Safeguarding Adults Review

SAR Case F 2022

'Godavari'

Background

Godavari was an elderly lady of Asian origin, Hindu, whose first language was Gujarati.

She lived with her two daughters. One was described as the main carer, and the other has her own care needs related to her mental health.

Godavari had physical health problems and care was provided:

- Physical Health – Arthritis, knee replacement, previous hip fracture, incontinent, poor skin integrity (pressure sores) and unable to weight bear.
- Care provided – all care provided on bed. Support with personal care, continence care, repositioning, skin integrity, meals, and drinks
- Equipment – walking frame, wheelchair, profiling bed, airflow mattress, echo move system, commode and stairlift.

Agencies identified as having contact with Godavari

- GP
- Community Physiotherapist and Community Nurses, Leicestershire Partnership NHS Trust (LPT)
- East Midlands Ambulance Service (EMAS)
- Leicestershire Police
- University Hospitals of Leicester (UHL).

Referral for Safeguarding Adults Review (SAR)

In mid-2022, Leicestershire Police notified Leicestershire Adults Social Care (ASC) of the recent passing of Godavari and requested information on any safeguarding concerns and support Leicestershire ASC provided. The contact generated a review of Godavari's ASC case records and established that the case met the criteria 2(a) for a Safeguarding Adults Review (SAR) referral.

The SAR referral was discussed at the Leicestershire & Rutland Safeguarding Adults Board Case Review Group (CRG). It was agreed that the case met the criteria for a SAR under Section 44.1-3 because:

- It involved an adult in the area with needs for care and support.
- There was reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.
- The adult had died.
- The Safeguarding Adults Board (SAB) suspected that the death resulted from neglect.

The decision of the CRG was to complete a SAR, using the Section 42 enquiry as the methodology to undertake the review.

Methodology

A Section 42 Enquiry[1], led by the Local Authority, was considered a proportionate method to identify single and multi-agency learning.

It was agreed that the Section 42 report would be presented to the Case Review Group and then, a Reflective Practice discussion would take place to identify actions for improvement.

Purpose of the Reflective Practice discussion

The purpose of the meeting was to develop the learning identified in the Section 42 Report (Appendix 1) and to develop any recommendations and actions.

Learning

As indicated in the Section 42 report, single agency actions have been undertaken.

Discussion in the Reflective Practice meeting highlighted the following:

Issue already being acknowledged by the Board as a priority
Application of the Mental Capacity Act (MCA) If there is doubt by professionals that a person has capacity, then an assessment should be done. There were missed opportunities in this case to do that which led to confusion between professionals and decision-making regarding hospital admission and Care and Support assessments.

[1] A section 42 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. This happens whether or not the authority is providing any care and support services to that adult.

Query how good are the capacity assessments that are done.

Consider action on the following		
Issue	**Action**	**By whom**
Mental Health Services involved with daughter. Leicestershire ASC and Community Health services involved with Godavari – no link between the services so the opportunity to consider the family dynamic was not identified. What is the lived experience for the mother and the two daughters?	Remind staff to check who is involved and make links	Leicestershire ASC and LPT Via the Safeguarding Matters publication
EMAS not involved in the Section 42 Enquiry East Midlands Ambulance Service (EMAS) not on the Case Review Group so concerns regarding the quality of capacity assessments and understanding of Safeguarding Thresholds need to be followed up	Set up meeting with EMAS Safeguarding link.	Leicestershire ASC and EMAS
Pressure Sores are a safeguarding issue. New guidance issued January 2024 is now available. https://www.gov.uk/government/publications/pressure-ulcers-how-to-safeguard-adults/safeguarding-adults-protocol-pressure-ulcers-and-raising-a-safeguarding-concern	New guidance from DOH – forwarded to the LLR SAB Procedures Subgroup Tissue Viability Team to do a presentation to ASC staff on pressure sores.	LLR SAB Procedures Subgroup Leicestershire ASC and LPT
Social Prescribers Social Prescribers are considered a very good service to link Health and Social Care and might have offered another way into the family	Seek clarity if this is available in all GP Practices and promote their use	LLR ICB
Referral routes Confusion at times regarding referral route for services e.g., referrals with regards to dehydration and pressure sores were made to ASC instead of	Flow chart/poster for staff:	Leicestershire ASC and Health representatives

Consider action on the following		
Issue	**Action**	**By whom**
raising these with the appropriate Health professionals. ASC made a continence referral to the GP, which could have been made directly to Single Point of Access (SPA) for the District Nurses to pick this up	• When to refer to GP • When to refer to ASC • When to refer to Community Nursing	

Messages for Safeguarding Matters / Safeguarding Matters Live
Opportunities should be taken to speak to the adult alone
Liaise with other workers to get the whole picture in the family
Refusal of services by a carer should raise concern
Familiarisation of Thresholds Guidance with particular focus on pressure sores and deteriorating health
Promote Social Prescribers
Article on Tissue Viability

APPENDIX 1

SECTION 42 ENQUIRY REPORT TO THE CASE REVIEW GROUP (CRG) REGARDING GODAVARI

On the directives of the CRG, a section 42 enquiry was completed following the passing of Godavari under the category of alleged neglect. Godavari was a lady in her early eighties, who according to Adult Social Care records from 2014, had Rheumatoid Arthritis for which she was in receipt of specialist services including regular hospital appointments and steroid injections.

Prior to her passing in mid-2022, Godavari lived at home with her two daughters Godavari was a carer for one of her daughters, until her health deteriorated to the point where she needed support herself. Her other daughter was described by all the professionals involved as the main carer for her sister and mother. Godavari's daughter was contacted as part of the section 42 enquiry, but she declined to take part.

Following the section 42 enquiry, the below is a summary of the findings.

What did the agencies involved do well?

Making referrals: Several referrals were made by the Community Psychiatrist Nurse (CPN) to Adult Social Care (ASC) to request for additional support for Godavari as she felt that this was needed despite Godavari's daughter's reluctance to accept support for her mother.

Whilst general practice did not have a lot of involvement with Godavari, it was, however, her last contact with the GP two months before her death, that flagged up the concerns regarding her daughter being unable to look after her and the subsequent referral made by the GP on that day to the ASC. It was this referral that led to a visit by ASC to see Godavari two days later. The GP present at the professionals' meeting, held in late 2022, was very keen to add that Health, particularly general practice, was very responsive with dealing with concerns raised at the time they were raised. All present at the meeting agreed that making timely referrals to the appropriate agencies was good practice, that Health did well to make the referrals as these led to visits.

Talking to each other: It was explained that the GP spoke with EMAS in about two weeks before the death regarding Godavari refusing to get out of bed. This was following a call from the District Nurses to EMAS because of their concerns about Godavari, which included that the oxygen saturation in her bloodstream was low and a query on whether she was dehydrated. It was added that Godavari refused the offer of a hospital admission at this time, and it was deemed that she had capacity to make this decision.

What did the agencies involved not do so well?

Liaising with each other: It was unanimously agreed that communication from ASC could have been better especially in terms of what was happening with the referrals made by the CPN. The CPN expressed at the professionals meeting, held as part of the section 42 enquiry, that she was pleasantly surprised that action was taken by ASC regarding her referrals, but she was only learning about this in the meeting.

ASC should have gone back to her to make her aware of the outcome of the referrals.

Mental Capacity Assessment: ASC questioned Godavari's capacity to make decisions regarding her care and support. They recorded that one was needed but this was not completed. Whilst EMAS stated that, in their view, Godavari had capacity to make the decision on whether to go into hospital or not, other professionals involved questioned her capacity to make this decision. The professionals that doubted Godavari's capacity to make decisions regarding her care should have completed capacity assessments for these decisions.

Whilst the GP noted that Godavari was not a lady with a known history of cognitive impairment or dementia, which could have flagged up a reason to doubt her capacity, in hindsight, they could have questioned her capacity in early July following her refusal to be admitted into hospital given that she passed away shortly after that. The GP added that they could have also gone out to see Godavari given her refusal to go to hospital, which would have given them the opportunity to gauge her capacity, but EMAS's assessment didn't sound worrying at the time.

Professional Curiosity: It was felt by all present that professional curiosity with regards to seeing Godavari on her own to ascertain her views with regards to her care would have been considered by all involved especially as her daughter was refusing to have ASC input.

Given that the daughter was accepting input from the CPN and the District Nurses, and most of Godavari's needs at this point were health related (looked dehydrated and had four pressure sores when she was admitted), the GP advised that, whilst they had discussions with EMAS and had no reasons to doubt their assessment as they have mutual respect for each other's clinical assessments, they could have called the family to double check if they needed support and could have spoken to Godavari. Again, realising that Godavari's first language was Gujarati, consideration for an interpreter could have been had.

No assessments. Care Act Assessments weren't done, so her needs weren't clear: As already mentioned, Godavari's capacity was doubted by ASC, but a capacity assessment was not completed regarding the decision for care and support. One of the professionals at the meeting advised that Godavari's daughter accepted a morning call on one of the visits but, as there was no assessment on the system to confirm this, it is difficult to know if this would have made a difference if implemented at the time of acceptance.

Inappropriate referrals: Referrals with regards to dehydration and pressure sores were made to ASC instead of raising these with the appropriate Health professionals. Rightly, the safeguarding concerns regarding allegations of neglect should have been made to ASC, but a follow up with Health colleagues regarding the actual health concerns should have been raised with the GP to start with. The GP present at the professionals meeting confirmed that these concerns should have also been raised with the GP surgery. On the other hand, ASC made a continence referral to the GP, which could have been made directly to Single Point of Access for the District Nurses to pick this up; or alternatively, the District Nurses could have picked this up themselves as they were involved at the time of the referral.

Communication: Communication amongst the agencies involved could have been better. ASC made a referral for a continence assessment to Single Point of Access as already stated but didn't share this information with the health colleagues involved, particularly the GP, who could have completed not only the continence referral, but a dietician referral given the concerns about Godavari's nutrition.

Improvements made since the section 42 enquiry.

-Professional online referral forms have been reviewed to make it easier for professionals to complete safeguarding referrals to ASC. Prior to the section 42 enquiry, there was a joint referral form for concerns for welfare and safeguarding concerns. There is now a safeguarding referral form clearly stating the safeguarding criteria and a link to the safeguarding thresholds included.

-ASC continues to have an urgent function where staff go out to see the person face to face to assess the immediate risk.

-All ASC staff involved with Godavari's case have had a reflective exercise regarding this case, and lessons have been learned going forward. For instance, staff have recognised that, whilst it is important to speak to family and friends, there is a high need to speak to the person involved directly, sometimes in the absence of family and friends.

-ASC is currently implementing the 3Cs model[2] where the plan going forward will be earlier allocation to a worker who will be the only person working with the individual requiring support. This will eliminate the need to pass cases or people to other teams or other workers.

-Recognising the need to know more about people's circumstances when they come into contact with the GP, the GP present at the professionals' meeting advised that they were going to look into how the Social Prescriber at their surgery gets more involvement with patients like Godavari, complete home visits if required so as to minimise the risk of this kind of situation happening again.

The GP added that Social Prescribers are so good at joining up Health and ASC as they are the right kind of people to investigate the fridge and cupboards asking why the person has not eaten, or why the Dossett Box[3] hasn't been opened, that their remit naturally crosses over the two agencies, which makes it possible for them to be able to identify people who have additional concerns.

The GP went on to state that the Social Prescriber at their surgery was brilliant, that he couldn't see that they were ever involved with Godavari, which perhaps, in hindsight, could have made a difference.

[2] https://www.trafford.gov.uk/about-your-council/strategies-plans-and-policies/docs/The-3Cs-model-and-Case-Studies.pdf
[3] Healthcare professionals support provided for patients to manage medications at home at end of life.