Safeguarding Adult Review

Adult 'Ruth'

Executive Summary

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Independent Reviewer
March 2023

1. **Introduction**

2. RUTH was a a white British female who was born in 1971. Sadly, RUTH passed away at the age of 49 on the 31st August 2020.

3. **RUTH as a person**

4. RUTH was raised in the Shropshire area but at the time of death had resided in the Worcestershire area for a number of years.

5. RUTH was the mother to four children. RUTH's children were taken into care and/or cared for by their fathers. All are now of adult age.

6. Whilst it is clear RUTH was loved by her family, they will confirm they had limited contact with her in the period before her death.

7. In the last years of her life, RUTH's main source of company appeared to be SIMON and other friends who visited her at home.

8. RUTH had a long-standing personal relationship with SIMON. This relationship appeared to be 'on' and 'off' at different times. However, there are serious concerns that RUTH was the subject of coercive control by SIMON at different times in their relationship.

9. **RUTH's family perspective and involvement**

10. During the course of the review the independent author met with and engaged with RUTH's family including her sister, mother, aunty, and niece.

11. RUTH's Sister is the primary point of contact for the family.

12. There is a recognition of the adverse effect RUTH's death had on the family.

13. The family are naturally distressed about RUTH's living conditions prior to death. Whilst the family contact with RUTH had decreased since 2018, it is clear that she was loved.

14. RUTH's family were also concerned over time around her relationship with SIMON.

15. **Circumstances of RUTH's death. 31st August 2020**

16. At 20.10 hrs NHS 111 received a call from 'Simon' stating that 'Ruth' was not eating and feeling unwell. During the eight minute call 'Simon' stated that he thought 'Ruth' was dying and she could be heard groaning in the background.

17. The call taker dispatched an ambulance who, upon arrival, found 'Ruth' collapsed, deceased and lay upon her bed. 'Simon' was sat next to her, stroking her hair. He informed Ambulance crew she had suffered a fit and taken morphine.

18. The Ambulance crew observed that 'Ruth' was wearing a soiled nappy which contained stale faeces and urine which appeared several days old. The crew also observed a large wound to RUTH under the nappy at the front of her body which gave off a 'pungent smell of decay' when exposed. It was noted that no treatment appeared to have been given to the wound infection.

19. At 20.42 hrs Police were contacted by Ambulance control and asked to attend the address.

20. 'Ruth's' flat was noted as untidy, dirty, and smelly. 8 cats were found on the premises. Fresh food was evident, and Ruth appeared well fed and hydrated. Bottles of oral morphine were recovered from the premises.

21. **Parallel Proceedings**

22. On the 2nd of September 2020 a Post Mortem was carried out by Dr Matthew Lyall at the University Hospital Coventry and Warwickshire. Dr Lyall concluded that "taking all the findings into consideration, it is my opinion that this woman (RUTH) died as a result of pelvic sepsis which had probably occurred due to complications arising from a colo-vesical fistula."

23. WMP arrested SIMON on suspicion of murder on the day that RUTH died. This was primarily due to potential discrepancies in SIMON's account and the reported presentation of RUTH. A Police investigation took place, entitled Operation Ghana.

24. This investigation was subsequently closed, and no further action taken against SIMON.

25. No other parallel proceedings have taken place.

26. No disciplinary action had been taken against any employee involved in the care and support of RUTH.

27. **Supporting Framework:**

28. The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

29. Section 44, Safeguarding Adult Reviews**:**

(i) 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:

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) condition 1 or 2 is met

(ii) 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)

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

30. **Agencies**

31. The following agencies were identified as having contact with RUTH and requested to contribute to the SAR:

- Worcestershire County Council - Adult Social Care (WCC ASC).
- Herefordshire and Worcestershire Clinical Commissioning Group on behalf of Hillview Medical Centre (HWCCG).
- West Mercia Police (WMP).
- Worcestershire Acute Health Trust (WAHT).
- West Midlands Ambulance Service (WMAS).
- Bromsgrove & Redditch Borough Council & Social Services Housing Team (BRBCHT).

32. **Terms of Reference**

33. The WSAB set the following Terms of Reference:

1. **How the agency held 'Making Safeguarding Personal' at the centre of the services provided?**
2. **How the agency worked as part of a multi-agency approach in dealing with this safeguarding referral?**
3. **How and when MCA (Mental Capacity Act) was applied and documented?**
4. **How and when was the consideration of self-neglect policy applied?**
5. **What referrals were made for support regarding Domestic Abuse?**
6. **How did the COVID pandemic impact upon the multi-agency approach?**
7. **Identify and share effective practice at agency or individual level.**

34. **Scope of the Safeguarding Adult Review**

35. The Scope of the SAR is from **1st of September 2019** to **31st August 2020.**

36. The Independent Reviewer did review material as far back as 2015 where relevant to do so.

37. **Effective Practice**

38. This SAR seeks to adopt a strengths-based approach. This is consistent with the WSAB approach in wanting to recognise positive practice where appropriate to do so.

39. The context in which agencies and professionals were working, during a period of rising demand and austerity, together with the pandemic from March 2020, should be taken into account.

40. At different times, professionals recognised RUTH's vulnerability and adopted a caring, supportive approach.

41. There is evidence of listening, and responding, to RUTH's wishes, sharing information, highlighting the potential risk, and putting support in. However, this was not done consistently or coherently.

42. Conclusion

43. It is clear RUTH had a difficult life. She suffered from a range of physical and mental health challenges, which meant her four children were taken into care, which understandably significantly affected her.

44. Over recent times, RUTH had less frequent contact with her family, including her sister. It seems RUTH became increasingly reliant on SIMON and other 'friends'. It appears SIMON may have physically, sexually, and financially abused RUTH.

45. Multi-agency working is challenging, but critical. It is recognised there is always a raft of competing demands on agencies. The pandemic would have presented additional challenges for professionals in the months leading up to RUTH's death. However, effective multi-agency working can provide an enhanced response, and protection, to individuals with multiple and complex needs.

46. RUTH's contact with agencies and professionals reduced over time. This resulted in limited multi-agency intervention to support RUTH, and address her physical and mental health needs, as well as her poor living conditions.

47. In undertaking this review there were some examples of good practice identified which are detailed earlier in the report.

48. However, taking into account the complex circumstances and range of needs, I would suggest professional practice was, on a number of occasions, reactive; rather than a proactive holistic assessment being taken relative to RUTH's risks and needs.

49. Professionals should consider earlier intervention to address the needs of people, who are presenting clear physical and mental health needs**.**

50. This review has identified a range of learning points for agencies and professionals, when supporting vulnerable people, who are subject of abuse and self-neglect. The learning includes:

- The importance of seeking to engage with people, in order to elicit a clearer picture of how things are for them and what their needs, wishes, beliefs, priorities, and motivations are
- The importance of the requirement to explore the person's needs, and to undertake robust and comprehensive assessments
- The importance of assessing the risk posed by people who elect to adopt a 'carer's' role
- The importance of taking robust action, and looking at the cumulative picture, when abuse is alleged
- The importance of multi-agency working, and the benefits of calling together a Professionals meeting at the earliest opportunity
- The importance of identifying a lead professional to lead, co-ordinate and monitor a multi-agency response
- The requirement to be professionally curious, particularly where the vulnerable person may be reluctant to engage
- The understanding and application of the Self-Neglect Guidance
- The importance of promoting safe relationships

51. A SAR triggered by the death of a adult, involving abuse or neglect of such person, is by nature a reactive activity.

52. A standard question to consider, as part of an SAR, is what learning and improvements in practice can Agencies take away.

53. In common with many SARs, this one raise questions regarding multi-agency working, training, professional curiosity, risk assessments, sharing of information and the balance between individual rights and duty of care. It is of note, within the professionals learning, they described many of these issues are repeated familiar themes, rather than isolated to this case.

54. RUTH's death was naturally very distressing for the family. There is clear learning for WSAB, and the agencies involved.

55. It is acknowledged that since RUTH passed away WSAB has supported a range of professional development activity across key areas such as domestic abuse,

professional curiosity, mental health, and self-neglect. The introduction of the CARM process is an important and positive step forward.

56. A critique of Safeguarding Adult Reviews over time will identify, despite the commitment of agencies and professionals to safeguard the most vulnerable, much of the learning in this review are common and repeated themes.

57. Determining how to instigate transformational sustainable change is a significant challenge for agencies and partnerships. The relevant learning, and from this review should be disseminated and monitored to support change.

58. **Multi Agency Learning**

59. **1. WSAB should share the findings of this SAR with the Domestic Abuse Partnership Board and seek assurance that the multi-agency domestic abuse training - supports professionals in identifying coercive and controlling behaviour where it may be 'hidden in plain sight' and reinforces the need for a safe space to talk**

60. **2. WSAB may wish to consider how they may work with Advocates and Community Services, where vulnerable people are reluctant to engage with statutory services.**

61. **5. Agencies should review their practice where a person may be supporting another to reassure themselves that there is clear consent, and the carer is acting in the person's best interests.**

62. **7. WSAB should ensure the importance of professional curiosity is embedded throughout the safeguarding competency framework.**

63. **9. When presented with a challenging complex case such as this, agencies should identify a lead professional (currently referred to as a 'key person'). Consideration should be given to bringing together a multi-agency professionals meeting at the earliest opportunity. This is particularly the case where people are reluctant to engage.**

64. **11. WSAB should reaffirm the importance of multi-agency working in complex safeguarding cases. WSAB may wish to consider undertaking audit and inspection activity, in order to provide reassurance policy and practice is complied with on a consistent basis.**

65. **12. WSAB should review the MCA competency framework to ensure that includes self-neglect.**

66. **13. WSAB should consider building upon the professional development completed or commissioned to date and continue to promote the Self Neglect Practice Guidance (July 2022). It is suggested an annual review should take place.**

67. **16. Progress on the recommendations contained within this Review, should be reported back to the WSAB on a quarterly basis.**

68. **<u>Single Agency Learning</u>**

69. **3. ASC to develop recording systems to support staff to identify patterns of behaviour.**

70. **4. Hillview Practice should review their Practice and Policy to ensure there is regular, and consistent attempts at contact with patients who have complex needs; particularly where they have disengaged.**

71. **6. WMP should ensure there is engagement with other agencies before deciding to close a Risk Management Plan.**

72. **8. The HAU should ensure there is consultation with all agencies, and a clear comprehensive record made of the risk, and the rationale, behind any decision making.**

73. **10. ASC to ensure that a multi-agency discussion or meeting is completed where the Section 42 enquiry duty is triggered.**

74. **14. Hillview Practice to review policy and practice and ensure patients, with complex needs who may be subject of domestic abuse, are appropriately flagged; particularly when Police notification is received.**

75. **15. WMP to raise awareness of the importance of recording historical crimes, in line with Force Policy and Home Office Counting Rules, and monitor compliance.**