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Safeguarding Adult Review: Following death of “Ms K” an adult at risk



Author: Georgina Diba, Strategic
Safeguarding Adults Service LBE

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Safeguarding Adult Review

1. Methodology & Involvement

Under Section 44 of the Care Act 2014, local safeguarding boards (SABs) are required to undertake a Safeguarding Adults Review (SARs) when an adult in its area dies or suffers significant harm as a result of abuse or neglect, whether it is known or suspected, and where there is concern that the partner agencies could have worked more effectively to protect the person at risk.

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the SAB, members of it or other persons worked together to safeguard the adult, and condition 1 or 2 is met

Condition 1 is met if -

- a) the adult has died, and*
- b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)*

Condition 2 is met if -

- a) the adult is still alive, and*
- b) the SAB knows or suspects that the adult has experienced serious abuse or neglect*

The Enfield Safeguarding Adults Board decided that Condition 1 had been met and there was an opportunity for learning by partners on how they worked together.

This Safeguarding Adults Review (SAR) was agreed on the 23rd May 2016. The Panel of Board partners had consensus that the most appropriate methodology was a Multi Agency Partnership Review. The purpose of this type of review is to focus on the multi-agency organisational learning for the specific organisations involved in a case and to undertake these on a collaborative basis between the agencies involved. SARs are not to apportion blame, but to identify learning and how we can as individuals, organisations and as a partnership identify alternative responses and ways of working.

The partners whom took part in this review included:

1. Adult Social Care Department, London Borough of Enfield
2. London Ambulance Service
3. North Middlesex University Hospital NHS Trust
4. Enfield Police & MPS Vulnerability and Adults at Risk Lead
5. North London Coroner

A roundtable learning event was held in October 2016 for partners to share their Individual Management Review (IMR) reports, to challenge one another and to share learning and recommendations. The Senior Coroner for North London provided direct feedback two days after the roundtable learning event.

The London Borough of Enfield took the lead in writing this report, which was agreed by all partners. Names and identifiable information have been removed from this report to protect the anonymity of the deceased.

The family of the deceased were contacted and invited to take part. This was not accepted at the present time.

2. Background as collated from partners

Ms K was an elderly woman whom lived with her adult son and daughter. On a Saturday in January 2016 a call was received into the London Ambulance Service (LAS) Emergency Operations Centre to attend an address. A Fast Response Unit and an ambulance were dispatched. The LAS provided immediate care and treatment before bringing Ms K to the North Middlesex University Hospital (NMH). On this same date the LAS raised a notification to the London Borough of Enfield (LBE) which raised a concern about possible neglect, due to the condition of Ms K on attendance and the state of the environment she was found in. The referral from the LAS makes reference to the low body temperature of Ms K, that her house was in a state of disrepair with no heaters in the home and holes in the floor. The referral goes on to note that Ms K was in a downstairs bedroom with had extensive mould on walls and on the mattress where Ms K slept. She was found unwashed, clothes dirty and lying in her own urine.

Ms K was received into the Emergency Department Resuscitation Room with hypothermia in peri-arrest. The doctors report her in severe hypothermia and unresponsive on admission. She was reported to be 'very, very unkempt', with soiled clothing and mould on her skin. There were differing accounts received from the family as to Ms K's presentation over the previous weeks, but it would appear at some point there was a fall and since this time a marked deterioration. Ms K was moved from Emergency Department to Intensive Treatment Unit, where she continued to receive medical treatment throughout the day. Her condition continued to deteriorate despite maximum intervention efforts.

Ms K passed away on the Intensive Treatment Unit on the Saturday at 23:32.

The referral from the London Ambulance Service was received into the London Borough of Enfield Multi Agency Safeguarding Hub (MASH) and reviewed on the first working day, which was the Monday. The MASH contacted partners over this day and attempted contact with the family. The following day they sent official requests for information to a number of partner, such as the Hospital, Coroner, Housing and others; concerns were shared with the Police through 101 reporting number.

On this Tuesday, three days after her death, Ms K's funeral was held.

The Police recorded the telephone call from the MASH on this day as a 'CAD', which referenced a wilful neglect allegation made by the MASH. This CAD was closed by the Police as the MASH were seen to be dealing with the concern, though Police agreed to undertake a welfare check at the family home.

On the Wednesday the MASH made telephone contact with the North London Coroners Office. Updates continued to be passed by the MASH to the Police on 101.

Eleven days after her death, a member of staff from the MASH and two Police Officers attended the home of Ms K. The daughter and son were present. Only two rooms were accessed and neither was seen as fit for habitation, with only a few lights working, drawn curtains and black bags placed over some windows. There was severe damp and mould. After leaving the property a neighbour flagged down the Police Officers and expressed his concern for Ms K as she would walk up and down the street with an empty pram; he was concerned she might get run over and appeared to have mental health issues.

The MASH continued to progress the cases under safeguarding, holding enquiry planning meetings and keeping in contact with the Police and contacting partners for information. Statements were received from North Middlesex Hospital staff whom provided treatment to Ms K, all of which

confirmed significant concerns about how she presented. The outcome of the safeguarding concluded that Ms K was an adult with care and support needs, whom had been unable to protect herself from abuse or harm as a result of those care needs. The Police were unable to progress their investigation further.

3. Challenges and Opportunities

Partners came together to share their reflections on what occurred and what systems may have impacted on the course of actions they took.

The aim was to identify what individuals or organisation could do in the future to enable an alternative outcome in holding persons alleged to have caused harm to account.

Some of the key reflections from partners are set out below.

On the day Ms K died (Day 1 -Saturday)

Partners identified that on the day Ms K died there was significant concern by both the LAS and NMH about her severely neglected state, and while a referral to the Local Authority was made by the LAS, the Police were not contacted. The learning event acknowledged that should a child have been found in the same severely neglected state as Ms K, the Police would have been called; as a partnership we hope that the abuse of adults at risk will stir the same emotive response as it does when involving a child whom has been severely abuse or neglected.

The key learning point for partners is the need for swift and immediate action in contacting the Police where there is the death of a vulnerable person and abuse or neglect is suspected.

The timeline of notification to the Police meant that forensic opportunities were missed. This highlighted the need for Police to be contacted by any organisations when they attend to a person whom may have been subject to a crime. The Senior Coroner for North London reflected that the early involvement of the Police is important and all partners should be empowered to report when they believe a crime has been committed. In this case, it was suggested that both London Ambulance Service on attendance to the home could have called the Police or furthermore this may have been an option to consider on admittance to the North Middlesex Hospital.

The key learning point is empowerment and understanding by staff around their safeguarding responsibilities.

Following the death of Ms K a death certificate was signed by a NMH doctor which did not record the concerning circumstances which staff at the hospital had documented around Ms K's presentation. Death certificates which indicate that one of the criteria to refer to the Coroner has been met could assist in identifying the need for a post mortem. Furthermore, partners acknowledged that Coroners are seen as key partners when a death of an adult at risk is believed to have been contributed to by abuse or neglect. This point of learning was agreed by partners as having national relevance and could be shared more appropriately though the General Medical Council (GMC) to all doctors. The NMH have confirmed that learning in relation to this point has already started implementation with staff and the Safeguarding Adults Group. The Senior Coroner for North London confirmed that anyone can refer to them, and this was therefore identified as an area in which clear reporting from all partners could be improved.

The key learning point is the need to refer to the Coroner in circumstances meeting their criteria.

On Receipt of Safeguarding Concern (Day 3- Monday to Day 6- Thursday)

Partners did not provide all of the information they held to the MASH within the timeframe in which it was requested. The safeguarding concerns raised were of such a serious nature that they were coded in the MASH as 'red', which means all partners were required to respond to information within

6 hours. This delay has the ability to impact on the action which partners, such as the Police, could take due to a lack of substantiating information from the partnership on the gravity of the concerns.

The key learning point is the responsibility of all partners to respond to requests for information which would enable effective risk assessment and management in safeguarding.

The MASH Team in the London Borough of Enfield identified that how information is passed to the Police through the 101 reporting mechanism created different expectations from the organisations involved. While MASH felt strongly that a crime may have been committed, the Police early on in the process were focusing on whether there could be other adults at risk in the property. In addition, it was suggested by the Senior Coroner for North London that email correspondence should be made with the Coroner in all cases to enable tracking of cases being brought forward.

The key learning point is that Police contact between the MASH and Officers can be strengthened through liaison in high risk cases with the Police lead in the MASH. Secondly, all cases in the MASH where there is a need to refer to the Coroner will be done via email correspondence in the first instance, with telephone contact secondary as cases require.

The MASH had primary oversight of the cases as it progressed under safeguarding adults and have the power to hold meetings under this process with partners to effectively set out the enquiry. Partners suggested that an earlier multi-disciplinary meeting could help to share information, agree enquiry terms of reference and responsibilities of each organisation. Due to the swiftness in which Ms K's funeral was held, it was acknowledged that in this particular case holding a meeting earlier while useful in sharing some information and responsibilities of organisations, there were existing gaps in information from partners, particularly around cause of death and statements from hospital staff.

The key learning point is the usefulness of multi agency meetings where partners have collated sufficient information related to the concern to enable effective partnership working.

Attendance to Ms K Home (Day 12 – a Wednesday)

It was noted by the Police in their report that during a visit to Ms K residence, they were approached by a neighbour whom had concerns about Ms K and her previous presentation. The group reflected on how empowered members of the public, including neighbours are, to raise concerns and publicity related to this. The partnership agreed that refreshed publicity in this financial year via the Safeguarding Adults Board collectively could contribute towards addressing this area

The key learning point is the responsibilities on all partners and the Safeguarding Adults Board to be assured there is sufficient publicity and awareness related to the safeguarding of adults at risk.

Systems & Knowledge

The NMH use a flagging system on Medway, which is a national programme, but does not include safeguarding. This will be raised with the Medical Director in the Trust, as a safeguarding flag could contribute to ensuring all staff are aware when there are concerns and help to prevent any missed opportunities for reporting, sharing information or safety planning for adults at risk.

The key learning is that systems can help support staff where designed bespoke to highlight safeguarding concerns.

The Police identified learning with respect to how reports via 101 or the Public Protection Desk were recorded, specifically where it falls upon local boroughs to investigate. The Met Police have reviewed their Sudden Death Policy and the next steps to consider following the learning from this case is how

staff can be equipped to investigate these often complex cases. It was recommended that Police Officers need specialist knowledge and early contact with the Crown Prosecution Service (CPS) to progress these cases robustly.

The key learning is the knowledge of front line officers in responding to cases involving the death of adult at risk experiencing abuse or neglect can be strengthened in how they are equipped to investigate.

4. Reflections from the Safeguarding Adults Board

The Safeguarding Adult Review Report was presented to the December 2016 meeting of the Safeguarding Adults Board. The Board heard about the challenges and learning, including an opportunity to add their reflections. These reflections are set out below.

4.1. Use of organisations internal processes during SAR

The purpose of a Safeguarding Adults Review as set out by the Care Act 2014 and related guidance is quite clear; the focus rests on lessons learnt and are not to apportion blame. Questions were raised at the Safeguarding Adults Board with respect to the role of the North Middlesex Hospital NHS Trust, while not in relation to medical care provided, but with their response to the safeguarding concerns which were evident.

An additional recommendation has hence been added for the North Middlesex Hospital NHS Trust to consider internally whether the Serious Incident (SI) Process would be an appropriate process to apply in this case.

4.2 Consideration for criminal action taken by Local Authority

A question was raised for the Local Authority as to whether criminal proceedings could be taken by the Local Authority once Police action was concluded. This was considered following the Board meeting and advice sought from legal to work through possible courses of actions. While the Local Authority has not identified any additional action to take at this time, it is acknowledged that there needs to be robust action against persons alleged to have caused harm and is committed to ensuring legal literacy in safeguarding; this will support staff to understand the recourse available, whether civil or criminal, for adults at risk of abuse. In practice, this legal literacy would enable practitioners from a range of organisations to consider, for example, wilful neglect under the Mental Capacity Act, and new laws such as the Serious Crime Act 2015 (coercive control) and Criminal Justice and Courts Act 2015 (wilful neglect or ill-treatment).

5. Learning

There were clear learning points for all partners, all of which have been translated into specific recommendations for Enfield and regionally or nationally were applicable. These learning points are set out in brief:

- All partners can be empowered to report to the Police where a crime is believed to have been admitted
- Multi agency safeguarding meetings, early on in complex cases, can help to clarify the information we hold and responsible persons for actions
- Where concerns exist the death certificate should be thoughtfully considered before completion
- Any partner can escalate concerns where they feel an organisation has not taken robust action; all organisations should welcome challenge as an opportunity to learn
- A picture is only as clear as the information which has contributed towards it; timely sharing of information in safeguarding is key to assessing risk
- Equipping staff with the knowledge to undertake safeguarding in complex cases which may involve a crime- whether as the referrer, co-ordinator of safeguarding or for Police Officers whom undertake investigations
- Everyone, including members of the public, need to know how to report concerns about adults at risk

Most importantly, the learning from this cases identified how a coordinated and timely approach by all partners could have changed the course of actions.

Recommendations

1. Strengthen the information sharing and communicate mechanisms between MASH and Police Officers whom operate in the Public Protection Desk as part of this partnership team. This will be done by agreeing pathway for MASH social workers to speak directly to a lead Police Officer for initial information and advice on cases. Secondly, to set out the escalation process in the MASH Operating Procedures for MASH social workers to take within Police structure.
2. A poster at the Enfield Acute Hospital Trust Accident and Emergency locations which highlights the need for all staff to report crimes to the Police upon presentation of adults at risk. This will be made available to all partners.
3. Empowerment for LAS staff to call Police when a crime has been committed. This will be actioned by an update of the LAS Procedures for Safeguarding Adults, strengthening of their training and an article in the LAS newsletter from learning in this case.
4. NMH staff to report to Police when they believe a crime has been committed. NMH will be running bespoke learning related to this event as a mechanism to address this area.
5. Improving the empowerment of organisations to call the Police. This will be contributed towards by a review of the safeguarding adults concern form to include clearer prompt for when person raising a concern should call the Police.
6. Use of multi agency meetings early on in high risk cases to bring partners together and set out responsibilities. This will be reformed by updating the MASH Operating Procedures.
7. NMH to explore addition of safeguarding flag on Meadway system.

8. For Police investigations involving death of adults at risk, the Met Police will review the process for investigating deaths involving adults at risk so officers are equipped to investigate.
9. Safeguarding Adults Board to consider how the partnership can contribute towards increasing the publicity of safeguarding and reporting of concerns. LBE to send out refreshed adult abuse line posters to key locations.
10. LBE to create a template for referrals to Coroners under safeguarding, so that these referrals by any partners are appropriately logged and can be tracked.
11. Learning Event Presentation to discuss case and issues around the issuing of a death certificate within the North Middlesex Hospital
12. Specific learning with the consultant at the North Middlesex Hospital around the death certificate and when to contact coroner
13. Review of Safeguarding Training in regard to death certificates and informing coroner
14. Learning tool to be created with respect to this case so that practice and outcomes in future will be transformed

6. SAR Action Plan

Action	By When	By Whom	Progress	Outcome
1. MASH Operating Procedures to set out pathway for MASH social workers to speak directly to a lead Police Officer for initial information and advice on cases.	Feb 1, 2017	MASH Team Manager		
2. MASH Operating Procedures to set out the escalation process for MASH social workers to take within Police structure.	Feb 1, 2017	MASH Team Manager		
3. Poster created for the Enfield Acute Hospital Trust Accident and Emergency locations which highlights the need for all staff to report crimes to the Police upon presentation of adults at risk.	Feb 1, 2017	Safeguarding Lead, NMH		
4. LAS Procedures for Safeguarding Adults to be reviewed and strengthen responsibility of LAS staff to report incidents of crime.	Feb 1, 2017	Safeguarding Lead, LAS		
5. LAS safeguarding adults training to be reviewed with particular emphasis on empowering staff to report to the Police. Learning from this SAR agreed as case example.	Feb 1, 2017	Safeguarding Lead, LAS		
6. LAS Newsletter to include article on learning from this cases.	Feb 1, 2017	Safeguarding Lead, LAS		
7. NMH to run bespoke learning event to set out learning points related to death certificates, referrals to Coroner, contacting of Police and raising of safeguarding concerns	Feb 1, 2017	Safeguarding Lead, NMH		
8. Safeguarding Adults Concern form in Enfield to be updated with additional prompts for those referring to contact Police if crime has been committed.	Feb 1, 2017	Team Manager, Strategic Safeguarding LBE		

9. MASH Operating Procedures to set out use of multi-agency meetings early on in high risk cases to bring partners together and set out responsibilities	Feb 1, 2017	Team Manager, MASH		
10. NMH to explore addition of safeguarding flag on Medway system	Feb 1, 2017	Safeguarding Lead, NMH		
11. For Police investigations involving death of adults at risk, the Met Police will review the related process so that officers are equipped to investigate	Feb 1, 2017	Met Police		
12. Partnership to set out how they can contribute towards increasing the publicity of safeguarding and reporting of concerns.	Feb 1, 2017	SAB Enfield		
13. Refreshed adult abuse line posters to be distributed to key locations	Feb 1, 2017	Team Manager, Strategic Safeguarding LBE		
14. Template for referrals to Coroners under safeguarding, so that these referrals by any partners are appropriately logged and can be tracked.	Feb 1, 2017	Team Manager, Strategic Safeguarding LBE		
15. Learning event for consultants at the North Middlesex University Hospital on death certificates and referrals to coroners	Feb 1, 2017	Safeguarding Lead, NMH		
16. Review of safeguarding training at the North Middlesex Hospital in regards to death certificates and informing the coroner	Feb 1, 2017	Safeguarding Lead, NMH		
17. Learning tool to be created with respect to this case so that practice and outcomes in future can be transformed	Feb 1, 2017	Strategic Safeguarding Adults Service, LBE		
18. Letter to GMC with summary from this case around signing of death certificates to request national sharing of learning with medical practitioners	Feb 1, 2017	Independent Chair of the SAB		
19. NMH to consider if the criteria for a Serious Incident (SI) has been met in this case	March 1, 2017	Safeguarding Lead, NMH		