

OVERVIEW REPORT

MR G

Published: September 2017

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Please note: confidential information has been redacted from this version of the report for data protection reasons.

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1. INTRODUCTION

1.1 The principal people referred to in this report are:

Mr G White British

Male M White British

Female P White British

1.2 Summary

This case involves a White British adult male (Mr G) who was born in Hadfield and resided in Manchester. He suffered a brain injury due to hypoxia during a cardiac arrest in 2008 / 2009; this resulted in him requiring constant care and support.

1.3 Mr G moved in with his brother, Male M and Female P in their home in Kirklees on 16/12/2013; there had been no contact between the brothers for up to 20 years.

1.4 Male M and Female P have multiple convictions for various offences including Fraud, Theft, Assault, and Burglary; there are also many safeguarding and domestic violence records relating to them both on West Yorkshire Police's local system.

1.5 West Yorkshire Police and Kirklees Children's Services records show that Female P has had at least eight children removed from her care due to inappropriate partners, neglect issues, physical abuse, drug and alcohol misuse.

1.6 Mr G was referred to Kirklees Adult Social Care in December 2013; day care (25/6/14 – 7/11/14) and residential respite (5/10/14 – 12/10/14; 26/10/14 and 22/12/14 – 5/1/15) was provided.

1.7 Mr G absconded from Male M's home 16/2/14, and was sectioned under Section 2 of the Mental Health Act with a diagnosis of organic amnesic syndrome. Mr G was discharged to Male M's care on 7/3/14.

1.8 Mr G absconded from respite care 26/10/14 and was discharged to Male M's care

1.9 Social Care Assessment requested by GP 28/10/2014 and a safeguarding alert relating to a facial bruise was received from the day care service by Kirklees Adult Social Care 29/10/14.

1.10 Anonymous safeguarding alert received on 02/02/15 by Kirklees Adult Social Care, regarding care and treatment concerns of Mr G and a facial bruise.

- 1.11 Home visit by Kirklees Adult Social Care on 27/02/15; Mr G found to be cold and unwell; admitted to respite care. Admitted to Intensive Care Unit with septicaemia 28/02/15.
- 1.12 Mr G died 03/03/15; a forensic Post Mortem determined the primary cause of death to be peritonitis, and malnutrition as a secondary cause.
- 1.13 West Yorkshire Police commenced a criminal investigation following allegations that Mr G was unclean, had no social outlets, was systematically unfed causing gastric perforation secondary to chronic malnutrition.

2. ESTABLISHING THE SAFEGUARDING ADULTS REVIEW [SAR]

This case fits the criteria detailed in the West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures which were published April 2013 and cover the period explored in this report. New Policy and Procedures were published in April 2015 to coincide with the Care Act 2014.

Where practice gives rise to concerns about how agencies have worked together when the death or serious injury of an adult at risk has occurred, the local Safeguarding Adults Board will consider requests to conduct a Safeguarding Adult Review. The purpose of having a serious case review is neither to investigate nor to apportion blame.

The objectives include:

- Preparing or commissioning an overview which brings together and analyses the findings of the various agencies in order to make recommendations for future action
- Establishing whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk
- Reviewing the effectiveness of both multi-agency and individual agency procedures
- Informing and improving local inter-agency practice
- Improving practice by acting on learning and developing best practice

At the time covered by this review (pre Care Act 2014) an adult at risk was defined as a person aged 18 years or over:

“who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against harm or exploitation” (Department of Health, 2000, No Secrets).

This case meets one of the criteria for undertaking a Safeguarding Adult Review

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death.

There has been an on-going police investigation into the death of Mr G; therefore it was felt prudent to ensure that the review process would comply with the guidance for Safeguarding Adult Reviews and that for Domestic Homicide Reviews (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf).

2.1 Decision Making

- 2.1.1 An information gathering meeting was held on 17th March 2015 and chaired by the Local Authority Head of Social Work and Safeguarding. Present at the meeting were: CCG Designated Professional for Safeguarding Adults, Police, Children's Safeguarding, Adult Safeguarding, Adult Social Care, Representatives from the Day Care Service, and representatives from home.
- 2.1.2 Police and Coroner's investigations were proceeding.
- 2.1.3 Adult Social Care Support Management North and ASOT (Safeguarding Team) produced chronologies of events and meetings have been held with all staff involved.
- 2.1.4 All partner agencies agreed to consider lessons learned and corrective action to be taken.
- 2.1.5 To make a referral for learning lessons review to be considered.
- 2.1.6 The decision to undertake a Serious Case Review was taken on 14th May 2015 by the Kirklees Safeguarding Adults Review Sub-group which is a sub-group of the Kirklees Safeguarding Adults Board (KSAB) and includes representation from the NHS, West Yorkshire Police, Kirklees Council and West Yorkshire Fire & Rescue. The sub-group is responsible for making recommendations to the Independent Chair of the KSAB about commencing reviews, making arrangements for conducting the review and monitoring the effective implementation of recommendations and related action plans arising from the review process. The Chair of the KSAB ratified this decision also on 14th May 2015.
- 2.1.7 The panel also met on 15th July 2015, 7th October 2015, 4th November 2015, 9th December 2015, 11th January 2016 and 11th February 2016.

2.2 Safeguarding Adult Review Panel

- 2.2.1 Gill Poole was appointed as the Independent Chair and Author from 15th July 2015. She is an Independent Chair of a Safeguarding Adult Partnership Board in Hull, and has a background and qualifications as a Nurse, Health visitor and Senior Nurse for Child Protection.

The Panel comprised of:

- Clinical Commissioning Group - Designated Safeguarding Nurse,

- Kirklees Adult Social Care - Head of Safeguarding and Social Support
- Kirklees Commissioning & Health Partnerships – Safeguarding Adults Partnership Manager
- Kirklees Commissioning & Health Partnerships – Safeguarding Adults Deputy Partnerships Manager
- West Yorkshire Police - Safeguarding Unit
- West Yorkshire Fire & Rescue Service - Prevention Manager,

2.3 Agencies Submitting Individual Management Reviews (IMRs) or Chronologies

2.3.1 The following agencies submitted IMRs.

- West Yorkshire Police
- Kirklees Adult Social Care
- NHS England / CCG – General Practice

2.3.2 The following agencies submitted chronologies.

- Children's services – chronology about Mr G's brother and partner and their children from 25.11.86 – 15.04.15

2.3.3 The following agency submitted a report

- Day Care Service

2.4 Notifications and Involvement of Families

2.4.1 The involvement of the family was discussed and due to the on-going criminal investigation, Male M and Female P were not consulted.

2.4.2 Mr G's mother, sister and previous partners were not consulted as his life with them was outside of the timeframe under review.

2.5 Parallel Processes

2.5.1 A criminal Investigation by West Yorkshire Police.

2.5.2 Safeguarding Adult Review

2.5.3 Domestic Homicide Review (there was potential for this review to become a Domestic Homicide Review, see Section 7.1.4)

2.5.4 Coroner's inquest

2.5.5 Internal Management Processes

3. TERMS OF REFERENCE

3.1 The purpose of this SAR is to:

- Ensure that the review works within both Safeguarding Adult Review and Domestic Homicide Review processes
- Explore critical points in time where other actions might have resulted in different outcomes
- Ascertain if there are lessons to be learned about the way in which professionals worked in partnership to support Mr G and his family and to safeguard Mr G.
- Review the effectiveness of policy, procedures and systems for both multi-agency and single organisations
- Make SMART recommendations and to share learning
- Improve practice and develop evidence based practice
- Inform and improve local inter agency practice

3.2 Timeframe under Review

This review focuses on agency involvement for the period including 1st December 2013 to 3rd March 2015; through the examination of detailed chronologies and consideration of any critical points in time where other or additional actions might have resulted in different outcomes.

Records prior to this timescale were also reviewed and summaries produced of any significant incidents and information that may be relevant about Mr G or his family.

3.3 Case Specific Terms - INCLUDED IN TERM OF REFERENCE

4. METHODOLOGY

4.1 Agencies were asked for detailed chronologies for the period including 1st December 2013 to 3rd March 2015; and to consider any critical points in time where other or additional actions might have resulted in different outcomes.

4.2 Agencies were also required to review records prior to this timescale and provide a summary of any significant incidents and information that might be relevant about Mr G or his family.

4.3 The agencies included in these activities were:

West Yorkshire Police

Kirklees Council – Adult Social Care

NHS England Yorkshire and Humber commissioned a GP IMR

Kirklees Council – Children’s Services (chronology only)

Day Care Service (Management Report)

- 4.4 A staff briefing session was held after submission of the IMRs to discuss the chronology and explore critical points in time where other actions might have resulted in different outcomes. In addition to ascertain if there are lessons to be learned about the way in which professionals worked in partnership to support Mr G and his family and to safeguard Mr G.

5. **BACKGROUND: Mr G, Male M and Female P**

Note: The information in this section is drawn from the IMRs, and the report provided by the day care service attended by Mr G.

- 5.1 Mr G was a 49 year old man who until December 2013 was living in Manchester with his partner.
- 5.2 Mr G had relationships with three partners, he had two male children with the first, a male child with the second, and his last partner had a girl from a previous relationship. Mr G’s father died in September 2013, his stepmother resides in a residential / nursing home.
- 5.3 In March 2008, Mr G sustained a hypoxic brain injury as the consequence of an asystolic cardiac arrest, where his heart stopped beating. His brain was starved of oxygen and this resulted in short term memory problems and on-going disorientation.
- 5.4 Mr G’s then partner provided care following the cardiac arrest, until December 2013. Mr G was left outside his stepmother’s residential / nursing home, as his partner was no longer able to care.
- 5.5 His step- mother is 75 and was unable to care for Mr G, so he moved to live with his brother Male M and his partner Female P.
- 5.6 Male M and Female P were known to Kirklees Children’s Service and to West Yorkshire Police; the information included prison sentences, child protection plans due to neglect, domestic violence, removal of a considerable number of children, pets dying from starvation, amongst other serious concerns.
- 5.7 Mr G, Male M and Female P relationship:
- Mr G had not had any contact with his brother Male M for up to 20 years. Mr G had no knowledge or relationship with Female P until he moved in with them in December 2013.

6. THE FACTS BY AGENCY

6.1 Introduction

The five agencies who submitted IMRs and a management report are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 7.

6.2 West Yorkshire Police

- 6.2.1 Mr G was known to West Yorkshire Police in relation to two missing person reports, one concern for safety incident and the on-going investigation into the circumstances of his death.
- 6.2.2 Male M was known to West Yorkshire Police in relation to domestic violence, child protection and adult at risk incidents. He also has previous convictions for Assault, Theft, Burglary and Possession of Controlled Drug offences.
- 6.2.3 Female P was known to West Yorkshire Police in relation to domestic violence, child protection and adult at risk incidents. She had a previous conviction and a Caution for Assault offences.
- 6.2.4 On 16/02/2014 West Yorkshire Police received a telephone call at 04:46 hours. The caller stated that he had driven past a male who had been laid in the road under a viaduct. The caller was worried that a car might hit the male. Police Officers were dispatched immediately and located Mr G at 04:57 hours. It was recorded on the Storm Log (See Glossary) that Mr G had slipped and injured his leg and that an ambulance was required.
- 6.2.5 The Police Officers observed that Mr G appeared to be very confused and suffering from an illness that interfered with his cognitive, social and emotional abilities. He told the Police Officers that he had just been released from prison two days earlier having been detained for stealing a car, although he had not come to the attention of the Police since 1995. He also thought that the year was 2009, two days before Christmas and he was in Manchester (later stating he was in Glossop then Liverpool). He was checked on PNC (see glossary) and enquires were conducted with relevant hospitals to check if there were any patients missing. Mr G was arrested under Section 136 of the Mental Health Act 1983 for an assessment by a Mental Health Practitioner. An ambulance was requested and he was transported, accompanied by Police Officers, directly to the 'place of safety' suite at Calderdale Royal Hospital. Police Officers conducted a Misper7 interview¹ although he was unable to provide accurate information as to where he had been and why he had left

¹ A return interview misper 7 form must be completed, every effort must be made to safeguard the person and prevent the person from going missing again.

home. As Mr G was unable to provide information for the Misper7 interview, the Misper7 form was completed with information obtained from his Brother Male M and the Hospital staff.

- 6.2.6 Shortly after Mr G had been admitted to Hospital on 16/02/2014, Male M telephoned West Yorkshire Police and reported Mr G missing at 05:52 hours. Male M had been to check on Mr G at 05:30 hours and found him to be missing. Male M had last seen Mr G when he went to bed at 22:00 hours. Male M disclosed that he had not had contact with Mr G for twenty years prior to Mr G moving to live with him on 16/12/2013 and that Mr G was unsteady on his feet and had dementia.
- 6.2.7 Immediate and extensive enquiries were conducted to locate Mr G and he was located at Calderdale Royal Hospital. He had already been transported there as a place of safety under Section 136 Mental Health Act (MHA) 1983 and admitted for a mental health assessment.
- 6.2.8 On 26/10/2014, Mr G was reported missing at 18:25 hours. He had been placed in a care home for two weeks respite care, arriving on 25/10/2014. He had left the Home three times on 26/10/2014, but had been located by the care home Staff. Mr G had last been seen at 17:40 hours and was noted to be missing at 18:00 hours. Care home staff had been out searching to locate Mr G without success.
- 6.2.9 Mr G was assessed as a high risk missing person. An emergency response was initiated and immediate and extensive enquires were conducted in West Yorkshire and Manchester areas. The West Yorkshire Police helicopter was utilised for the area search.
- 6.2.10 Mr G was located by a West Yorkshire Police Officer at 19:59 hours on 26/10/2014. The care home was unable to accept the return of Mr G and it is recorded that they had not been made aware of Mr G's tendency to go missing and would not have accepted him on a placement had they known this. Mr G was transported back to his home address (Male M's house). His medication and personal effects were collected from the care home by Police Officers and returned to Mr G at his home address.
- 6.2.11 Mr G was unable to answer any questions posed to him during the Misper7 interview. He appeared to be fit and well and the Police Officer completed the Misper7 interview using information obtained from the Care home and the circumstances in which Mr G was found. There was no recent photograph of Mr G available from either the care home or Mr G's family. A photograph was taken of Mr G by Police Officers and scanned onto Niche for future reference should he be reported missing again. A post incident review was undertaken by Police Supervision of the incident. The Police response was assessed as effective, prompt and well-co-ordinated.
- 6.2.12 There are no further recorded incidents or contact between West Yorkshire Police and Mr G until 03/03/2015 when West Yorkshire Police were notified of the death of

Mr G by email from Adult Social Care. On receipt of this email, an investigation into the circumstances of the death of Mr G was initiated.

6.3 Kirklees Council Adult Social Care

- 6.3.1 The family concerned was first known to this agency following contact from the District Nursing Service that made a referral on 28/01/14 to the Single Point of Access (SPA). This was in relation to Male M having financial difficulties since his brother Mr G had moved into his home in December 2013. In January 2014 Male M contacted the council to request help; the main concern was around finances but further input led to an assessment of Mr G's needs and those of his brother as carer. Mr G was allocated a personal budget which was used to attend 3 days at a day centre, which commenced in June 2014. In addition Male M was keen to for respite from caring for his brother, he requested residential respite care for his brother on a number of occasions.
- 6.3.2 In March 2014, there was an incident when Mr G went missing from home, was found by the police and admitted to hospital where he was sectioned under the Mental Health Act and was discharged back to his brother's care.
- 6.3.3 On the 4th of March 2014 a further referral was received from Calderdale Social Work Department as Mr G had been initially found by police under a railway arch in his pyjamas and was subsequently sectioned under the Mental Health Act Section 2 at a hospital in Calderdale. The reason for the section is not clear from records.
- 6.3.4 Mr G was discharged home on the 7th of March 2014. The Kirklees Assessment and Hospital Discharge team arranged for a home visit to take place on the 10th of March 2014; and subsequently a Person Led Assessment (PLA; see glossary) was completed. A care plan was formulated which stated that Mr G's overall level of need was 'critical'; which meant he was eligible for social care support.
- 6.3.5 Between the 1st of April 2014 and the 11th of June there were four home visits, during this time no services were provided. Service provision of 3 days at the day care centre eventually started and Mr G started to attend on the 25th of June 2014.
- 6.3.6 On the 11th of June 2014 Male M requested respite care for Mr G in a care home from the 5th to the 11th of October as Male M and Female P were going on holiday. Due to this request for additional services the case was transferred to the Assessment and Hospital Discharge Team.
- 6.3.7 Mr G's needs were assessed initially as 'critical' but were then reduced to 'greater substantial'. Records do not explicitly state the reason; however Mr G had started to attend a day service 3 days a week at this point.
- 6.3.8 There was no recording stating that consideration needed to be given to completing a Mental Capacity Assessment, under the Mental Capacity Act 2005.

- 6.3.9 5th August respite of 14 nights was approved for the 5th to the 11th October at a residential home.
- 6.3.10 8th September 2014, a financial assessment for Adult Social Care was completed by Male M at Mr G's home on a Personal Financial Statement form; Male M signed indicating that he dealt with Mr G's financial affairs and/or he is signing on his behalf. At this point in time no Mental Capacity Assessment was in place therefore staff were assuming Mr G had capacity.
- 6.3.11 Male M stated on the Person Led Assessments dated the 12th of March and the 29th July 2014 that he had appointeeship for Mr G's benefits. However on the subsequent Person Led Assessments dated the 6th November 2014 and the 11th December 2014 Male M stated that he had Lasting Power of Attorney (see glossary) for health and welfare decisions as well as for financial matters. There are no records or any evidence that confirm that Male M did in fact have any formal legal rights. This was never checked by Adult Social Care.
- 6.3.12 On October 29th 2014 a safeguarding alert was raised by the day centre manager as Mr G had a facial bruise and could not recall the cause. The alert was closed down as it was deemed that the bruising may have been accidental. Contact was made with Male M who stated that his brother was hard work (i.e. wandering, leaving the gas on) but was still committed to caring for him. Regular respite was requested to support Male M to continue caring for his brother. Male M reported his own issues with anxiety. Following the safeguarding alert Mr G stopped attending the day centre; Male M stated that he thought his brother was not getting anything from the day centre hence his non-attendance.
- 6.3.13 In November 2014, social care carried out home visits and discussed respite with Male M for 2 weeks covering the Christmas and New Year period. The respite provider gave feedback that Mr G arrived needing a 'good wash' and with one change of clothes. They felt that his personal care was not adequate, and had concerns regarding his weight which was 54kg.
- 6.3.14 In early January 2015, the social care worker was sick and Mr G's case was reallocated to another worker.
- 6.3.15 On 2nd February 2015 a further safeguarding alert was received by adult social care. The safeguarding alert alleged that Mr G had to sleep on a two seater sofa in the living room which had plastic bags covering the cushions and in the day time he was made to sit on a stool at the back of the room. This was some distance from the halogen heater which Male M and his partner were using as their boiler had been broken for several months.
- 6.3.16 In addition, allegedly Mr G was being made to wear a catheter all the time due to issues about his continence and that he had a large bruise on his face. The alerter

stated that Female P had 11 children removed by Children's Services; and indicated that Female P was pregnant with a warrant out for her arrest.

- 6.3.17 Discussions and information gathering took place within Adult Social Care, and on 20th February the decision was made to proceed to strategy and the case was assigned to another adult social care team.
- 6.3.18 On the 27th February the assigned Social Worker discussed the case with her line manager. It was agreed that a home visit needed to take place that day. A call was made to Male M and the visit and was carried out on the same day. Mr G was found to be in a poor physical state and the home was cold. Male M stated that it was difficult to care for Mr G and that he had refused to eat for 2 weeks. He thought he had swallowing problems as he was holding food in his mouth.
- 6.3.19 Following the home visit Mr G was taken to a residential home as a place of safety whilst the safeguarding investigation was carried out and to look at options for Mr G's future care.
- 6.3.20 On arrival at residential home Mr G collapsed and had to be assisted into the home using a wheelchair. The home staff reported concerns to the social worker as Mr G appeared much thinner than he had in December/January and was generally looking ill and weak.
- 6.3.21 On the 28th February the Out of Hours GP was contacted by the home as their concern escalated regarding Mr G's health. He was admitted to hospital where he deteriorated further and was placed in intensive care where he died on the 3rd March.

6.4 NHS England

- 6.4.1 The General Practice which was responsible for providing GP services to the three members of the household – Mr G, Male M, the patient's brother and main carer, and Female P, the brother's partner had two General Practitioners. During interviews with GP1 the household was described as "chaotic" on account of numerous problems affecting the family.
- 6.4.2 The GP Practice had a Child Safeguarding Policy but not an Adult Safeguarding Policy.
- 6.4.3 20/12/13 Mr G was registered at the Practice by his brother, who was his main carer. Medical records show that Mr G was suffering from the aftereffects of a significant brain injury sustained in 2008 as a result of a myocardial infarction during which his heart stopped beating, causing brain damage. This damage had a significant and permanent impact on Mr G's abilities. In brief he was unable to make decisions for himself and needed prompting to undertake even the simplest of activities of daily living. Mr G was referred to Continence Service for problems with urge incontinence

(an inability to perceive the need or to get to the toilet in time) of both urine and faeces.

- 6.4.4 05/02/14 Mr G attended an appointment with GP1, Male M was present and reported that Mr G was due to have a urinary catheter (sheath-type) fitted. Mr G was discharged by Community Nursing Service, no further support was thought to be necessary. 13/02/14 Mr G was discharged unseen by Continence Service because he did not respond to the "opt-in letter". There was no evidence of any follow-up.
- 6.4.5 28/10/14 GP1 attempted to refer Mr G for alternative respite care but was informed that he was no longer under the care of SW1. GP1 was informed that SW2 was not available for 2 days. GP1 felt that the matter was of greater urgency and so made a new referral.
- 6.4.6 24/12/14 Respite Home reported that Mr G's feet were weeping, GP1 prescribed Potassium Permanganate soaks.
- 6.4.7 04/02/15 GP2 reviewed Mr G's medication (patient not seen) and made note to discuss Temazepam use with carers. 09/02/15 a telephone call was made to Male M GP2 advising a gradual reduction of Temazepam.

6.5 Kirklees Council Children's Services

- 6.5.1 A comprehensive 24 page family chronology covering the period from 25.11.86 to 15.04.15 was supplied by children's services. This chronology contained an in-depth description of Female P and Male M's unsuitability to care for children and by association adults at risk.

The chronology contained details of prison sentences, child protection plans due to neglect, domestic violence, removal of a considerable number of children, pets dying from starvation, amongst other serious concerns.

- 6.5.2 This information and the level of risk was not known to Kirklees Adult Social Care or the GP Practice, and the knowledge would have contributed greatly to any assessment processes and informed assessment outcomes.

6.6 Day Care Service Dates of attendance: 25.6.14 – 7.11.14

The SAR Panel agreed that Gill Poole, independent author should work with the day care service to produce a report. It would not be possible for them to produce an IMR as it is a small service and all staff had contact with Mr G. Gill Poole met with the manager and assistant manager to discuss the requirements of the report. They were both concerned about Mr G and the support he received, the response to their safeguarding concerns and that Mr G did not attend their service after their contact with Adult Safeguarding Services.

- 6.6.1 Mr G was referred to the day care service by Kirklees Adult Social Care on 1.5.14. They were told that Mr G was 48 years old with a toxic brain injury due to having a heart attack, that he had memory problems and mental health issues and was living with Male M and Female P.
- 6.6.2 The day care service were told that Male M had not seen Mr G for 16 years as he had been living in Manchester but after having his heart attack and acquiring his brain injury, his partner had just left him at his step mothers' home. His step mother could not help Mr G as she was elderly and lived in sheltered housing so Male M said that he felt obliged to take him in. Although he admitted that he suffered from depression and anxiety problems. Male M could not tell the day care service much about Mr G because he had not seen him for so long.
- 6.6.3 Mr G presented as a very confused and timid man, he seemed to have no confidence and sat 'hunched over'. He could not answer any questions himself and when asked anything he would just shrug his shoulders and say "I don't know", it was clear to the day care service staff that he had limited capacity. He looked quite frail but seemed clean and well presented.
- 6.6.4 Mr G attended the day care service for 3 days per week. They tried to build his confidence by interacting with different work groups e.g. recycling department, wood work, greenhouse etc. and tried to get him to think for himself by asking him questions e.g. "do you remember what we do in here?" He required full support at all times, supervision was required in groups to prevent him from wandering off and he needed prompts to use the toilet and to continue with his tasks. In the 4 months he attended all the staff saw that he was beginning to show some recognition to routines.
- 6.6.5 The first concerns were raised when Mr G came to work with bruises on his left cheek and neck and also had a black eye. The assistant manager asked Mr G what had happened and he said he didn't know so she called his home and spoke to Female P who said that he had fallen whilst in the bath, an explanation that all staff accepted as being true.
- 6.6.6 On 25th October 2014 the day care service Managing Director, received a call from the police on that evening saying that Mr G had gone missing from respite, he then called the manager and assistant manager to inform them.
- 6.6.7 On 27th October 2014 the day service assistant manager telephoned Kirklees Safeguarding regarding Mr G's weekend events and they were already aware. They then called Male M to ask what had happened and were told that Mr G was back at home and had been found in Halifax by Police and had been returned home. Male M was very angry that the respite home had refused to accept Mr G back after absconding and he said that he was going to refuse to have Mr G back until the Tuesday as arranged. Mr G was kept at home to rest on that day, Male M was very

upset. Mr G next attended on 29.10.14 and he couldn't remember anything that had happened the previous weekend.

- 6.6.8 The following week Mr G attended the day care service on Monday, Wednesday and Friday as usual but on the Friday they noticed a large bruise on his cheek, when asked about it Mr G didn't know anything about it. The day care service manager was informed and rang Kirklees Adult Safeguarding Operational Team to report the bruise.
- 6.6.9 Mr G did not attend the day care service again; the assistant manager made several phone calls to his home, eventually getting through to Female P and was told that Mr G was in bed full of cold due to having his flu jab. The assistant manager asked that they call the office every time he would be absent to make sure that he had not arrived and wandered off, Female P agreed. No such calls were ever received by the day care service.
- 6.7.1 6th November 2014 the day care service received a letter from the Adult Safeguarding Operational Team saying that they had considered the information supplied and have decided not to proceed to a safeguarding investigation.
- 6.7.2 21st November 2014 the day care service manager called Mr G's home to ask how he was doing; there was no answer so he left a message on the answer phone.
- 6.7.3 26th November 2014 the day care service manager rang Mr G's Social Worker, regarding Mr G non-attendance for 3 weeks and not being able to contact his family. The person on the switchboard said that they would pass on the message and ask for a return telephone call, this did not happen.
- 6.7.4 28th November 2014 the day care service manager rang the Social Work Team again to speak to the social worker to pass on his concerns. He was put through to a Duty Social Worker who said she would look into it. She rang back the same day and said that she had spoken to Mr G's family and they had said that they didn't want him to attend the day care service again as they did not feel that he was getting anything out of being there. The day care service manager said that Mr G had been happy attending and all this had happened since he reported the bruise to Safeguarding. The Duty Social Worker agreed that it did not sound right and she would pass everything onto Mr G's Social Worker and get him to ring the following Monday. Mr G's Social Worker called the day care service manager and asked him about his concerns. The day care service manager explained the situation and the social worker said that he was happy with Mr G's care and was in the process of setting up some new respite for him. The social worker also said that he would try and get Mr G to attend the day care service.
- 6.7.5 The day care service did not hear anything about Mr G until they received a phone call from a Social Worker who said there had been significant changes and arranged

a meeting at the day care service on 24th February 2015. This meeting was cancelled on the day due to the social worker having to deal with another case.

- 6.7.6 3rd March 2015 the same social worker called again saying that she needed an urgent meeting the same day. She arrived with a colleague around lunchtime and told them that Mr G was in a serious condition in hospital and was not expected to live much longer. About an hour after the meeting she called them to say that Mr G had passed away.

7. ANALYSIS AGAINST THE TERMS OF REFERENCE

7.1 Introduction

7.1.1 The analysis section examines the reasons why people or organisations acted in the way they did. In this way meaningful lessons can be identified, without the overuse of hindsight. The lessons should be capable of being turned into realistic and achievable recommendations which when implemented will support future victims of neglect.

7.1.2 Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the SAR's Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

7.1.3 The objectives of the SAR are to:

- Ensure that the review works within both Safeguarding Adult Review and Domestic Homicide Review processes
- Identify critical points in time where other actions might have resulted in different outcomes
- Explore whether there are lessons to be learned about the way in which professionals worked in partnership to support Mr G and his family and to safeguard Mr G.
- Review the effectiveness of policy and procedures for both multi-agency and single organisations
- Make SMART recommendations and to share learning
 - To inform and improve local inter agency practice
 - To improve practice and develop evidence based practice

7.2 ***Ensure that the review works within both Safeguarding Adult Review (SAR) and Domestic Homicide Review (DHR) processes***

The Panel discussed whether a DHR would be undertaken, as it was likely that the situation could meet the criteria for a DHR, depending on the outcome of criminal proceedings. As the case clearly met the criteria for an SAR, it was decided to progress with one and ensure that both SAR and DHR processes could be run effectively together.

The report template used is that of the DHR in order that one report can be used for either purpose.

7.3 ***Exploration of critical points in time when other actions might have resulted in different outcomes:***

September 2008 – (Although outside of the remit and timescale of this review it seems relevant to comment.) Mr G was discharged from Devonshire Specialist Neurohabilitation Centre to his then partner. The NHS England IMR specifies that a discharge letter stated that he needed verbal prompts to initiate daily tasks; was easily confused if given too many options; resulting in the need for one-to-one supervision. Occupational therapists records stated that Mr G would continue to need daily verbal and visual prompts to orientate himself in place, person, date, time and conversation. Occasional incontinence was also mentioned.

There is no mention of support for his partner who was presumably going to be his carer, nor is there any suggestion of on-going support for Mr G from health or social care. Lack of support may have contributed to Mr G's partner leaving him at his mother's home.

7.3.1 **December 2013** – when Mr G arrived at his brother's home if information had been known about Male M and Female P; agencies might have been concerned about their ability and suitability to care.

The GP practice had no Safeguarding Adult policy, although safeguarding training had been undertaken by one GP. Mr G's GP was also GP for Male M and Female P, so was aware of the chaotic nature of the home in which he was living. But was not aware of the information known to Children's Services and West Yorkshire Police.

7.3.2 **January 2014** – District Nurse referred Mr G to Social Care Single Point of Access. The actions and timescales might have been different if the past history had been known concerning previous convictions of both Male M and Female P in relation to domestic violence, assault of vulnerable victims, safeguarding records, fraud, and removal of children due to neglect, physical abuse and drug and alcohol abuse.

The Adult Social Care IMR author suggests that there was knowledge that Mr G's partner had found it difficult to cope with his care needs. This did not necessarily indicate that Male M would not be able to cope, however it does imply that Mr G's presentation could be stressful for his carers and was the first early indicator that Male M may find it difficult to cope.

7.3.3 **16th February 2014** – Mr G was found under a bridge with a leg injury having gone missing from Male M's home, he was detained under Section 136 of the Mental Health Act 1983 by West Yorkshire Police. Male M and Female P were both known to West Yorkshire Police in relation to domestic violence, child protection, adult at risk incidents, assault, and possession of controlled drug offences. No enquiries seem to have been made into the reasons why Mr G might have left the home.

The West Yorkshire Police response to the Concern for Safety telephone call and the subsequent missing person report on 16/02/2014 was fully compliant with Force

Policy and expected standards of practice at the time. It is also evident that the West Yorkshire Police Officers who located Mr G under the viaduct took the time to communicate effectively with Mr G whilst waiting for ambulance attendance. This enabled the Police Officers to make an assessment of the situation. The arrest of Mr G under Section 136 Mental Health Act and the contact with the place of safety suite at Calderdale Royal Hospital for a place of safety was appropriate in relation to safeguarding Mr G. He was transported by ambulance directly to the place of safety suite, and did not enter a West Yorkshire Police Custody Suite at any time.

The action taken by the West Yorkshire Police Officers in relation to the Concern for Safety incident (16/02/2014) would be compliant with the College of Policing (2015) Approved Professional Practice: Mental ill health and learning disabilities.

The completion of a Misper 7 report (interview) using information obtained from family and the Hospital complied with Force Policy. The incident was well supervised and the actions taken well documented on the Storm Log and Niche Occurrence.

The Adult Social Care IMR author commented that at the end of January 2014 Male M initially contacted the council for support with finances. Only 3 weeks passed after this before Mr G was found by the police and taken to hospital in Calderdale on the 19th of February 2014 where he was subsequently sectioned until he was discharged home on the 7th of March 2014. This may also be an early concern indicator that Male M may have been struggling to care adequately for Mr G. This information should have been considered as part of the assessment process, alongside the fact that Mr G's ex-partner and step-mother could not cope.

As part of the Person Led Assessment undertaken on 10th March 2014 by Adult Social Care service Mr G informed SW2 that he wanted to return to Manchester and there was no follow up relating to SW2 trying to find more information about his children and contact with them. The assessment should have followed a whole family approach. The Adult Social Care IMR author found no evidence that any of Mr G's views, wishes and feelings were taken into consideration, or a willingness to work together to further explore outcomes with him. Further exploration may have led to a different pathway including the use of an independent advocate.

There is evidence to suggest that a Mental Capacity Assessment needed to be carried out to establish Mr G's capacity to be involved in the assessment process and subsequently make decisions about his care needs and how these were to be met. It is likely that Mr G would not have been deemed to have capacity to provide information and make decisions relating to his needs. This would have involved a Best Interest meeting and subsequently have led to decisions being made on his behalf in his best interests.

- 7.3.4 **October 2014** – The day care service contacted the local authority to raise a safeguarding alert. Mr G did not return to the service after this time. Had Mr G

continued to attend the Day Care Service, the day care service might have been able to monitor Mr G's condition.

The West Yorkshire Police response to the missing person report on 26/10/2014 was fully compliant with Force Policy and Mr G was quickly located.

When the care home was unable to accept the return of Mr G, he was transported by West Yorkshire Police to Male M's home address and left in the care of his brother. This was appropriate action to take in the circumstances at the time.

The action taken to collect Mr G's personal effects and medication from the care home and return them to him was good practice. The completion of the Misper 7 report (interview) using the available information was compliant with Force Policy. There was no recent photograph of Mr G and the action to take a photograph of him and scan it onto his Niche record, is seen as good practice and compliant with the principles underlying the Herbert Protocol.

West Yorkshire Police signed up to the Herbert Protocol in May 2014. The original aim of the Protocol was intended to identify residents in a care home with a pre-determined risk who were susceptible to going missing due to deteriorating mental health. It is also intended to speed up and simplify the response of the Police and other agencies when a vulnerable person and in particular a frail older person with dementia is reported missing, ensuring that the right information is readily available so that the search can be targeted appropriately.

The Police response to the missing person report (26/10/2014) was subject to a post incident review by supervision at the time. The IMR review found the Police response to be effective, prompt and well co-ordinated.

The Adult Social Care IMR identifies that a key factor which could have resulted in a different outcome for Mr G was his withdrawal from the day service coincidental with a safeguarding referral by the service. Male M stated that Mr G was not getting anything from the day care service. The Adult Social Care IMR author's view was that Male M's motive should have been explored further; particularly as he had previously indicated how keen he was for respite services to be put in place for Mr G. In the IMR author's professional opinion, this was an indicator something might not be right, and that there 'some very visible concerns emerging that timely and appropriate assessment of risk, social work intuition, observation and analysis should have identified'.

Following Mr G absconding from the residential home during his second stay, it became apparent that this home was not appropriate for him. Even though there was no Mental Capacity Assessment in place, Mr G was known to be at risk of attempting to leave the home. Had a Mental Capacity Assessment been carried out, in the opinion of the Adult Social Care IMR author, it is highly likely that Mr G would have been deemed not to have mental capacity to make a decision to go into a respite

bed. A decision specific Mental Capacity Assessment undertaken by the managing authority (the home) carried out at this point, may have led to a Deprivation of Liberty Authorisation being requested by the managing authority and authorised by the supervisory authority (Local Authority). This judgement is based on the factors within the 'Deprivation of Liberty Safeguards' where someone is deprived of their liberty because they lack mental capacity and they are under continuous supervision and not free to leave. These measures aim to safeguarding vulnerable people who lack mental capacity.

Mr G put himself at risk on two occasions; once when he wandered from Male M's home then from the residential home. At no point was Assistive Technology such as a Global Positioning System² (GPS) device or an alarm on the external door in his home considered. In the opinion of the Adult Social Care IMR author Mr G was clearly at high risk of 'absconding' and for his own safety consideration should have been given to the use of Assistive Technology. Assistive Technology provides equipment that aims to support adults at risk in a least restrictive way.

7.4 *Are there lessons to be learned about the way in which professionals worked in partnership to support Mr G and his family and to safeguard Mr G.*

7.4.1 There was information about Mr G's brother and his partner on children's services and West Yorkshire Police systems. Female P used different names and moved address frequently, this made it difficult to track her and access the information about her past. Had this information been available to Adult Social Care, the support provided would almost certainly have been different.

The Panel debated this point at length and agreed that current systems would make it difficult for the information to have been known by Adult Social Care.

The NHS number is the only National Unique Patient Identifier. It is used to help all healthcare staff and service providers to match individuals to their health records. Everyone registered with the NHS in England and Wales has their own unique number. If the information about Female P and Male M including prison sentences, child protection and neglect issues, domestic violence, removal of children by social care, and other serious concerns had been on NHS records, when they registered with the GP practice this information would have been known.

7.4.2 Although there are several comments in agency records about Mr G's lack of capacity, confusion and need for supervision; no formal mental capacity assessment was undertaken.

² A Global Positioning System (GPS) is a space-based navigation system which provides location and time information.

7.4.3 The Adult Social Care IMR author suggests that there was a lack of liaison with colleagues in health to establish Mr G's full past medical history, and in particular his hypoxic brain injury and how this impacted on Mr G's daily living. Subsequent specialist support such as rehabilitation may or may not have taken place in Manchester. Further exploration may have led to a different pathway. There is no evidence of any continuity in Mr G's care relating to his brain injury in any of the agency IMRs.

7.5 ***Review of the effectiveness of policy and procedures for both multi-agency and single organisations***

7.5.1 The description of Mr G suggests that he was an adult at risk. He had care and support needs and was at risk of, abuse or neglect, and as a result of those needs was unable to protect himself against abuse or neglect.

7.5.2 Section 1.5.2 of the Multi-Agency Safeguarding Adults Policy and Procedure for West Yorkshire & North Yorkshire (September 2015) 'Abuse by and of unpaid carers' states:

When a safeguarding concern is raised regarding a relative or unpaid carer, consideration should be given to the specific circumstances, the nature of the issues and the appropriate proportionate response.

The decision should consider an outcome which supports or offers the opportunity to develop, or maintain, a private life which includes those people with whom the adult at risk wishes to establish, develop or continue a relationship. Responses should ordinarily seek to support the continuation of family and caring relationships where this is consistent with the wishes and desired outcomes of those concerned.

There is no evidence that Mr G's wishes were considered, or that an assessment was made of his capacity to state his wishes and feelings

7.5.3 West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures which was published April 2013 Section 1.6.2 describes abuse by carers who are relatives or friends. It establishes that there is a difference between unintentional harm caused inadvertently by a carer and a deliberate act of either harm or neglect.

The policy states that a carer's assessment should take into account the following factors:

1. whether carer demands exceed the carer's ability or capacity
2. the emotional and/or social isolation of the carer and the adult at risk
3. communication difficulties between the adult at risk and the carer
4. whether the carer is in receipt of any practical and/or emotional support from other family members or professionals
5. financial difficulties
6. whether the carer has a lasting power of attorney or appointeeship

7. a personal or family history of violent behaviour, alcoholism, substance misuse or mental illness
8. the physical and mental health and well-being of the carer

Such an assessment does not appear to have been undertaken, as a number of the factors are present for Mr G, Male M and Female P.

- 7.5.4 There was an absence of challenge from the Adult Social Care management in the Assessment and Hospital Discharge Team and the Support Management Team in relation to the lack of enquiries to establish information about Mr G's family in Manchester, his medical history and his background; or attempts to explore Mr G's wish to return to Manchester. There was also considerable delay (until 27/02/2015) in management initiating conversations relating to the absence or consideration of a Mental Capacity Assessment.
- 7.5.5 Interviews with various staff from the Adult Safeguarding Operational Team, the Support Management Team and the Assessment and Hospital Discharge Team establish a lack of clarity about the interface between the Adult Safeguarding Operational Team and other social care assessment teams. There is an inherent belief across social care teams that 'no procedural action' can be taken relating to a safeguarding case until the Adult Safeguarding Operational Team makes an initial decision following the screening process. It is clear that some of these assumptions around practice have developed over time in the absence of clear protocols to support robust practice, accountability and responsibility. Naturally this leads to more drift and delay that can subsequently contribute to on-going risks.

All workers have a duty of care and are professionally registered with the Health Care Professional Council. The ability of managers and practitioners to challenge effectively when the needs of a service user are compromised is a crucial part of social work practice.

There was additional delay caused by this case waiting for sign off of the decision tool by an Adult Safeguarding Operational Team manager. The risks in the case suggest that it needed priority attention and this was not provided in a timely manner. A quicker decision may have resulted in a different outcome for Mr G. Central to this case was the need to offer safety and support that would have, in the short and longer term, sourced a better quality of life and risk minimisation for Mr G.

8. Lessons Learned – taken from the agency IMRs

8.1 West Yorkshire Police

- 8.1.1 On 14/08/2015, the Herbert Protocol was extended to include vulnerable adults living in sheltered accommodation or their own home. Carers, family members and friends

can complete in advance, a form recording all vital details, such as medication required, mobile numbers, places previously located and a photograph.

- 8.1.2 West Yorkshire Police has made it mandatory for all frontline Police Officers and Staff to complete the NCALT (National Centre for Applied Learning Technologies) e-learning Mental Health and Disability Awareness training course. This objectives of this two hour course is to enable officer to recognise and identify a range of indicators and responses to a variety of mental ill health issues including mental illness and learning disabilities
- 8.1.3 As of 19/03/2015, 51.60% of West Yorkshire Police employees have completed this training. This module is designed for officers and staff who come into contact with members of the public.
- 8.1.4 West Yorkshire Police has received positive feedback from the public in respect of the use of the Herbert Protocol and dementia awareness training.

8.2 Kirklees Adult Social Care

The author of this review is aware that a clear vision for redesign of adult safeguarding processes and systems was developed prior to the commissioning of this review. There are examples of good practice which have occurred since this case became apparent, some of which were already intended, others which were a definitive response to the case:

- 8.2.1 The lack of a timely, adequate and proportional assessment in this case demonstrates consequences for the individual and agencies supporting individuals. All assessments need to be timely, proportionate, holistic, person and family centred and need to consider a person's history to inform the most appropriate pathway and support needed for each individual. In this case it was particularly important to understand these factors in order to determine how risks could be managed. It is vital that the things that matter most to the person concerned are taken into consideration and represent their views, wishes and feelings especially when an individual may lack capacity.
- 8.2.2 Although staff have been appropriately trained on undertaking a Mental Capacity Assessment in order to act in a person's Best Interests, it is evident in this case that this was not followed through in practice. The Person Led Assessment form does not explicitly refer to capacity in a way that prompts the worker to consider this integral part of assessment. This needs immediate attention to ensure that the adult central to the assessment is involved or represented appropriately around decisions about their life.
- 8.2.3 The importance of robust management oversight is important in ensuring the quality of practice and assessment documentation demonstrates a holistic assessment of the person's needs. The management role in the assessment of care and support and/or safeguarding needs is vital to try to ensure the right outcomes. It provides

appropriate challenge and support and adds an additional layer of accountability to the social work assessment function. There is limited evidence to suggest that these quality assurance mechanisms are adequately and routinely in place.

- 8.2.4 Reflective supervision is in place across services, however this case indicates that this needs to be strengthened in terms of evidencing challenge and effective practice.
- 8.2.5 The importance of validating important information provided by family and carers on behalf of service users. For example, if a carer is stating that they have Lasting Power of Attorney for someone, then the worker should routinely seek evidence to support the statement. It is important to establish fully if someone has legal powers to act on someone's behalf, that this is in fact accurate and not just assumed to be accurate. Any uncertainty around said arrangements can then be explored further and can in some cases lead to further enquiries being made.
- 8.2.6 The Adult Social Care IMR makes it clear that the systems and processes in the Adult Safeguarding Operational Team were insufficient. Work is proactively underway to review the Adult Safeguarding Operating Model. It is important that all staff receive clear guidance that safeguarding adults at risk is everyone's business across the whole of adult social care and the wider partnership.
- 8.2.7 During the fact finding exercise for the purpose of the Adult Social Care IMR, the author read various records on the Carefirst system. On reading several of the observation records on this system it became apparent that many workers were not stating recording their name and team. This led to a lack of clarity and delay in establishing the facts. Team managers need to encourage better practice in this area to increase accountability and evidence based practice.
- 8.2.8 The number of staff and teams involved in this case, led to cumulative delays for Mr G, there is a wider system challenge around the flow of work and how it needs to be managed and prioritised to achieve appropriate outcomes for adults at risk.
- 8.2.9 When Carefirst, the IT system used by Kirklees Council, was checked there was no evidence of involvement with the Children and Families Team. If there had been liaison with the Children and Families Team at an earlier stage, the history of Female P would have raised serious concerns about her suitability as a carer of Mr G. Whilst it is difficult to determine the point at which these checks should have been made, there is an evident risk threshold in this case, that could have been informed by information from children and families. The Children and Families Team chronology provides a detailed log of historical concerns about Female P as a perpetrator of child abuse that could have informed the safeguarding adult assessment. Council staff need to proactively consider the option of these checks within routine and complex risk management to inform decision making and action.

8.2.10 There are examples of good practice which has occurred since this case became apparent, some of which were already intended, others which were a definitive response to the case:

- 1 The safeguarding and social work services within Adult Social Care swiftly took action to facilitate reflective practice and therefore the teams have pro-actively identified lessons learned.
- 2 The Safeguarding and Social Work services within Adult Social Care commissioned an internal report that identifies immediate lessons learnt and practice issues. This has been discussed with staff widely.
- 3 Adult Social Care service undertook a review of Management Structures within safeguarding and social work services which was completed by December 2015.
- 4 The Adult Safeguarding service examined systems for duty arrangements in the team and has also carried out reflective sessions for those staff involved. The volume of work in the Adult Safeguarding Operational Team is part of a systems thinking project that will lead to a new operating model for adult safeguarding. In the meantime staffing levels have been strengthened and there is increased management oversight of case work and allocation.
- 5 The Adult Social Care Social Work service recently undertook a review of assessment documentation with a view that it is strengths based. This review has had service user and carer involvement. The author has been informed that the Adult Social Care senior management team will review the latest versions of assessment documentation to ensure it maintains changes that service users and carers want, but also ensures Mental Capacity is evident. The key issue is about embedding this into practice and the adult social care senior management team is currently commissioning a new learning model based on a strengths based approach but which will incorporate Mental Capacity and family.

8.3 NHS England – General Practice There are examples of good practice which have occurred since this case became apparent, some of which were already intended, others which were a definitive response to the case:

- 8.3.1 28/10/14 GP1 was not prepared to wait two days to speak to SW2 because they felt that Mr G's case was of sufficient urgency. This is an example of good practice.
- 8.3.2 There is evidence of good inter-agency communication between the GP Practice, the District Nursing Service, and the Continence Service, this is facilitated by the fact that they share the same computer system (SystemOne).
- 8.3.3 The Practice's attempts to reduce Mr G's Temazepam intake should be applauded, particularly against the background of his carers being reluctant to comply as they

were prescribed similar medications and they were using Temazepam to control his behaviour (to stop him wandering at night by sedating him).

- 8.3.4 The Practice clinical staff usually record the details of the person attending with a vulnerable adult or a child. It is considered good practice with children; since repeated attendances with adults other than the parents (and in particular, a variety of different adults) may be an indicator of potential abuse / child sexual exploitation. It is the NHS England IMR author's opinion that, whilst it would have been unlikely to have made a difference in this case, it would be helpful to extend this practice to adults at risk.
- 8.3.6 Mr G missed a number of appointments at the Practice, but not consecutively. When a patient fails to attend on three consecutive occasions they are discussed as part of the Practice's DNA policy; to try and reduce the number of DNA's as these are a significant drain on resources. They are not usually intended for the identification of potential risks to patients.
- 8.3.7 There is no evidence of any communication between Social Services and the Practice. The NHS England IMR author has discussed this with GP1 who has confirmed that at no time during the timeframe of the review was the Practice contacted by Social Care with regard to any concerns relating to Mr G's health.
- 8.3.10 GP1 has confirmed that the Practice were only aware of the history of the removal of children in the past, but had no details about Female P's history. The Practice assumed that a thorough assessment of Female P's suitability as a carer had been carried out by those responsible for the decision to place Mr G with Male M and Female P.
- 8.3.11 Because Mr G moved to live with Male M and Female P as a private arrangement there was no initial social care input or assessment of suitability.
- 8.3.12 The Practice does not currently have an Adult Safeguarding Policy, but is in the process of writing one.
- 8.4 Day Care Service – taken from discussions with the manager and assistant manager
- 8.4.1 The day care management felt a disconnection between themselves, adult social care and safeguarding.
- 8.4.2 The day care management would have found it easier to have one point of contact within adult social care
- 8.4.3 The day care management found it difficult and frustrating when they could not speak with Social Workers or anyone knowing about the case.

9. Conclusions

- 9.1 The review identified practice and systemic concerns in some of the agencies involved with Mr G; and concluded that had these concerns been identified and addressed differently the death of Mr G may have been avoided.

In particular:

The lack of knowledge of information relating to Male M and Female P and their potential inability to care and support an adult at risk appropriately.

The number of social care workers and teams involved in Mr G's case and the number of times his case was transferred was not good practice. This may have contributed to inconsistent understandings and approaches which may have impacted on the ability to monitor and manage risks.

Adult Social Care, in particular Assessment and Support Management and Adult Safeguarding did not carry out appropriate assessments based on the information available. Nor did the agency make use of all relevant information to inform decision making at various points in the care and support or safeguarding pathway for Mr G. In addition to these practice concerns, decisions were delayed due to weaknesses in the systems implemented in teams and the number of different staff involved in the case across services. This resulted in several missed opportunities where Mr G could have been supported to a place of safety and that his quality of life could have improved over time.

There seemed a general lack of consideration that a Mental Capacity Assessment would be appropriate for Mr G.

There is no record of consideration of domestic abuse; which suggests that agencies did not have an awareness of domestic violence involving adult males.

10. Recommendations

10.1 All SAB partner agencies

- 1 Ensure Mental Capacity awareness is embedded in practice for key staff – this recommendation came from panel discussions and the overview report author

10.2 Adult Social Care

- 1 The Person Led Assessment should have explicit links to the assessment of Mental Capacity so that the worker ensures a Mental Capacity Assessment is considered and where required one is undertaken.
- 2 Mental Capacity needs to be better embedded into social care practice, and be supported by workforce development methods. This will grow confidence and capability in the workforce to complete Mental Capacity Assessments in cases of this kind.
- 3 Adult Social Care need to ensure that routine mechanisms for quality assurance are embedded into day to day assessment practice, including standards of practice around Mental Capacity. This will grow organisational confidence around the quality of practice and will also identify areas of practice that require improvement. Quality

assurance mechanisms should contribute positively to a learning culture within Adult Social Care.

- 4 Adult Social Care, with Client Financial Affairs (CFA) should ensure that evidence of registered Enduring Power of Attorney, Lasting Power of Attorney or Deputyship is established and recorded appropriately on the user's record. This will help in circumstances where concerns arise that may relate to financial mismanagement or abuse.
- 5 Management should ensure that all staff as a matter of routine practice record their name and team on all observations recorded on Care first system to increase accountability and enable swifter fact finding for all.
- 6 The SAR sub group to be informed of progress around on-going developments associated with the Safeguarding Adults Service, in particular the systems thinking and service re-design work.
- 7 Review of risk identification, assessment and management processes, and ensure effective training in risk assessment and management

10.3 **NHS England / GP Practice**

- 1 That the Practice ensures that their already good practice of recording the details of the adult(s) accompanying a child or vulnerable adult when they attend the surgery is extended to all relevant patients.
- 2 That the Practice amends it's Did Not Attend Policy to include briefly reviewing the records in all cases of a child or vulnerable adult failing to attend a Surgery or Hospital appointment, to determine the number of such episodes and, when a number are found, reviewing the child or vulnerable adult's record and those of their family/household in more detail to check for Safeguarding risk factors or concerns.
- 3 That the Practice ensures that the production of its Safeguarding Adults Policy is completed in a timely manner.

10.4 **Day Care Service** – these are suggestions from the day care service management

1. Improved sharing of information and vetting of family/carers
2. Information should be readily available on how to complain when not happy with Social Worker decisions
3. For an adult at risk to have a single point of contact within adult social care services

10.5 **Overarching recommendations for the Safeguarding Adult Board to be assured in partnership with the Domestic Abuse Strategy Group**

- 1 That domestic abuse training is available across agencies and organisations

- 2 Safeguarding adults training embeds a practical response to all forms of domestic violence and interpersonal abuse (i.e. e-learning package for GP's on domestic abuse)
- 3 Review information sharing protocols and consider options for multi-agency information sharing, including 'Think Family' which is about improving life chances of families at risk.
- 4 The Kirklees Council Provider Forum explore the issues raised by the day care service
- 5 The SAB to consider facilitating the development of a shared and common multi-agency understanding and approach to the identification and management of risk.

Appendix A Definitions

Domestic Violence

The definition of domestic violence and abuse, as amended by Home Office Circular 003/2013 came into force on 14.02.2013, is:

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

Adult at risk

An adult at risk was defined (pre Care Act 2014) as a person aged 18 years or over:

“who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against... harm or exploitation” (Department of Health, 2000, No Secrets).

Domestic Homicide Review

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). The guidance was revised in August 2013. The act states:

A domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

- (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

Herbert Protocol

The original aim of the Protocol was intended to identify residents in a care home with a pre-determined risk who were susceptible to going missing due to deteriorating mental health. It is also intended to speed up and simplify the response of the Police and other agencies when a vulnerable person and in particular a frail older person with dementia is reported missing, ensuring that the right information is readily available so that the search can be targeted appropriately.

Appendix B

KSAB SAFEGUARDING ADULTS REVIEW AGENCY ACTION PLAN Mr G

RAG STATUS KEY	
	Action required (red)
	Preparation underway (amber)
	Action completed (green)

Update required	
Board dates	

Recommendation 1 - All SAB member agencies Ensure Mental Capacity Act awareness is embedded in practice for key staff							
1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
Mental Capacity Act training available for relevant staff	Staff aware of Mental Capacity Act and assessments of mental capacity are made and / or undertaken appropriately	All					Training records Peer audit of files MCA appropriately referenced in documentation and records

Recommendation 2 - Adult Social Care							
The Person Led Assessment should have explicit links to the assessment of Mental Capacity so that the worker ensures a Mental Capacity Assessment is considered and where required one is undertaken.							
1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
Ensure assessment of mental capacity is included in the Person Led Assessment	Mental Capacity Assessments are undertaken appropriately and individuals are enabled to make their own decisions or decisions are made in the individual's best interest	Adult Social Care	Health				Audit of PLAs

Recommendation 3 – Adult Social Care							
Mental Capacity to be better embedded into social care practice, and be supported by workforce development methods.							
1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
Effective training for adult social care staff on Mental Capacity	Adult Social Care staff aware of Mental Capacity Act and assessments	Adult Social Care					Training records

Act and implications for practice							
Supervision for adult social care staff to include use of Mental Capacity Act	Mental Capacity Assessments to be undertaken appropriately and in a timely fashion						Audit of supervision and user records

Recommendation 4 - Adult Social Care
Adult Social Care, with Client Financial Affairs (CFA) should ensure that evidence of registered Enduring Power of Attorney, Lasting Power of Attorney or Deputyship is established and recorded appropriately on the user's record.

1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
Adult Social Care, with Client Financial Affairs (CFA) should ensure that evidence of registered Enduring Power of Attorney, Lasting Power of Attorney or Deputyship is established and recorded appropriately on the user's record.	This will help where concerns arise that relate to financial mismanagement or abuse.	Adult Social Care	Client Financial Affairs (CFA)				Audit of recording of evidence of EPA, LPA or Deputyship on client records

Recommendation 5 - Adult Social Care

Management should ensure that all staff as a matter of routine practice record their name and team on all observations recorded on Care first system to increase accountability and enable swifter fact finding for all

1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
<p>Adult Social Care managers to ensure that all staff as a matter of routine record their name and team on all observations recorded on Care First system.</p> <p>Briefing note to all team managers and stressed at team meetings</p>	<p>Increased accountability and enable swifter fact finding for all</p> <p>adherence to HCPC Standards of performance conduct and ethics in relation to duties to keep accurate records</p> <p>http://www.hcpc-uk.org.uk/assets/documents/10003B6Estandardsofconduct,performanceandethics.pdf</p>	<p>Adult Social Care</p>					<p>Audit of Care First</p>

Recommendation 6 – Adult Social Care

The Safeguarding Board to be informed of progress around ongoing developments associated with the Safeguarding Adults Service, in particular the systems thinking and service re-design work.

1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
Safeguarding Adults Service Managers to report on service redesign work to SAR sub group	The SAR sub group to be informed of progress around ongoing developments associated with the Safeguarding Adults Service, in particular the systems thinking and service re-design work.	Adult Social Care					Minutes of progress reports on service redesign.

Recommendation 7 – Safeguarding Adults Board (SAB)

The SAB to be assured that partner agencies have a shared and common multi-agency understanding and approach to the identification and management of risk.

1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence

<p>SAB Task and Finish group to facilitate development of a multi-agency risk management approach.</p> <p>Review of risk identification, assessment and management processes, and ensure effective training in risk assessment and management</p>	<p>Effective risk identification, assessment and management</p> <p>Training records and staff surveys</p> <p>Staff in partner agencies to use the same definitions and approach</p>	<p>Adult Social Care</p>					<p>Audit of records and processes</p> <p>A multi-agency risk management tool in use</p> <p>Appropriate and proportionate response to risks and concerns</p>
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***Recommendation 8 – NHS England, supported by The Clinical Commissioning Groups
The GP practice ensures that their already good practice of recording the details of the adult(s) accompanying a child or vulnerable adult when they attend the surgery is extended to all adults at risk.***

1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
<p>GP Practices record the details of adult(s) accompanying an</p>	<p>Information recorded and available of carers and others who attend with</p>	<p>NHS England</p>	<p>GP practice</p>				<p>Audit of records of children and vulnerable</p>

adult at risk when they attend the surgery.	children and vulnerable adults						adults
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Recommendation 9 – NHS England supported by The Clinical Commissioning Groups
The GP Practice amends it's Did Not Attend Policy to include briefly reviewing the records in all cases of a child or vulnerable adult failing to attend a Surgery or Hospital appointment, to determine the number of such episodes and, when a number are found, reviewing the child or vulnerable adult's record and those of their family/household in more detail to check for Safeguarding risk factors or concerns.

1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
The GP Practice to amend it's Did Not Attend Policy to include briefly reviewing the records in all cases of a child or vulnerable adult failing to attend a Surgery or Hospital appointment.,	The earlier determination of the number of episodes and identification of safeguarding risk factors or concerns.						Audit of records and record of review of records

Recommendation 10 – NHS England supported by The Clinical Commissioning Groups The GP Practice ensures that the production of its Safeguarding Adults Policy is completed in a timely manner.							
1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
GP practice develops a safeguarding adult policy	Ensure the GP practice appropriately discharge their statutory responsibility to safeguard adults at risk	NHS England	GP Practice				The GP practice have a current safeguarding adult policy

Recommendation 11 - Safeguarding Adult Board to be assured / receive assurance in partnership with the Domestic Abuse Strategy Group Ensure that domestic abuse training is available across agencies and organisations							
1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
Ensure that domestic abuse training is available across	Staff in all agencies will be aware of and know how to identify, manage and appropriate refer	?					Training available Training records

agencies and organisations	domestic abuse						
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Recommendation 12 - Safeguarding Adult Board to be assured in partnership with the Domestic Abuse Strategy Group
Review that there are effective information sharing protocols and consider options for multi-agency information sharing, including 'Think Family' which is about improving life chances of families at risk. (Links with day service recommendation - Improved sharing of information and vetting of family/carers)

1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
<p>Task and Finish group to be created to consider options for multi-agency information sharing, including 'Think Family'; potential link to unique NHS number</p> <p>Check for information held by partner agency including MASH where professional judgement considers risk to be significant and whenever there is a</p>	<p>Improved life chances for adults and families at risk</p> <p>Robust information sharing processes between agencies and adult and children's services</p> <p>Process to 'refresh' information on systems after initial checks are made</p>	Adult Social Care	All	<p>Link to Vanguard Work</p> <p>Interface with Gateway to Care</p>			Information sharing protocols include Think Family practice

Section 42 enquiry							
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Recommendation 13 - Safeguarding Adult Board to receive assurance in partnership with the Domestic Abuse Strategy Group The Kirklees Council Provider Forum explore the issues raised by the day care service							
1. Action/s	2. Measurable results/outcomes	3. Lead Agency	4. Other Agency/ies involved	5. Progress	6. RAG status	7. Completion date	8. Evidence
To take action on the issues raised by the day service detailed in the overview report	All services feel engaged in safeguarding adults at risk and proportionate concerns are raised	Adult Social Care	Kirklees Provider Forum				Survey of providers

APPENDIX C Glossary

Records of Police action were accessed from the following West Yorkshire Police database systems:

Niche: This database contains the case records of all criminal investigations

Storm: This is West Yorkshire Police's Command and Control system and records the receipt of calls to West Yorkshire Police

Corvus: This is a search engine which retrieves records from current and archived West Yorkshire Police computer systems

PNC: This is the Police National Computer and part of its function is to record a nominal's previous conviction history, bail conditions, warning markers and modus operandi

Person Led Assessment (PLA) assessment for adult social care and support

Lasting Power of Attorney (LPA) is a legal document which lets individuals appoint one or more people (attorneys) to help make decisions, or make decisions on their behalf. There are two types of LPA which cover health and welfare and / or property and financial affairs; people may have one or both types of LPA depending on their needs.