SALFORD COMMUNITY SAFETY PARTNERSHIP

&

SALFORD SAFEGUARDING ADULTS BOARD

LEARNING REVIEW IN THE CASE OF MARY

TIME PERIOD UNDER REVIEW JANUARY 2012 TO DECEMBER 2015

INDEPENDENT AUTHOR : MAUREEN NOBLE

1. INTRODUCTION AND BACKGROUND TO THE LEARNING REVIEW

1.1. Circumstances Leading to the Review

Mary was an 85 year old woman who died in hospital in December 2015. At 00.50 hours on 5th December 2015, Mary was taken to the Accident and Emergency department at her local hospital (Hospital 1). Information provided on the ambulance sheet states that Mary had called her friend requesting help on the evening of 4th December.

Paramedics had been called to Mary's home, by her friend, who was concerned for her. On arrival, paramedics found Mary to be in a poor physical condition. The condition of the immediate surroundings were also of concern.

Mary was admitted to Hospital 1 suffering from a number of serious medical symptoms and conditions. There was no indication of any physical injury to Mary that may have been sustained as a result of assault. There was no indication that any of her medical symptoms were as a result of an assault.

Mary was assessed as requiring specialist treatment and in line with clinical policy was referred to the Vascular Unit at Hospital 2 at 07.43 hours.

Hospital 2 assessed Mary as requiring surgery, however there were concerns that she would not survive surgery given her very poor physical state. Mary was described as being in a moribund condition. She sadly died at Hospital 2.

At post mortem Mary was found to have a number of serious medical conditions some of which were unknown to her or to her general practitioner before her death. The coroner recorded death as of natural causes.

1.2 Background

Mary lived at home alone although her son George lived nearby and appears to have spent a lot of time with Mary. *(George was invited to participate in the review but did not respond to a letter from the panel; it is therefore not clear how much time George spent with Mary or the extent of his role as a carer).* Mary and George owned their own properties and lived a short distance from each other.

George appears to have looked after Mary as she became older and increasingly infirm. George had not been formally identified or assessed as an informal carer and therefore the extent of his caring responsibilities is not known. As far as can be ascertained, he did not receive any financial benefits or allowances for any care he provided to Mary.

In 2012 Mary made a codicil to her Will preventing George from selling the property

without her consent (known as a Restriction in favour of Mary). The learning review panel made enquiries with the Land Registry in relation to both properties to confirm ownership. No reasons were recorded for the codicil made by Mary.

During the period under review, Mary experienced a deterioration in her physical health and appears to have been neglectful of her own needs. She also appears to have experienced episodes of confusion and anxiety which were witnessed by professionals through her contact with emergency services. On one occasion Mary told the emergency services that George had hit her; she later retracted this statement and said that he was a good son who looked after her.

Mary's episodes of confusion may have accounted for the way in which she sought help from emergency services when she felt anxious. Professionals from emergency services who came into contact with Mary sometimes witnessed Mary in a confused state and interpreted Mary's confusion and anxiety as 'dementia' however medical and social care professionals had no reason to doubt that Mary had mental capacity and she was deemed as being able to make decisions about her care and other needs as defined in the Care Act (2014).

Mary received primary care services from her General Practitioner with whom she appears to have had a good relationship. She also attended appointments for the treatment of medical conditions at a local hospital. Her attendance at hospital appointments was sporadic and there were a number of occasions on which Mary did not attend.

George accompanied Mary to a number of appointments with services and was present on a number of occasions when Mary presented to accident and emergency.

1.3 Reason for the undertaking the review

On the night that Mary was admitted to hospital, George was arrested on suspicion of allowing a vulnerable person to suffer serious physical harm which is contrary to section five 5 of the Domestic violence, crime and victims act 2004.

In line with national legislation, Police initially determined that the case met the criteria for conducting a Domestic Homicide Review (DHR). The case also met the criteria for a Safeguarding Adults Review, and in recognition of this, it was agreed that the Safeguarding Adults Board would contribute to the terms of reference for the review.

The DHR was later rescinded when the Crown Prosecution Service advised that there were no grounds for prosecution and the criminal investigation was closed. As the panel had identified learning in the review it was decided that a learning review report should be produced for the Community Safety Partnership Board and the Safeguarding Adults Board, it was agreed that there was no requirement to publish the report.

In November 2016 an inquest took place into Mary's death at which the Coroner found that Mary had died of natural causes.

1.4 Timeline for the Review

The panel agreed that events that took place between 2012 and the date of Mary's death were most relevant to the terms of reference of the review, and that this period of scrutiny would offer learning that could influence current practice.

1.5 Parallel Processes

1.5.1. A police investigation which included the commissioning of medical reports from expert sources began following George's arrest in December 2015. George was placed on police bail pending a decision from the Crown Prosecution Service in relation to charges.

In October 2016 the Crown Prosecution Service advised Greater Manchester police that there were no grounds to bring charges against George in relation to Mary's death.

1.5.2. Professional Standards Branch Investigation

Following Mary's death, Greater Manchester Police (GMP) made a referral to the Independent Police Complaints Commission (IPCC) due to police involvement in an incident that was reported to the police on 30th November 2015 as a concern for Mary's welfare. The IPCC subsequently returned the case to GMP for a local investigation by the Professional Standards Branch (PSB).

The investigation by the PSB focused on the police involvement in the incident reported on 30th November 2015.

There were no other parallel investigations or enquiries relating to Mary's death.

1.6 Family Involvement in the Review

The learning review panel notified Mary's daughter in writing that a learning review was taking place. There was no response to this communication.

Due to the criminal process, George was not invited to participate in the review until a final decision was made regarding possible charges. In November 2016 the Chair of the Review wrote to George to ask him to participate in the review however he did not respond to this invitation.

2. PURPOSE OF THE LEARNING REVIEW

The aim of the review is to understand how agencies worked with Mary and to learn lessons about whether services could be provided differently in the future to better support Mary (and George).

In line with the agreed terms of reference the review has focused on the following key issues:

- Non engagement/refusal of services
- Assessing mental capacity & working with fluctuating capacity
- Working with carers who do not engage with services or recognise themselves as a carer
- Partnership working and sharing information appropriately to manage risk

The initial scope for the review identified key themes underpinning the review as follows:

(i) Domestic Abuse

The review aimed to understand how agencies respond to domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions.

(ii) Self-neglect

Self-neglect is defined in the Care Act 2014 as covering 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings'

This review aims to understand to what extent Mary's self-neglect was an informed choice in which she was fully aware of all the consequences, and to explore how agencies could have worked together more effectively to engage and support both Mary and her son George as an informal carer.

Since this review was undertaken Salford Safeguarding Adults Board has issued a revised person-centred multi-agency self-neglect policy with tools to support in the assessment of self-neglect. The policy can be found on the SSAB website.

https://safeguardingadults.salford.gov.uk/for-professionals/multi-agency-policy-procedures-and-guidance/procedures/self-neglect/

2.1 Terms of Reference

The panel agreed terms of reference for the review which were amended following the decision to rescind the Domestic Homicide Review (DHR).

TOR 1:

To establish what was known by each agency about Mary's care needs and how these

needs were acted on.

TOR 2:

To establish what actions were taken to safeguard Mary and whether these were robust and effective. In particular, how well agencies worked together to recognise, identify and respond to issues of:

- Mary's physical health and deterioration
- Mary's mental capacity
- George's role as a carer for Mary
- Non engagement/refusal of services by Mary

TOR 3:

To establish whether Mary's reports of physical abuse by her son were acted on appropriately and whether any risks he may have posed to her were properly assessed.

TOR 4:

To establish whether agencies communicated and shared information appropriately.

2.2 Conduct of the review

A review panel was established and met on six occasions to oversee the review.

An independent author was appointed to oversee the review process and write the learning review report.

The panel received reports from agencies and dealt with all associated matters such as family engagement and liaison with the Coroner's Office. In addition the panel liaised with local police in relation to the criminal investigation that took place following George's arrest.

Two agencies from the independent sector attended panel meetings to advise on specifics aspects of the review; these were SIDASS (Salford Independent Domestic Advice and Support Service) and Age UK. A representative of the Safeguarding Adults Board was also invited to join the panel to ensure that the review was properly aligned to the adult safeguarding functions

2.3 Panel Membership

Role	**Agency**
Head of Service for Community Safety	Salford City Council

Named Nurse Adult Safeguarding	Salford Royal Hospital NHS Foundation trust
Matron/Named Nurse Adult Safeguarding	Central Manchester University Hospitals NHS Foundation Trust
Community Risk Manager	GM Fire and Rescue Service
Principal Policy Officer	Salford City Council
Staff Training & Development Manager	Age UK Salford.
Divisional Director of Social Care	Salford Royal NHS Foundation Trust
Lead Nurse, Safeguarding Adults	Hospital 3 NHS Foundation Trust
Detective Sergeant, Serious Case Review Unit	Greater Manchester Police
Manager	Salford Women's Aid
Business Manager Adult Safeguarding Board	Salford City Council
Designated Nurse Safeguarding Adults, Mental Capacity Act Lead and Prevent Lead	NHS Salford Clinical Commissioning Group
Head of Service (Care Act Implementation)	Salford Royal NHS Foundation Trust
Safeguarding Practice Manager	North West Ambulance Service NHS Trust
Head of Safeguarding, Adults and Children	Central Manchester University Hospitals NHS Foundation Trust
Lead Nurse, Safeguarding Adults	Hospital 3 NHS Foundation Trust

ICO Partner/Adult Services	Salford City Council

Individual Management Report authors attended a panel meeting to present and discuss their reports. There were no conflicts of interest recorded during the Review. Authors of Individual Management Reports and short reports had no direct involvement with the case and did not sit on the Review Panel other than in the case of the co-author of the GP report who was also a panel member. This was declared at panel meetings and presented no conflict of interest as the author is the Designated Nurse Safeguarding Adult's for the Clinical Commissioning Group (CCG).

2.4 Sources of Information to the Review

Following initial scoping for the review, the following agencies were identified as having had contact with the Mary and/or George.

Agencies that had significant, relevant and/or prolonged contact with Mary and/or George were asked to provide Individual Management Reports. Other agencies were asked to provide short reports.

Agency	**Role**
Adult Social Care	Offered support to Mary following contact from other agencies (this support was declined by Mary) Submitted a full IMR to the review
General Practitioner	Provided primary care services to Mary. George was registered with the same practice. Submitted a full IMR to the review

Greater Manchester Fire and Rescue Service (GMFRS)	Managed the Community Risk Intervention Team (CRIT)[1] who attended Mary's address on one occasion Submitted a short report to the review
Hospital 1	Provided A&E and outpatient services to Mary Submitted a full IMR to the review
Hospital 2	Provided end of life care to Mary Submitted a short report to the review
Hospital 3	Provided A&E services to Mary Attended a panel meeting
North West Ambulance Service	Provided emergency ambulance response services to Mary Submitted a full IMR to the review
Greater Manchester Police	Provided emergency response services to Mary Submitted a full IMR to the review

Each agency was asked to make single agency recommendations based on learning from the review. A summary of agency recommendations and action plans is provided at Appendix 1.

The learning review panel saw photographs of the home conditions in which Mary was living prior to her death. The panel decided not to view photographs of Mary's physical condition to respect her dignity in death.

[1] 1 https://www.manchesterfire.gov.uk/media/2258/crit_briefing_leaflet.pdf

The learning review panel made enquiries with the Land Registry Office regarding a change to Mary's will in respect of her property. The learning review panel viewed a copy of Mary's will and saw correspondence that Mary had with her daughter. The learning review panel also had access to witness statements made in the criminal investigation.

Police commissioned expert medical reports in relation to Mary's physical condition prior to her death. The learning review panel had sight of these reports in October 2016 following the CPS decision not to prosecute George in relation to Mary's death. Relevant extracts from these reports are included in this report.

3. CONTACT WITH AGENCIES DURING THE PERIOD UNDER REVIEW

Mary was a woman in her mid-eighties. She had a number of chronic medical conditions for which she received treatment from her GP and other specialist services within the local area and in a neighbouring borough. The review does not make comment on Mary's medical treatment for chronic and acute conditions but has noted that Mary did not always attend medical appointments and appears to have sometimes neglected her physical health.

Between January 2013 and November 2015, Mary made ten 999 calls to police and ambulance services. Each of these calls is referred to in this report. Not all of these calls relate to Mary's relationship with her son however they do indicate Mary's state of mind and her concerns about her wellbeing at the time she made the calls.

3.1 Contact with Agencies – Brief Chronology

3.1.1. Events in 2012

Mary made a codicil to her will restricting the sale of her property by George. This change was recorded in the Land Registry records although no reason is given for the codicil.

3.1.2. Events in 2013

On 26th January at 01.31 hours, Mary telephoned North West Ambulance Service (NWAS) via a 999 call. She said that she wasn't sure where she was and needed help. Paramedics attended Mary's home and took a history (via George) who said that she had been more confused than usual over the past few weeks but stated that the GP had not shown concern about this. Observations and some routine medical tests were conducted by paramedics and they advised George to see the GP regarding Mary's health.

On 2nd February at 02.00 hours Mary made a 999 call for an ambulance saying that she had symptoms of anxiety. She said that she had rung her GP after she had fallen and the GP had advised that Mary should call an ambulance (the GP was under the impression

that the fall had just occurred as Mary did not make it clear that she was referring to a fall that had happened six weeks ago).

The ambulance crew examined Mary and found her to be alert and responsive, she was also fully mobile. It was recorded by ambulance crew that Mary's family were present at the address and that she lived with her son. The paramedics noted that she appeared to be very anxious after having been told by her GP to call an ambulance. Paramedics checked Mary and advised that she contact her GP if she continued to be concerned; Mary was offered a referral to the 'falls' service but she refused this.

Fourteen days later on 16th February at 19.58 hours Mary rang 999 for an ambulance saying she had woken up feeling confused. She was able to state where she was and give her address. She presented to the ambulance crew as slightly confused (however the notes also state that she was alert and oriented). Mary complained of feeling nauseous. Paramedics noted a smell of urine and that Mary may be incontinent. There was no record that George was present at this contact. Mary was transported by ambulance to the Hospital 3 Accident and Emergency Department where she was seen by a doctor who noted that the episode of confusion had 'resolved' following which Mary left A&E.

On 2nd March at 07.55 hours Mary rang police via 999 to report that she had had an argument with George. She was apologetic about phoning the police; she said there had been no violence and never has been. George was noted by the call handler to be in the room with her. She then said that she was OK and did not need the police. The call handler noted that she sounded 'unnerved and vulnerable' but no specific questions were asked about vulnerability.

Police went out to see Mary immediately following the call to check on her welfare. George was present and spoke to the police officer in attendance. George said that he stayed with his mother 'more often than not'. George refused to disclose his home address to the officer. The officer spoke to Mary who said that her son would not get up out of bed. The officer noted that she was a little confused. The house was noted as being clean and comfortable. The officer concluded that both Mary and George would benefit from some support. A Protecting Vulnerable People (PVP) referral was made to Adult Social Care (ASC) with a risk rating of low.[2]

ASC received the referral and made contact with Mary two days later via a home visit. Mary was observed to be coherent and there were no issues observed in relation to capacity. She said that she was aware of the referral and said that she had spoken with other members of the family who were going to support her. The referral was recorded

[2] Annex D of the PPIU Handbook 2013, and a low risk classification was recorded, which is defined in the PPIU Handbook as: *"minor concerns, no offences, family may have additional needs, which may benefit from the support of other services."*

as requiring no further action by ASC.

On 30th April at 03.11 hours, Mary rang police to say that she had fallen on the floor and that she was shaken but not injured. Mary declined several offers by police to call an ambulance. George could be heard in the background shouting at Mary because she had woken him up to help her. A police officer was sent to Mary's home address at 03.28 and saw Mary, noting that she was safe and well and that an ambulance was not required. The officer noted that George was rude and had to be reminded that his mother could not help being confused. A 'concern for welfare notice[3]' was created and referred to ASC. A risk rating of low was applied by police.

ASC responded to the concern for welfare notice within two days. ASC contacted Mary however she was unwilling to undertake an assessment of need. Mary said that she wanted her son and other family members to provide all her care and did not want assessment or services from ASC. The SW noted this request and made a note to inform police for future reference which was done that same day.

Police noted that two referrals had taken place within a short time, that both had been followed up by ASC but that Mary would not accept assessment or services. It was also noted that the SW had suggested that if George required help with caring for Mary he could contact ASC and request a carer's assessment. However there is no record that George requested a carer's assessment by any agency.

On 16th May at 06.03 hours Mary rang NWAS to report that she was breathless, she said that George was with her. She gave a history that she was scared of falling and did not want to be alone. Mary was noted to be alert and anxious. George was heard to become verbally aggressive to Mary saying that there was nothing wrong with her. The ambulance crew felt that George was obstructing Mary receiving treatment. The ambulance crew called police at 06.30 to assist them as they were concerned about George's aggressive behaviour. A re-call was made at 06.36 as the paramedics decided that police assistance was no longer required.

Mary was taken by ambulance to Hospital 3 accompanied by George. She was seen by a doctor who felt the episode was due to a panic attack. Mary made no reference to any 'social concerns' or any concerns about her son. NWAS notified ASC of the incident.

That same day ASC received a notification of the incident from NWAS. The contact team at ASC received the contact and telephoned Hospital 3. They were informed that Mary had been discharged that morning at 09.00. Hospital 3 said Mary had no problems on arrival at hospital, that she was observed and discharged for her son to take her home.

The referral was discussed with a senior practitioner in ASC and it was agreed that two members of staff would visit Mary at home. The visit was assigned to the local SW team who visited that same day, however there was no one at the address and a neighbour

informed the SWs attending that Mary and George were not at home.

Later that day ASC conducted a second home visit. George refused entry to the home and said there was no need for the SW to enter. George told the SW that Mary 'becomes anxious and panics when she is alone' and that he cares for her. Whilst the SW was not permitted entry to the home, they did see Mary and George at the door. The SW knew Mary and George well and when interviewed expressed that at this point, they had no doubts about Mary's capacity or any concern that she was at risk from George. The SW suggested to George that he raise the issue of Mary's anxiety with the GP at the next appointment. The SW recorded that no further action was needed at this time.

On 19th July Mary had an appointment with her GP where they discussed a heart condition which could result in breathlessness. An EEG was arranged. In September Mary was seen in the Cardiac Clinic for EEG.

In the intervening period Mary had only routine contacts with medical services.

On 31st December Mary rang police at 01.57 hours; the call handler noted that she appeared to be confused and Mary said that she did not know where she was and was frightened and asked for a doctor. Police called for an ambulance and went out to Mary's address. When the ambulance crew arrived they were met by police leaving the premises. The police officer informed them that an ambulance was not required as Mary had called by accident due to 'dementia' and that George was caring for her. Police spoke to Mary and George who said that she had fallen asleep on the sofa and had awakened in a confused state, not realising that George was at home with her, hence she had called the police. Police noted that Mary was safe and well and apologetic about calling them. Later that morning police entered a concern for welfare and notified ASC of the incident.

ASC received the notification and noted it was the third notification received that year. The circumstances of the call and visit were noted and it was also noted that there was a possible onset of dementia. The police notification was rated low risk. The referral was discussed with the social worker and no further action (NFA) was agreed. A letter was sent to the GP but there was no record of this being received.

3.1.3. Events in 2014

On 3rd February 2014 the GP contacted ASC to request assessment for Mary saying that she 'cannot do things on her own' and had recently been ringing the surgery every-day.

ASC spoke to Mary on 7th February following the call from her GP. Mary said that she lived with her son and that he supported her. She said she did not want any assessment from ASC and refused to say anything further about her son. Mary ended the call by putting the phone down. ASC call back to speak to Mary but there was no response. ASC then wrote to Mary saying that she should contact them if she changed her mind.

Over the next few months Mary had routine contact with her GP and with other medical services in relation to her medical conditions.

In late May, Mary rang her GP to say that she could not cope at home and that she 'gets scared when her son goes out.' The GP suggested a social care (ASC) assessment to which Mary agreed. George could be heard in the background saying that she did not need one. One hour later Mary contacted the surgery to say she did not want an assessment as her son had come back and she was 'OK'. There was no further follow up to this contact as Mary had said that she did not want any help from ASC.

On 26th July Mary rang the police at 00.52 hours and spoke to a call handler who noted that Mary was confused. The caller handler noted hearing a male in the background and that Mary was distressed and shouting 'help me'. The call handler made this a Grade 1 response (emergency) which was then changed to a Grade 3 (routine) response following research of previous incidents.

At 01.08 hours on that same morning police received a second call from Mary. She sounded distressed and panicking and said that her son had hit her. This call was coded with a domestic incident code.

Due to a high volume of incidents on the local division the response to this call was delayed and police did not arrive at Mary's address until 09.57 that morning.

During the period between receiving the call and attending at Mary's address the response to the call was reviewed on ten occasions (including a service call at 04.13) however there continued to be a delay in the police response as there were no patrols available to attend the home address of Mary. This was due to a number of other grade 1 incidents that were ongoing on the division at that time.

At 04.13 police made a service call to Mary but no response was received. At 08.54 police made a service call to Mary who responded by saying that she had rung the police but did not know why, she said that her son had not hit her and that he was a great son.

Police did not visit Mary at home until 09.57 that morning. Mary was seen safe and well and the officer who spoke to her recorded that there was no domestic incident. Between July and November Mary had routine contact with medical services.

On 19th November the GP noted that Mary had telephoned the surgery the day before saying that she needed someone to talk to. The person taking the call (a member of the administrative team) offered to make a referral to ASC. Shortly afterwards a call then was received by the GP surgery from 'someone' with an abrupt tone (presumed to be George) saying social services are not needed, the phone cut off during the conversation. The GP rang back but there was no response. The GP then spoke to the Hospital 1 Safeguarding Team rather than the CCG safeguarding team to seek advice on whether there were any current safeguarding concerns. The safeguarding team advised that there were no

current concerns. The GP appropriately spoke with a Social Worker at ASC who said they would arrange a visit to Mary at home.

ASC assigned the referral to the local team for a home visit. ASC tried to telephone Mary at home but no reply was received. It was noted that George had previously refused entry to a Social Worker Following a brief discussion of the case at a Gold Standard Framework (GSF) meeting, a SW from ASC tried numerous times (on the same day – 10th December) to ring Mary at home and received no reply; SW attempted to ring the GP to give an update but could not get through to the surgery. Later that day SW called at Mary's home address but received no reply and left a note asking that Mary get in touch if any support was needed.

The SW then rang the GP to feed back that they had been unable to see Mary. On 23rd December an entry was recorded to discuss the case at the next Gold Standard Forum (GSF) meeting. This meeting took place on 30th December where it was fed back that it might be useful for the GP to raise with Mary at the GP's next visit (on 2nd February) whether she would like to see a social worker. It appears that the GP was not present at this meeting or any recorded minutes sent to the GP and there was therefore no follow up.

3.1.4. Events in 2015

Between January and June 2015, Mary had routine medical appointments relating to her ongoing medical conditions.

In early June 2015, a letter was received by the GP regarding Mary's consultation in cardiology advising that surgery may be required if there was further deterioration in the condition. George was present at this appointment.

Between June and November Mary had routine medical appointments relating to ongoing medical conditions.

On 30th November the GP rang police to report that they had a concern for the welfare of Mary. This was following a call to the GP from George at 10.00 saying that Mary was not well; George had been asked to re-call in 30 minutes and had not done so. The surgery tried to telephone George but the number was unobtainable.

The GP established that there was no one at Address 1 at 13.25 by asking a neighbour to check. The GP rang the safeguarding team at the CCG to discuss their concern. Police were notified and at 15.54 a police call handler rang the GP to clarify the nature of their concerns so that an appropriate response could be arranged. The call handler noted that an ambulance or Community Risk Intervention Team (CRIT)[4] might be best able to respond to the concerns rather than police.

At 16.18 hours that same day, the police tasked CRIT to attend Mary's home address to assess the situation regarding the GP's concerns. The team were mobilised to the address at 17.18hrs and arrived at the property at 17.30 hours.

George answered the door, he refused to allow entry for the team to speak with Mary and spoke with CRIT staff at the front door. It was noted that Mary could be heard in the background and staff assumed that Mary was safe and well in the living room. The CRIT Team advised George to ring the GP surgery and arrange a revisit. At no time did the CRIT Team actually see Mary.

CRIT gathered the GMP 1-8[3] details from George, updated GMP and cleared from the scene at 1800hrs. The CRIT informed the GP that they had called to the property and that they had spoken to George.

On 4th December at 22.48 police received a call from ambulance control that stating that a friend of Mary's had telephoned and stating that Mary required an ambulance. Mary had told the neighbour that her son had assaulted her and that he had refused to call an ambulance.

Two police officers were sent to Mary's home address and gained entry after initially receiving no reply. At 22.58 the Force Wide Incident Notice (FWIN) was updated with information that the ambulance had been cancelled and there had been no assault. However police reassessed the need for an ambulance based on Mary's presenting condition. At 23.10 hours, an ambulance was requested as Mary was seen to be in a poor state of health by paramedics. Mary was transported to Hospital 1 by ambulance. The ambulance crew made a safeguarding referral to ASC.

Mary arrived at Hospital 1 just after midnight where her medical needs were assessed. She spent around 7 hours at Hospital 1 and was then transferred to a specialist unit at Hospital 2.

George was arrested on 5th December 01.25 hours. The following day he was placed on bail pending further investigation.

On 6th December Mary sadly died at Hospital 2.

4. ANALYSIS OF AGENCY PRACTICE

4.1 Adult Social Care

ASC responded in a timely manner to referrals made by the police, NWAS and Mary's GP.

---

3 http://www.gmp.police.uk/content/WebAttachments/77E3BB34DF35BA6B80257D3500425E97/$File/domestic%20abuse%20policy%20and%20procedure%20-%20v0.16%20(june%202014).pdf

On each occasion that Mary was referred to ASC, staff made contact either by telephone or in person. On each occasion Mary declined support from ASC saying that she wished to be looked after by her son.

The Mary's case had very little social work involvement. Where referrals were made by other agencies, Mary was unwilling to engage. The case was deemed a relatively low profile with ASC based on the risk assessment and lack of take up of services.

ASC felt that Mary coped well with her vulnerabilities until a few days before the end of her life and that Mary's GP did not express persistent concern about these.

George was not previously known to ASC and they had little contact with him during the period under review, and his capacity as an informal carer for Mary was unknown.

An assessment of Mary's mental capacity was not made because she gave no reason to doubt her having capacity, this practice followed guidance in the Mental Capacity Act 2005

4.2 General Practice

Mary had a long history of contact with her GP mainly in relation to treatment and care for ongoing medical conditions and monitoring of a cardiac condition. The GP records show that Mary did not always attend for treatment and these occasion were sometimes followed up by the GP.

Mary's GP was aware of her home circumstances and made enquiries regarding her relationship with her son. It is recorded by the GP that Mary never expressed any cause for concern about the relationship, either in face to face or telephone contacts.

Within the GP records, there is reference to two occasions where Mary reported feelings of anxiety an two telephone conversations relating to medication.

GP1 stated that Mary had presented with feelings of anxiety since the death of her daughter in 2010. As a result of this GP1 felt confident to provide treatment appropriately via telephone consultations. GP1 had never heard Mary express concerns regarding George nor did she ever suggest that her anxiety was related to feelings of concern about George.

There is reference within adult social care records that GP1 referred Mary for a social care assessment on 7th February 2014. Although the electronic records confirm that a referral was made, the GP did not clearly record why this referral was made.

In May 2014, Mary had a telephone consultation with the GP where she said she was unable to cope and was scared when her son goes out. Mary agreed to a social care assessment at this time. An hour later, Mary contacted the GP practice to cancel this

request. It was not unusual for Mary to change her mind in this way and there was no reason for the GP to doubt Marys' mental capacity.

At this time, GP1 had no previous awareness of any concerning behaviour from George that may have raised safeguarding concerns. It should also be noted that the GP would not have had sight of any previous police welfare notices in respect of Mary at this time. During the consultation, Mary did not state that she was scared of her son.

Had information in the police welfare reports been available to the GP, this may have prompted a different response but this was not available nor would it of itself have suggested a different course of action.

A contact was made on 19th November 2014, when a locum GP received a call from Mary seeking support. During the telephone contact, it was recorded that 'someone with an abrupt tone' stated no help was required and cut the call off. Taking into account the similar incident in May 2014, the GP correctly followed the safeguarding procedure and contacted the safeguarding team for advice whilst placing a flag on the patient's record. The GP was advised by the Safeguarding Team to refer to ASC and did so appropriately.

ASC records show that following a Gold Standards Framework (GSF) meeting, and the difficulties accessing Mary by ASC due to her unwillingness to engage, a planned joint visit should have been arranged with the GP on 2nd February 2015.

There is no record that this appointment was arranged and no record with the GP that any appointment took place. It is unclear where the discussions to arrange an appointment were held, as there was no GP present at the GSF meeting on the date recorded, see minutes of the meeting.

The GSF meeting is not the appropriate forum for discussing concerns such as this but it appears that multi-agency staff, (prior to implementation of MDG meetings), would take the opportunity to discuss complex and/or difficult cases whilst the relevant expertise was available, which should be commended. Unfortunately, this results in a lack of appropriate recording of such discussions and subsequent decision making.

The final significant intervention from the GP practice was on 30th November 2015. It is apparent that contact was made by Mary to a member of reception staff at approximately 12.42 p.m. The call stated that Mary had swollen legs and black toes and requested a visit. This information was forwarded to the GP appropriately with a view to undertaking a home visit to Mary.

The GP attempted to visit Mary at approximately 13.25pm and was unable to gain access. They then made attempts to contact Mary by telephone at home but the number appeared to be disconnected. Although alternative numbers were not sought from the practice, the GP made additional attempts to gain contact by approaching a neighbour and posting a note through the door at Mary's home address.

Given their concerns, the GP acted accordingly and contacted the CCG Safeguarding Team for advice. The GP was advised to contact the police and request a police welfare check which was appropriate advice.

According to the records, George contacted GP3 after 17.00pm at the request of the CRIT Team. GP3 did not speak directly with Mary at this time as they understood she would have been seen by attending police officers (as expected practice by GP's at this time).

George informed GP3 that Mary was fine and did not require a home visit and that she would be reviewed in a planned appointment on the 18th December. It would appear on reflection, that GP3 lost sight of the initial reason for Mary requesting a home visit (black toes) and allowed himself to be reassured by the welfare check (he believed that Mary had actually been seen) and the reassurance offered by George. In hindsight, it is agreed that this was a missed opportunity to gain access to Mary on that day or the following day.

The GP practice demonstrated effective initiation of the Safeguarding policies and made contact with the safeguarding team for advice and support which was promptly given.

One of the Locum GPs did however make contact with the Hospital 1 safeguarding team rather than the CCG safeguarding team. However the advice that he received was appropriate. As a result this will be reviewed to ensure consistency of contacting the CCG safeguarding team in the first instance with the development of a GP resource file due for launch in July 2016.

The CCG has provided a single agency action plan with identified specific and measureable learning actions from the case.

4.3 GMFRS (CRIT)

Staff from the CRIT team[4] had only one contact with Mary. They were called by police to visit her at home following concern for her welfare expressed by her GP on 30th November 2015.

The CRIT team acted as a first response in many cases to low priority calls for assistance – calls where individuals had fallen in their home or required support for mental health issues.

The CRIT team worked closely with North West Ambulance Service and GMP.

The CRIT officers, were refused access to the property by George. They did not see Mary but recorded that they heard her speaking.

The CRIT officers administered a standard safety assessment tool (see earlier footnote) designed to ascertain whether Mary (and George) were safe and that there were no

[4] The Community Risk Intervention Team (CRIT) was a pilot project funded by Fire Transformation funding with a remit of providing support and advice to vulnerable persons in the community by carrying out a wide range of prevention activities

vulnerabilities or concerns.

George answered these questions on Mary's behalf and the officers took his answers at face value. They did not establish whether Mary was safe by seeing or speaking to her.

After leaving the property, CRIT officers notified Mary's GP that they had visited the property and that Mary was safe and well (they did not indicate that they had not seen Mary).

This was a missed opportunity to fully assess whether Mary was safe and to give her an opportunity to say whether she had any concerns about her safety.

4.4 Hospital 1

Mary had nine contacts with Hospital 1 relating to management of ongoing medical conditions which are not considered by the panel to be relevant to this review.

It is evident that Hospital 1 provided a good standard of care to Mary. The electronic patient records show that several appointments were not attended however Trust policy was followed and the General Practitioner was informed of these non-attendances. This is intended to ensure continuity of care and communication.

Mary's 10th contact took place when she attended Hospital 1 A&E Department by ambulance on 5th December 2015. Staff documented safeguarding concerns and noted that police and social workers were involved. Mary required specialist intervention and was transferred to Hospital 2 approximately 7 hours after admission to A&E. The electronic patient record does not indicate that there was any knowledge of domestic abuse and Mary did not disclose any information which could have been interpreted as a safeguarding concern. As a general rule, Safeguarding questions are asked within the Emergency Department (although these are not mandatory). When Mary attended the ED, the Safeguarding questions were not asked as the Electronic patient records indicate that Mary lacked capacity (it is not clear how this conclusion was formed). However staff were made aware that this attendance was as a result of a concern for welfare and that George, who was the documented next of kin, had been arrested.

Written documentation from Hospital 1, states that George attended with Mary at clinic appointments however the clinician confirmed that unless Mary had asked to be seen her own, then it is assumed that she wished for the relative to remain. There was also nothing in Mary's electronic records that would indicate she had any reduced capacity and it could therefore be assumed that she could consent to her care (however the presentation on 5th December does refer to Mary lacking capacity although it is not clear how this was assessed).

Analysis of the care provided by Hospital 1 does not appear to indicate whether any opportunity or change in practice would have highlighted safeguarding concerns.

Mary had several A&E presentations with panic and confusion which may have provided an opportunity for routine enquiry into domestic abuse. However, had routine enquiries taken place Hospital 1, there is a reliance on patient disclosure and if the patient declines to inform them of concerns (and has capacity) then any concerns remain invisible.

George was not known to Hospital 1.

4.5 Hospital 2

Mary had only one contact with Hospital 2. She was transferred to Hospital 3 from Hospital 1 on the morning of 5th December and remained on a ward in Hospital 3 where she died on 6th December. Hospital 2 administered appropriate end of life care to Mary.

George was not known to Hospital 2.

4.6 Hospital 3

Mary had two contacts with Hospital 3. The first of these contacts took place in February 2013 when Mary attended the A&E department by ambulance. At the time Mary was experiencing an episode of acute confusion. She was observed in A&E and the episode 'resolved' following which Mary was discharged to her home.

Mary's second contact with Hospital 3 was in March 2013 when Mary was brought to the A&E Department following an episode of breathlessness that had led to Mary become panicky. Mary had said that she was scared and didn't want to be on her own. She was accompanied by George.

A&E staff were informed by ambulance crew that George had been aggressive to Mary and had told her there was nothing wrong with her. On arrival at A&E, Mary appeared calm and was not in any distress. The Doctor who examined Mary felt that the breathlessness was due to a panic attack/anxiety and she was discharged home.

On the first presentation in February 2013, there is no record of the decision to discharge Mary, only that the acute confusion had resolved. This decision should have been supported by a more detailed entry into the patient record.

On the second presentation in March 2013, there is no record of any enquiry as to whether Mary was concerned about George's aggression or whether she was in fear of him or experiencing domestic abuse. Given the presenting circumstances and George's aggression this was a missed opportunity.

George was not known to Hospital 3.

4.7 North West Ambulance Service (NWAS)

NWAS had six contacts recorded for Mary. NWAS paramedics recorded that Mary was an anxious woman who, was described at times, as confused about what was happening to her but who could also be alert and orientated when speaking to the crew.

During the first contact with NWAS on 26th January 2013, George said Mary had become more confused over the past weeks but that the GP was not concerned.

Mary's second contact was on 2nd February when she called for an ambulance following advice from her GP. It was noted that she was very anxious however there is no indication that her anxiety was explored.

Mary was offered a falls referral but there is no exploration of the reasons why a falls referral was rejected by Mary. George is not mentioned in the record on that day. The IMR author has reflected that something appeared to be not quite right during this contact but that discussions between Mary and ambulance crew have been accepted at face value.

On 13th December 2013, a 999 call was responded to by the police following a call to them by Mary. The attending ambulance crew were told by police that they had checked Mary and the ambulance crew then cleared from the scene. Although the police said they had checked Mary, the attending crew should not have cleared from the scene. It is the crew's responsibility and expected practice to check for themselves on the welfare and medical condition of the person they are attending. The crew should have investigated further as there could have been a number of reasons for Mary's call to the police including non-medical reasons.

NWAS has provided a single agency action plan that identifies specific and measurable learning actions from the case.

4.8 Police

Prior to police contact with Mary and George on 4th December 2015, there was no suggestion from Mary that George had previously or was currently physically abusing her and Mary was not identified as at risk of domestic abuse.

Officers interviewed for the learning review said that Mary presented as a somewhat confused female with signs of the onset of a possible dementia type illness; in light of this she was identified by police as a vulnerable adult with some officers noting that Mary and George might need some level of support from other agencies and made appropriate referrals to ASC.

In relation to the three incidents reported in 2013, the police responded appropriately, following guidance set out in the PPIU Handbook 2013, identifying Mary as a vulnerable adult and closing each FWIN as a concern for a vulnerable person (coded G16). The necessary 1-8 write up was completed on each occasion in accordance with Annex D of the PPIU Handbook 2013 as a low risk classification (see footnote).

The response to the two calls made by Mary on 26th July 2014 did not meet acceptable standards. When Mary made these two calls she presented as a vulnerable adult, who

was both distressed and frightened; Mary told the police call handlers on a number of occasions that she wanted someone to *"help"* her. One of the callers made the first call an emergency response. However, the decision by the OCR supervisor to then downgrade this to a routine response did not recognise the concerns of the call taker.

The IMR author and the learning review panel believe that this FWIN should have either remained a grade 1 response, or, because Mary was not thought to be in immediate danger, been afforded a grade 2 priority response.

The officer who was monitoring FWINS on the sub-division, was quick to research the background to previous contacts. He identified a number of previous calls to Mary's home address, which then prompted him to endorse this FWIN with his findings. As a consequence, he made a request for Address1 to be visited *"sooner rather than later"* to ensure that all of Mary's *"needs are met and more importantly to establish if there is any evidence of any elder abuse".*[5]

The officer had provided good supervisory oversight at the outset; he had considered the previous incidents and had recognised Mary to be a vulnerable adult. His request to respond *"sooner rather than later"* was also a reflection of his desire to check on the on Mary's welfare given her vulnerability.

The second call made by Mary that same day at 01:08 hours, 16 minutes after her previous call, should have raised concerns. Although the officer had incorrectly recorded that George had *"hit"* his mother, FWIN 273 had been created as a domestic assault and given a grade 2 incident response. It would not have been unreasonable to assume that the second call by Mary was an escalation to the events that she had reported to the police a short time earlier; what should also have been of some concern is that the second call had ended abruptly when Mary had cleared the line.

When spoken to at 08:54 hours, and then again by the attending Response officer at 09:57 hours, Mary stated that she had not been assaulted and indicated that when she had made the earlier calls she was confused and disorientated; however, notwithstanding what she told the officers, the delayed police response to two calls made by a distressed and vulnerable adult was not in line with standards in these circumstances and did not follow the guidance provided in the GMP Incident

Response Policy 2011[6], which sets out the overarching objective to deliver a response to incidents, which meets the needs of the community, whilst identifying and mitigating risk and harm.

No referral was made to ASC in relation to the call on 26th July 2014 and this was a missed

5 https://www.nice.org.uk/guidance/PH50/documents/report-5-elder-abuse-2

6 http://www.gmp.police.uk/live/Nhoodv3.nsf/WebAttachments/0E66911B9286F90880257D34004A38F2/$File/incident%20response%20policy%20october%202011%20%20v1.0.pdf

opportunity to share information with ASC, which might have been of value to a further assessment by ASC, particularly given the comments recorded on the FWIN in relation to additional support, the vulnerability of Mary and the aggressive nature of George.

Following the events on 26th July 2014, the police had no direct contact with Mary and George until 4th December 2015, although they were notified of some concerns in relation to the welfare of Mary on 30th November 2015 when Mary's GP contacted police with a concern for welfare. On that occasion the police made contact with the CRIT at GMFRS who were deployed to Mary's home address as set out above.

When CRIT personnel made contact with the police control room following their attendance at Mary's home address, they did not highlight any concerns in relation to the safety of Mary and neither were any further concerns raised by the GP. At that time, police were not made aware that the CRIT personnel had not seen Mary and that they had been refused entry by George who had completed the concern for welfare 1-8 questions with the CRIT officers.

In assessing the police response to the call made by the GP, it is prudent to mention that whilst there was concern for the welfare of Mary, the GP did not suggest that Mary was in any immediate danger, which might account for his decision not to report his concerns to the police until some hours after George had called the surgery that morning. The police contacted CRIT who had been delivering prevention services for some time when a call out is classed as 'low priority'.

Due to Mary's physical condition when she was admitted to hospital on 4th December, it was not possible to ascertain from her whether she felt she was suffering from neglect and/or physical abuse. There were no injuries to suggest that Mary had been physically abused.

5. SUMMARY ANALYSIS AND LEARNING FROM THE REVIEW

Each agency who had contact with Mary provided a detailed a report of their involvement and demonstrated an understanding of her care needs and how they were acted on.

TOR 1: What was known by each agency about Mary's care needs and how these needs were acted on?

Mary was a vulnerable older person with chronic and acute health problems for which she received appropriate medical care.

Mary's medical care needs were responded to by her GP and by other services as set out above. Mary attended the Accident and Emergency Departments of two local hospitals; both of whom provided appropriate medical interventions to Mary.

At Mary's attendances to A&E Departments, she was brought in by ambulance crew. On a number of occasions, Mary was accompanied by George. These presentations were primarily responses to Mary having been confused or panicked sometimes not knowing where she was and being afraid of falling and afraid of being on her own

Although Mary was referred to ASC on several occasions as vulnerable person, and despite ASC acting on these referrals in a timely manner, Mary was unwilling to accept assessment or services from ASC saying that she preferred to allow her family (son) to care for her.

Mary was deemed to have mental capacity to make decisions about her care. This review has concluded that Mary did not fully respond to her own care needs (this is sometimes referred to as 'self-neglect')[7].

Where a person has mental capacity and does not properly look after themselves, agencies have no statutory powers to make the individual engage. In these circumstances agencies should work with carers to monitor any changes and attempt to encourage engagement. A recommendation is made in relation to mental capacity assessment.

TOR 2: What actions were taken to safeguard Mary and whether these were robust and effective? In particular, how well agencies worked together to recognise, identify and respond to issues of:

- **Mary's physical health and deterioration**
- **Mary's mental capacity**
- **George's role as a carer for Mary**
- **Non engagement/refusal of services by Mary**

See TOR1, Mary was monitored by her GP and had regular routine appointments. Mary was also referred to specialist services for medical conditions.

Mary's medical condition deteriorated in the latter months of her life. This deterioration appears to have been compounded by a lack of contact with services during the final three weeks of Mary's life.

Extract from Prof McCollum's Report

There is nothing to suggest that Mary's care at home was poor up until 3rd October 2015 when she was seen by her GP. Her weight was remarkably similar to that recorded in her GP notes in 2011: She was not suffering malnutrition. There is no doubt that her

[7] Self-neglect is recognised as the failure or unwillingness to provide oneself with the basic care needs required to maintain health. (Burnett et al, 2007a, p 36;emphasis added)

circumstances were entirely unacceptable when the Police and Ambulance Services gained access to her home on the evening of 5th December 2015.

Normally, ischaemia of the lower legs would cause severe pain. There is no suggestion in the notes that Mary was complaining of pain, but there is no evidence that she had direct contact with her GP or the medical staff at her GP Surgery at any time after 23rd October 2015. The notes do not suggest that she was suffering foot or leg pain at that time.

My impression is that Mary was reasonably lucid up until her terminal illness. There is no suggestion in the medical records up until 23rd October 2015 that she was in any way unhappy about the care arrangements at home. In May 2014 she did telephone her GP to say that she could not cope at home as she was scared when her son went out. She agreed to a social assessment and it does appear that her son discouraged this.

- Mental Capacity

Mary experienced episodes of confusion which were witnessed by George and recorded by professionals in police and NWAS to whom Mary made emergency calls. These calls appear to have been made primarily when Mary was confused or afraid.

Information on calls to these services is not routinely shared with medical services (this would be impractical) however consideration should be given to sharing information by emergency services when a high volume of calls may indicate deterioration in mental capacity.

There is no indication that any agency spoke to Mary (or George) about lack of engagement with services and the implications that this may have on Mary's health and well-being at the time and in the future.

There is no information to suggest that George lacked mental capacity.

- **George's role as a carer for Mary**

George provided care for Mary during the period under review, staying at their home on occasions and was involved in interactions with services. However the panel has not been able to ascertain whether George considered himself to be Mary's carer or the extent of his caring role.

There is also no indication that George asked for support in this context. A recommendation is made in this regard.

Mary appeared to call emergency services (NWAS and police) when she did not know what to do or who to contact i.e. when she was confused or anxious about a particular situation. On some occasions she was alone when she called these services and on other

occasions George was present.

Police responses to Mary's calls for assistance were dealt with in a timely, appropriate and sensitive manner. There was one occasion on which the response to an alleged incident of domestic abuse did not comply with police policy in that the response was downgraded and delayed.

On one occasion police referred the call out to the CRIT service. The panel considers the call to have met the criteria for referral to the CRIT service however it is the view of the panel that the practitioners who attended Mary's address should have exercised greater professional curiosity in relation to the Mary's safety rather than accepting George's account. A recommendation is made in this regard.

- **Non engagement/refusal of services by Mary**

Although Mary missed some medical appointments, for the most part she engaged with medical services and attended both routine and specialist appointments.

Extract from Prof McCollum's report to police says the following:

'I have also seen many elderly patients who are reluctant to be admitted to hospital or even to be seen by their doctors, despite clear evidence that they have severe medical problems. Under these circumstances, the elderly may make unreasonable demands on their relatives to provide care at home even when this care becomes grossly unacceptable. There is nothing in the medical records that clearly determines whether Mary was refusing to attend hospital and to accept medical care, or whether her son was unreasonably determined to provide her care even when her circumstances became grossly unacceptable.'

TOR 3: To establish whether Mary's reports of physical abuse by her son were acted on appropriately and whether any risks he may have posed to her were properly assessed.

Mary was not perceived or assessed to be a victim of abuse by any of the services with whom she had contact although the panel would wish to see greater professional curiosity being exercised in relation to the potential for elder abuse.

Mary's GP enquired about her relationship with her son (who was recorded as being Mary's carer). Mary gave no indication that she was in fear of her son or that she had experienced any form of abuse from him.

There was one occasion on which Mary told professionals that she had been assaulted by her son. Mary told a police call handler that George had hit her. When police attended her home address (6 hours after she first rang them to say that she had been assaulted) Mary retracted the allegation. Officers saw Mary safe and well and believed her retraction.

Agencies did not know of or suspect abuse other than the occasion where Mary told

police that George had hit her, therefore agencies did not conduct any domestic abuse assessments, referrals or interventions for Mary. The panel noted that on this occasion police did not conduct a DASH risk assessment with Mary as the officer concluded that there was no domestic abuse incident to record. On the evening that Mary was admitted to hospital prior to hear death, her friend provided information to police to say that Mary had told her that George had hit her. It was not possible to corroborate this allegation with Mary when she was admitted to hospital due to her deteriorating medical condition.

Information was appropriately shared with other agencies by police in relation to Mary's allegation and retraction.

Professionals who came into contact with George found him on occasion to be aggressive and frustrated with Mary. He challenged her when she rang emergency services for assistance and he was hostile to both police and ambulance staff. George also intervened on one occasion when Mary rang her GP for help saying that she did not require assistance.

There are records that staff from police services, CRIT, ASC, Hospital staff and General Practice advised George that he should seek help in caring for his mother. However there is no record of any formal assessment of George's needs as a carer or of Mary's care needs. As referred to earlier in this report, Mary refused assessment of her care needs by ASC.

George has not been known to the police since 1977 prior to his arrest in December 2015. George does not appear to have consulted any service regarding drug or alcohol misuse. George did not consult services regarding mental health issues.

6. FINDINGS AND RECOMMENDATIONS

The key findings and learning from this review have been grouped under thematic areas which link to the single and multi-agency recommendations emerging from the review. These are set out below:

6.1. Self-Neglect

Mary's physical deterioration was monitored and responded to by health agencies through routine appointments (GP and Cardio Vascular services) and when she was referred (e.g. Hospital 2). However, Mary appears to have sometimes been neglectful of her own needs and was not always co-operative with services.

Mary engaged with medical services in crisis situations and appeared to have responded well to planned and routine care. However she did not wish to engage with Social Care services and may have responded better to her GP with whom she appears to have formed a good relationship.

When police and ambulance services were called to Mary's home address by her neighbour on 4th December 2015, Mary was found to be in a very poor physical condition. Her home conditions were of concern indicating that Mary had been exposed to a lack of care and/or self-care for a period of time. It may be that Mary's underlying medical conditions contributed to a rapid deterioration in her physical condition; however this review should point out the extreme conditions in which Mary was found.

There were a number of indicators that Mary was unwilling to access services which may have indicated self-neglect. In relation to self-neglect versus a right to self-determination there is a matter of professional judgement/duty of care to be taken into consideration which should be guided by the following key principles:

- to keep a focus on person centred engagement and risk management
- to consider if the individual is more inclined to engage with some organisations than others. In this case Mary clearly was more inclined to engage with the GP than ASC
- The response needs to be proportionate to the level of risk to the person and others – in Mary's case the level of risk increased significantly before her admission to hospital prior to her death
- Multi-agency meetings are a helpful approach for more complex cases that are higher risk - these should be considered in cases where a single agency approach has been exhausted and a substantial risk still remains. Balancing choice, control, independence and wellbeing calls for sensitive and carefully considered decision-making.

Recommendation 1

The complex relationship between neglect, self-neglect should be the subject of ongoing joint work and training. The Safeguarding Adults Board should continue to develop clear guidance to professionals regarding the relationship between neglect and self-neglect and establish a pathway for identification and referral.

6.2 Risk Management and Risk Assessment

There was no formal risk assessment by any agency of the potential risks posed to Mary by George. On the one occasion that police attended a call out when Mary said that George had hit her, they were delayed by several hours. By the time they arrived the crisis had passed and Mary retracted the allegation of being hit by her son and said she had a good relationship with him. No DASH risk assessment was completed on this occasion.

George was perceived as acting in an uncaring way on some occasions by professionals and he was on more than one occasion aggressive and hostile to professionals. These situations were not perceived or assessed as risk factors in relation to safeguarding Mary.

There were some indicators of domestic abuse that fall within the wider definition of domestic abuse i.e. George may have exerted power and control over Mary in relation to her access to treatment and care services; on a number of occasions George showed hostility and aggression to Mary and on occasions she did say to professionals (and allegedly to her friend who contact the ambulance service on 4th December 2015) that she was afraid of George.

On the one occasion that Mary reported that George had hit her, she retracted this allegation and no further enquiries were made by police.

The importance of routine enquiry into the circumstances surrounding non-attendance where vulnerable/elderly patients regularly DNA planned appointments is highlighted as an area for further exploration.

There is no evidence to suggest that George was financially controlling or manipulating Mary. Mary did amend her will to prevent George from selling her property without her consent however no reason was entered onto the land registry record for this decision.

Recommendation 2

The CSP should be assured that professionals in all agencies have sufficient awareness and understanding of domestic abuse and elder abuse to enable them to make routine enquiries, accurate assessments and appropriate referrals. [8][9][10][11]

Recommendation 3

The CSP should ensure that all incidents assigned a Domestic Abuse code or responded to within the required timescale and that a CAADA DASH[13] risk assessment is conducted at the time of the incident. The CSP should also ensure that agencies acting on behalf of the police (in this case the CRIT) are fully conversant with the DASH risk assessment procedures and that cases are not closed without full assessment of risks (i.e. seeing the individual safe and well).

6.3 Mental Capacity Assessment

Mary was deemed to have mental capacity. Multi-agency understanding of mental

[8] https://www.nice.org.uk/guidance/ph50

[9] http://www.gmp.police.uk/content/WebAttachments/77E3BB34DF35BA6B80257D3500425E97/$File/domestic%20abuse%20policy%20and%20procedure%20-%20v0.16%20(june%202014).pdf

[10] http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/~/media/Files/CIRC/Clinical%20Priorities/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx

[11] http://www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

capacity needs clarification as some professionals attending emergency calls in the night, believed that Mary lacked capacity and that she was showing symptoms of a dementia type illness.

Recommendation 4

The Safeguarding Adults Board should be assured that multi-agency professionals understand and apply the guidance contained in the Mental Capacity Act 2005.

6.4 Multi-agency co-ordination and support for unregistered carers

It is not clear to what extent, if at all, George accepted a carer role for himself. Support for informal carers was not addressed in this case although agencies were aware that George was frustrated (and possibly angry) at his mother's deteriorating condition and being in the role of carer for her.

Multi-agency co-ordination was lacking in the case. A multi-agency meeting to discuss Mary's deteriorating physical condition and increasing reports of confusion and anxiety would have assisted in planning interventions for Mary and offering George support in looking after her.

The panel recognises that Mary may not have accepted the support and interventions offered to her but in itself this should not be a barrier to improved multi-agency co-ordination.

Recommendation 5

The Safeguarding Adults Board should be assured that there is clear guidance to professionals that enables the role of informal and unregistered carers to be recognised. This should include assurance that informal carers are offered support and encouragement to become a registered carer where appropriate.

The needs of carers should be recognised and responded to across all agencies and communication between practitioners should be supported.

Recommendation 6

The system for initiating multi-agency meetings to safeguarding vulnerable adults should be reviewed in light of the findings of this case and any improvements required should be reported to and acted upon by the Safeguarding Adults Board and other relevant strategic partnerships.

6.6 Record Keeping and Information Sharing

The significance and importance of accurate, concise and contemporaneous records

which appropriately reflect actions taken and requests including referrals is highlighted in this review. There is a specific issue around the requirement to obtain clarity in relation to ongoing reasons given for DNA appointments where the patient/client is elderly and vulnerable.

A welfare check should only be considered concluded when the individual concerned has been seen in person. This also highlights the significance of sharing key information in relation to changes in services/ procedures (For example, police welfare visit/ CRIT team intervention) with all partners across Salford to ensure all practitioners are informed/ aware. While the police have a legal right of access it does not appear that this also applies to the CRIT service.

Recommendation 7

The Safeguarding Adults Board and Community Safety Partnership should be assured that record keeping and systems for information sharing in relation to safeguarding vulnerable adults are fit for purpose.

6.7 Areas of Good Practice and Early Implementation

The issue of self-neglect is already being considered by Salford's Safeguarding Adult Board and as a result, training is being developed.

The actions taken by the GPs involved in this case demonstrate the effectiveness of safeguarding training received to date.

Such training should raise awareness around service users who repeatedly miss planned appointments and encourage information sharing between relevant agencies.