.5.12 It's also unclear whether during the period of ET being in the care home, whether mental capacity was formally assessed at any stage regarding ET's ability to consent to being in the care home. There appeared to have been communication with family but limited communication directly with ET. It's not evidenced that if she lacked capacity whether there were any 'Best Interest' discussions/meetings to evidence decision making. (Any learning for Adult Social Care will be referenced in the SSAB action plan)

7.5.13 Following the 2nd sexual assault the male was given 28 days notice by the care home, however, this was met with some challenges due to the Covid-19 restrictions and the lack of capacity in specialised placements which resulted in the male not moving as quickly as it would have been expected given the nature of the concerns/risk that had been highlighted.

7.5.14 On 21/09/2021 - 1-1 support was commissioned to ensure the male was appropriately supervised.

Skin tear to the leg

7.5.15 On 05/10/2021, there was safeguarding concerns reported from the care home regarding an injury to ET which was a skin tear to her leg which needed hospital treatment. Family were informed of the incident but could not be provided with an explanation to how it had happened.

7.5.16 Care staff were suspended and the incident was reported to the police, a formal investigation followed but there were no charges made due to a lack of evidence. Both members of staff have been formally interviewed regarding ET's injury and how it could have been sustained, they maintained their accounts that they did not know the mechanism of the injury to ET and that as soon as they realised ET was injured, they carried out the correct procedure by alerting the manager. Following the interviews the care home manager confirmed that the correct procedure had been followed.

7.5.17 On reviewing the care home records, there was an accident form that recorded that on the morning of the 04/10/2021 whilst ET was being hoisted into wheelchair, the care staff noticed bleeding on right leg when putting her foot onto her footplates. First aid was given. There was a call made to District Nurses who put a bandage on and 999 was contacted. The care home manager and family were notified. ET was taken to hospital by ambulance for treatment. The incident was recorded in the daily notes. A safeguarding concern was submitted to report the unexplained injury.

7.5.18 It has been acknowledged by Northern Care Alliance that there was a missed opportunity to complete defensible documentation when there was a safeguarding concern about a serious wound that was sustained in a care home and the patient was discharged back there once the wound had been cleaned. (Defensible documentation means a document that not only clearly demonstrates the patient's

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story but also provides information that the service provided were medically necessary).

7.5.19 As a result Northern Care Alliance has ensured Emergency Department staff continue to report safeguarding concerns to the appropriate team. Staff have completed mandatory safeguarding adult and children training. Emergency Department has safeguarding link nurse teams to assist in cascading of key information to the rest of the team.

7.5.20 Following the discharge back to the home, it was noticed that ET had started to become unwell, medical attention was sought and it was confirmed that she was in heart failure.

Blocked catheter

7.5.21 ET was discharged from hospital with a catheter, the information provided by the hospital is that this should have been on a short-term basis but it remained in. The care home reported some challenges managing the catheter because it often blocked.

7.5.22 There was one occasion when it was reported to be blocked and it has been suggested there was a delay in the District Nurses attending.

7.5.23 Information provided by Northern Care Alliance, advised that the District Nurses received a phone call on the 01/10/2021 about a blocked catheter. District nurse gave advice over the phone. Following the advice being given, it appeared that the catheter started to drain into the leg bag.

7.5.24 District nurse gave further advice to the care home to monitor ET and if there were any concerns to return the call, the care home was provided with the contact numbers should any further concerns with the catheter arise. The catheter care plan was updated by the district nurse.

7.5.25 On the 02/10/2021, the district nurse visited ET at the care home. On arrival, the nurse was informed by the care home they had been reporting that the catheter had been blocked for the last 3 days. There is no record of this by the District Nurses, there was no recorded reports made to them about catheter being blocked until the 01/10/2021 and this was due to it bypassing. At the visit on the 02/10/2021, the district nurse changed the catheter.

7.5.26 The district nurse informed the care home she would report this back to the manager and it was discussed at safety huddle. **(this is being acknowledged as expected/good practice)**

7.5.27 Admin confirmed they received only one call about problems with the catheter which was on the 01/10/2021.

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7.5.28 The District Nurses were visiting ET in the care home following the hospital discharge to administer sub cut Tinzaparin which is expected practice after surgery. The last dose required was on the 30/08/21, no further visits were required. The district nurse service advised that from their electronic records there was no reports or complaints made about the catheter until the 01/10/2021.

7.5.29 District Nurses then received a further call on the 05/10/2021 due to reports of bypassing catheter again, on arrival the catheter was draining into the bag and pad/sheets were dry.

7.5.30 A further call was made on the 06/10/2021 regarding a bypassing catheter. District Nurse's visited, the catheter was checked and it was draining well and ET was dry, manager of care home was made aware.

7.5.31 The care home records have been reviewed and there is no evidence that the care staff have alerted the District Nurses prior to the call made on the 01/10/2021.

Management of the Section 42 – Safeguarding Enquiries.

7.5.32 Whilst ET was a resident in the care home there were a number of safeguarding concerns within a short period of time, this included two incidents of a sexual assault (August and Sept 2021) and skin tear to ET leg (Sept 2021).

7.5.33 At the time that the author of the report visited ET's family in April 2022, the family advised there had been no meetings held that they were aware of or been invited to regarding the safeguarding concerns so they were unaware of the outcome from the safeguarding enquiries.

7.5.34 Adult Social Care advised that the social worker was addressing the issues as they arose in real time but due to pressures and workload was delayed in finalising/writing up the safeguarding documents. The other contributing factor related to the transition and migration of electronic records in Adult Social Care. The change took place in August 2021. It appears that some dates that were put on the system were incorrect. The outcome meeting to the safeguarding enquiries has since been arranged for June 2022. **(SSAB to seek assurance).**

7.5.35 There has also been a sense that ET's voice may have been lost within the safeguarding process.

Deprivation of Liberty Safeguards

7.5.36 Article 5 of the Human Rights Act states that 'everyone has the right to liberty'. The Deprivation of Liberty Safeguards (DOLs) is the process and procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lack capacity to consent to their care and treatment in order to keep them safe.

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7.5.37 Due to ET being deemed to lack capacity, this legal framework should have been implemented.

7.5.38 In the information returned by single agency, the local hospital and the resident care home both made reference to having a required authorisation in place. However the information provided by the Local Authority Deprivation of Liberty (DOLS) Team that manages and undertake some of the required assessments to approve authorisation have no record of application from either the hospital or the resident care home being made.

7.5.39 As a result, the SSAB will seek assurance from individual agencies regarding the process that was followed to understand if this was an administration error. **(SSAB to take further action and seek assurance on individual agencies process and procedures)**

End of life Care

7.5.40 Following the confirmation on the visits from the medics on 07/10/2021 when the care home and ET's family were advised that she was in heart failure. ET was deemed to be at end of life. A prescription was written for end-of-life drugs. Arrangements were made for family to collect the drugs (07/10/2021 at 7.30am). Unfortunately, the prescription was incorrect and the drug could not be administered. This resulted in a new prescription being written but ET had passed away before they could have been administered.

7.5.41 Northern Care Alliance confirmed that the District Nurses received a call on the 07/10/2021 due to ET being observed to be in discomfort and the anticipatory medication had arrived at the care home which needed to be given subcutaneous fluid (Subcutaneous fluid administration is a method of infusing fluid to maintain adequate hydration when they are mildly or moderately dehydrated). District Nurses attended the care home at approximately 9.30am. However, there was a delay in ET receiving appropriate pain relief and end of life drugs because the prescription stated the medications were to be given orally and ET was pooling the medications in her mouth and was unable to tolerate oral medication due to decline in her physical health.

7.5.42 The District Nurses then contacted the Practice GP that covered the care home to request the prescription to be changed to administer the medications sub cut. Unfortunately ET had passed away before the medication could be administered. The error on the prescription possibly contributed to the delay. **(SSAB to seek assurance)**

7.5.43 Family said that ET's own GP was excellent **(positive feedback from family),** however a week before ET died her care was transferred to the GP practice that oversees the care home residents, they didn't feel their experience with that practice was as positive.

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7.5.44 The family GP had started to have discussions regarding planning for end-of-life care, but the family didn't realise it would be needed so quickly.

7.5.45 The family have advised the review that in the latter stages of ET's life (the Wednesday/Thursday before she died)), the care staff at the home were very compassionate and it became apparent that they cared deeply for ET. The care home accommodated the family to enable them to stay overnight so ET wasn't alone, the family said that this was very much appreciated and resulted in her family being with ET as she passed. **(This is being acknowledged as expected/good practice)**

8. Summary of the review using the Safeguarding Principles

Empowerment

8.1 Empowerment under the safeguarding principles focuses on ensuring people are supported and have the confidence in making their own decisions and giving informed consent.

8.2 It was clear throughout the review from the information provided by agencies and family that ET was very much loved by all who knew her, and she had a very supportive family that surrounded her.

8.3 From information provided by the family, ET's wish which was shared by the family is that she would have liked to continue to live in her own home, unfortunately due to the lack of capacity in the care market, the impact covid continued to have on social care and there wasn't any flexibility in the care offer within Salford, this was not an option for her and it was recognised by the review that she wasn't able to return home at the latter stages of her life.

8.4 Throughout the review it appeared that even though family were consulted there appeared to be a lack of evidence in the early stages that there was any consultation by professionals with ET to ensure her views, wishes and feeling were considered regarding what she would like to happen. The initial assessment was completed over the telephone and information appears to have been gathered through ET's daughter.

8.5 When the family initially contacted Adult Social Care for support, ET was assumed to have capacity so this would have been a good opportunity for professional to engage directly with ET with support being provided by family.

8.6 When concerns started to be raised regarding ET's health deteriorating which may have impacted her ability to make informed choices, it was appropriate at that stage for family to be consulted but it doesn't appear there was any formal capacity assessments undertaken to confirm that ET lacked mental capacity in being able to make informed choices regarding care and support.

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8.7 The review acknowledges that assessing mental capacity is time and decision specific, but regardless of a person's ability to make informed choices/decisions.

8.8 Having good communication with people who have a diagnosis of dementia is an important part of being able to live well. It helps people with dementia to keep a sense of self, sustain relationships and maintain their quality of life, more importantly it empowers them to be supported to have choice and control within their own life when so other elements of their life they won't have control of due to the condition they are living with.

8.9 Towards the latter stages of ET's life, she started to struggle to communicate and engage in conversation but this also highlights the important of exploring different method of communication including non-verbal.

8.10 Non-verbal communication may be especially important to enable adults to communicate their emotions and for ET accessing additional support from specialist services would have been beneficial.

Prevention

8.11 Following ET's move into residential care, she was extremely unfortunate because there were a number of different incidents that happened to her during the short stay which resulted in concerns being reported under safeguarding of the Care Act 2014 and section 42 enquiries being initiated and ET needed to be safeguarded. These included:

- An unwitnessed fall
- Two alleged sexual assaults by the same male resident (who also suffered from a cognitive impairment)
- Unexplained laceration to her leg which required medical attention.

8.12 In addition, there were also concerns that ET had a catheter which became problematic and an error with a prescription issue by the GP who visited the care home which resulted in end-of-life medications not being prescribed in time to offer ET support in the last stages of her life.

8.13 There is no evidence that any of these incidents were intentional but the review needs to acknowledge that it would have had a serious impact on ET; including her physical, emotional and psychological wellbeing as well as causing additional upset and distress to her family.

8.14 The residential care home acknowledged this with the family.

8.15 There is no evidence to suggest that the unwitnessed fall could have been prevented. It was apparent that the appropriate action was taken and medical attention was sought.

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8.16 However, it was unfortunate there was a delay of 6 hours for the ambulance to arrive, which resulted in the medical treatment that was required being delayed. The lack of capacity across this service has been widely reported nationally. The NHS England website (1st February 2023) have reported that a MAJOR national plan has been developed to help recover urgent and emergency care services, reduce waiting times, which will lead to improvement in patient care across the North West , with dedicated staff. This includes 800 new ambulances.

8.17 In respect of the safeguarding concerns relating to the male, its doesn't appear the first incident could have been prevented, however, once the care home became aware of the concerns, there has been suggestion that 1-1 supervision could have been arranged earlier. However, it is important to acknowledge that action was taken at the time to try and safeguard ET.

8.18 The review acknowledged the challenges with the catheter and also the end-of-life drugs and this will be areas of assurance the SSAB will be seeking from individual agencies.

Proportionality

8.19 This principle states that those responsible for safeguarding should provide the least intrusive response appropriate to the risk presented.

8.20 The relationship between attending to risk and promoting empowerment is raised frequently in literature, research and learning from Safeguarding Adult Reviews and it's a very difficult one to balance.

8.21 This is an area that requires exploring in greater detail and depending on the outcome may need strengthening to ensure that 24-hour care is not offered as a solution when the assessed outcome may not be available.

8.22 For ET, it was deemed through the social care assessment and information provided by family that a formal care package was required, this would have enabled her main carer to return to work and for ET to remain in her own home whilst ensuring all her daily needs could be met.

8.23 However, from the review there was no clear evidence from the multi-agency discussion and information provided whether any other options were explored such as direct payments. It appears that 24-hour respite care was offered and accepted by the family.

Protection

8.24 In relation to all the safeguarding concerns, all incidents were reported as expected and action was taken to try and safeguard ET but the review does need to acknowledge that due to the number of incidents within a short period of time, this started to have an impact of ET's general and emotional wellbeing, more so in the

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latter stages of her life when the family reported that she stopped trying to communicate and was presenting as being in low mood.

8.25 For reference only, the residential care home has been through the inspection framework since the scoping period of this review, the report has been published in 2022 and the overall rating has been deemed as good, including the domain of 'safe'.

Partnership

8.26 The partnership principle encourages collaboration between partners.

8.27 For ET, there appears to be many stages when she needed partners to come together but the feedback from family and also members of the review group was due to the pressures within the system relating to covid, this wasn't always possible.

8.28 ET's family has reported that they didn't feel involved in the discharge planning and felt at times they had to chase different agencies and professionals for updates.

8.29 Despite the number of safeguarding concerns that had been raised, there were no meetings held, either under safeguarding or the best interest framework. It was acknowledged from Adult Social Care that this was due to pressures within the system but action was taken in 'real time' to ensure ET was safeguarded. However, it doesn't always feel that this may have been communicated as well as it should have been with ET's family.

Accountability

8.30 Under the safeguarding principle everyone has a responsibility to keep others safe. All safeguarding concerns were reported and the relevant agencies were made aware of the incidents.

8.31 To conclude, Safeguarding Adult Reviews (SAR) are about learning and not blame or accountability, to ensure there is learning from the review the Salford Safeguarding Adult Board (SSAB) will be approaching the agencies involved to seek assurance on areas of reflection which will identify single and multi-agency learning.

8.32 On behalf of the Salford Safeguarding Adult Board (SSAB), I would like to take this opportunity to thank all the professionals involved in the review who have provided information and supported the review process.

8.33 I would also like to say thank you to ET's family for their contribution to this review and on behalf of the Salford Safeguarding Adult Board extend our condolences.

9. Author and Date discretionary review was completed

Jane Bowmer – Business Manager – Salford Safeguarding Adult Board
27/02/2023

1. Care Act 2014 – Section 44
2. SSAB Safeguarding Policy and Procedures – Criteria for Mandatory and Discretionary SARS
3. Quick Guide - Discharge to Assess –issued by NHS England supported by Department of Health and ADASS
4. Regulation 28 - Prevent Future Deaths
5. Deprivation of Liberty Safeguards (DoLS) at a glance | SCIE – this link provide an overview what Deprivation Liberty Safeguards