

Portsmouth Safeguarding Adults Board

Safeguarding Adults Review 'Mr F'

Executive Summary

1. Introduction

- 1.1. This is a summary of a Safeguarding Adults Review commissioned by Portsmouth Safeguarding Adults Board (PSAB) to understand the circumstances leading to the death of an individual, Mr F, an older man, who was receiving care, treatment, and support from health and social care organizations in Portsmouth. The Safeguarding Adults Review subgroup recommended to PSAB's Chair that the case met the criteria for a mandatory Safeguarding Adults Review because of concerns about the neglect he had experienced prior to his death and the effectiveness of agency involvement with Mr F and his family. Safeguarding Adults Boards are required by the Care Act 2014 to carry out a Safeguarding Adult Review when an adult at risk in their area has been seriously harmed or has died, and abuse or neglect is suspected, and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future.
- 1.2. A Review Panel was established, and an Independent Reviewer was commissioned to lead the process and to write the report. Terms of Reference for the review were agreed. Initial scoping chronologies were used to inform the Review, supplemented by additional information as required, with a Practitioner Event based on a 'Strengths, Weaknesses, Opportunities, Barriers' analysis. The methodology used focused on systems and how the different parts of it work together, rather than individual practice. It is not about blame but about learning from experience to protect vulnerable people in future. It is desirable in reviews to involve the family. Mr F's stepson and stepdaughter acted as his main carers and were invited by letter to participate in a way that suited them; however unfortunately no response was received.

- 1.3. This report is an executive summary produced by the SAR subgroup, based on the full report produced by the Independent Reviewer. The Board decided not to publish the full report to protect Mr F and his family's anonymity.
- 1.4. The Panel carried out its work between March 2021 and January 2022. The Final Report has been delayed by several months due to the impact of the pandemic.

2 Background to the Review

- 2.1. Mr F was an older man in his eighties who had a number of mental and physical health conditions, including dementia, depression, kidney and respiratory disease. Little is known about Mr F's earlier life, but he was described by visiting practitioners as a pleasant man who was happy to engage with services in general.
- 2.2. Mr F lived with his stepson, who was his main carer. Mr F was referred to Adult Social Care by his GP in September 2018, and following a hospital admission in November 2018 he was discharged with a package of care. He lacked insight into his needs and refused many aspects of care offered by practitioners. He reduced his care package and eventually cancelled it, putting him at significant risk of harm. Although he was considered to have mental capacity to make this decision, he was influenced by his stepson, and his mental capacity was doubted at times by professionals.
- 2.3. There were a number of concerns identified about the care provided by Mr F's stepson, including poor medication management, keys being removed from the key safe which caused practitioners difficulty in gaining access, and a lack of awareness of Mr F's poor health. Professionals also noted the stepson's misuse of substances.
- 2.4. In September 2019 Mr F was found in a poor condition by a visiting professional who called an ambulance. No action had been taken by his stepson. Mr F died in hospital 3 days later.

3 The Panel's discussion and analysis

3.1. The Review addressed the following key questions:

- How did professionals engage with Mr F and his family?
- Were expectations from agencies that family members would provide personal care reasonable?
- How effectively was Mr F's voice heard by professionals, and his views and wishes considered?

- How effectively were risks of harm to Mr F recognized and managed by professionals and how were the appropriate risk management/neglect tools used?
- How was the Mental Capacity Act applied?
- How effective was communication and multi-agency working?

4 Findings

4.1. This SAR has shown that practitioners worked hard to support Mr F in his chosen home situation. However, there were opportunities to improve practice or to intervene which were not taken. The following identifies the key areas and makes recommendations for improvement.

4.2. **Mental Capacity.** There was doubt about Mr F's capacity to make informed decisions which impacted significantly on his health and safety. This is a complex area, with changes to the law imminent. It is evident that front-line practitioners do not always have the awareness or the confidence to raise concerns about capacity, especially in situations where they perceive that this may risk their ongoing relationship and access to the individual. However, failure to assess mental capacity appropriately means that there is no clarity regarding the legal framework for interventions.

4.3. **Safeguarding Adults / Multi-Agency Risk Management Framework.** The concerns raised to the Multi Agency Safeguarding Hub about Mr F are likely to have met the threshold for further enquiries as set out in the Care Act 2014. This may not have prevented his death, but it may have resulted in a different care and support outcomes for Mr F. If it did not meet the threshold, the Multi Agency Risk Management Framework could have been used to manage risk more effectively and kept Mr F safe. The Framework was in place before the period under review, but practitioners were not fully aware of it or its benefits. It is considered that working within an appropriate multi-agency framework would give practitioners greater confidence in challenging the issues they identified and enabled a more robust approach to seeking solutions. In this case, input from the Police on Coercion and Control and Drugs Misuse would have been valuable, as would input from Domiciliary Care Agencies on daily events in the household.

4.4. **Financial Abuse.** It was suspected at the time that Mr F's care package may have been cancelled for financial reasons, increasing the risk of harm to him significantly. Further investigations could have been made to understand and address the situation. If this could not be done by negotiation, consideration could be given to setting up Lasting Power of Attorney for Finance, if Mr F was considered to have capacity, or an application to the Court of Protection if he did not.

Other options may also be available, such as writing off debt for financial contributions or applying for funding from other sources. It is understood that this is a sensitive area for many families and practitioners may not tackle it for fear of jeopardising a tenuous relationship. However, it is essential to Practitioners to explore the options to continue care. It could have made a difference to Mr F's comfort and wellbeing at the end of his life.

4.5. **Coercion and control.** Practitioners considered in hindsight that coercion and control were 'highly likely' to have been a factor in this case, resulting in the cancellation of Mr F's care and the subsequent increase in risk to him. The situation may not appear to have met the full legal definition for a criminal offence but discussion with the Police would have clarified this and assisted understanding about how to manage the situation.

4.6. **Advocacy.** Mr F was able to make his views known but his insight into his needs was declining due to dementia. It is also suspected that his carer was exerting a controlling influence over him. In this situation an independent advocate may have been able to help Mr F to understand the care options available to him.

4.7. **Information Sharing.** There is evidence of some good information sharing in this case, but practitioners identified that more could be done, especially regarding information about clients passed to Care Agencies by Adult Social Care when a service is commissioned. This may have avoided one agency giving notice and providing greater continuity.

5 Good practice identified

5.1. **Determination and persistence:** From the start of services, frontline staff engaged with this case and did their best to continue their contact with Mr F, despite numerous obstacles. This included Mr F's own resistance to care and treatment, his carers' lack of engagement or co-operation and frequent practical difficulties such as access to the property and resources in the home to keep Mr F clean and comfortable. They used their skills to negotiate with Mr F and referred to other services when necessary.

5.2. Some professionals were able to build a good relationship with Mr F and provided excellent support to him, especially during his final few days.

5.3. There was evidence that Primary Care worked well with Community Teams, involving a range of practitioners to assist with different aspects of Mr F's needs.

6 Recommendations

- 6.1 It is recommended that PSAB use the opportunity afforded by the launch of the new Mental Capacity Act/ Liberty Protection Safeguards in April 2022 to increase awareness and confidence in implementing the requirements of the law. It is also recommended that sources of expertise are readily available to practitioners involved in complex cases where individuals are at serious risk of harm.
- 6.2 It is recommended that PSAB expand training and awareness of the MARM to all partners so they can use it appropriately.
- 6.3 It is recommended that PSAB request partners to draw up simple guidance on financial abuse and misuse of funds together with information about the solutions available in different circumstances and how to action them.
- 6.4 It is recommended that PSAB ensure that practitioners can identify coercion and control or other potentially illegal activity which impacts on an individual at risk of harm and understands how to access expertise.
- 6.5 It is recommended that PSAB request that the Local Authority ensures that practitioners are informed about the advocacy services provided under the Care Act 2014 and the Mental Capacity Act 2005 and that they know how to refer appropriately.
- 6.6 It is recommended that the PSAB request that Adult Social Care review the client information given to a Care Agency when they are commissioning to ensure all essential information is passed on.