Walsall Safeguarding Partnership

Safeguarding Adult Review – SAR12

Review in Rapid Time Report

'CD'

1. Details of Initial Referral

'CD' was a 61 year old White British woman, with restricted mobility and diagnosed mental health conditions including paranoid schizophrenia. She was subject to S117 under the Mental Health Act 1983 amended (2007). She was found deceased on 3rd April 2023 following a fire at her home address. Her husband also died as a result of the fire.

2. Review in Rapid Time

Reporting Agency: Adult Social Care, Walsall Council
Date submitted to WSP: 4 April 2023

Short summary of rationale for referral:

'CD' was found by emergency services at her home address following a fire. Her husband was also found deceased in the premises.

The decision to refer for consideration of a Safeguarding Adult Review (SAR) was taken by ASC as Subject had Care and Support needs, and a history of involvement with services including ASC, Fire, Police and a range of Health agencies.

She had received an Adult Care and Support Assessment as a result of which she had been allocated a Support Worker since 2nd September 2019.

The nature of the support provided included accessing legal advice regarding housing and living arrangements as to whether she would stay with her husband. Their relationship had been described as 'fractious'. Subject was inconsistent in terms of whether she wanted to stay or find alternative accommodation.

The Support Worker had noted that their property was cluttered.

There had been a referral to the West Midlands Fire Service as Subject was a known smoker whose habits presented a risk. She had received fire safety visits that resulted in the deployment of equipment such as fire retardant covers for her chair, a fire mat and a fire bin for her cigarette ends.

There had been a fire at the address in September 2022 when the Subject lit a candle which was placed on the windowsill and set light to a curtain. Subject had apparently dealt with this herself but sustained minor burn injuries to her hands. There were smoke alarms in the house.

The Support Worker last visited on 28th March 2023 to assist with a move to alternative accommodation but no vacancies were available. Her husband had indicated he would continue to support her if she found alternative accommodation.

Recorded Safeguarding Concerns 2017 – 2022:

- **Safeguarding Concern 17.02.2022:**

'CD' disclosed that her husband had "thumped" her on Saturday. She said he had hit her on her arm. Slight bruising noted to her left arm. However, she'd reported "do not feel any threat or concern to her safety".
Safeguarding Enquiry completed: Outcome: "The primary risk still remains and will be addressed through close collaboration between health and social care services and Black Country Women's Aid. I have provided Subject with advice and information regarding steps to minimise future risk. She has agreed to implement these by calling the Police when she feels in danger. To be referred to Black Country Women's Aid for support. Has capacity. Support worker to support her desired outcome to move to an alternative accommodation".

- **Safeguarding Concern 22.10.2020:**

Concerns financial abuse. The Beacon reported concerns: Making large donation to charity following inheritance.
Safeguarding Enquiry completed 05.02.2021: **Outcome**: 'CD' is able to make decisions around how to spend her money as per the assessment outlined in the Mental Capacity Act 2005 section 3. She has a right to unwise decisions (s.1.4) as well as a right to private and family life (Article 8, Human Rights Act 1998). *It was noted elsewhere that much of the money donated was returned.*

- **Safeguarding Concern 05.11.2019:**

Raised concerns that husband is trying to poison her and controlling her finances.
Outcome of enquiry 02.12.2019: the primary concerns that 'CD' has alleged has no real substance and her train of thought seems to suggest that she is unsure on whether these issues are happening or not. Based on the enquiries made it's likely that her mental health has started to deteriorate and compounded her current problems with her husband.

- **Safeguarding Concern 28.8.2019**

'CD' has disclosed physical, emotional, psychological and financial abuse from her husband and on one occasion from her brother.
Enquiry Outcome: Closed: 'CD' advised "I never said husband hit me, I said my brother hit me many years ago at my mum's funeral, and guess what I found out it was not my mum". Safe and well visit completed by Support Worker.

- **Safeguarding Concern: 10.5.2017:** 'CD' was observed being kicked by another patient.

Outcome: Safeguarding closed.

3. Family Context

At the time of the incident 'CD' was living at home with her husband, who fulfilled the role of her carer.

Her husband/carer had previously expressed concerns as to his ability and willingness to continue caring for her due to her attitude and presenting behaviours.

4. Initial Scoping Discussion

The initial referral had been submitted by Adult Social Care (ASC) due to 'CD's acknowledged Care and Support needs, and because of concerns as to whether partner agencies had missed opportunities to effectively work together to safeguard her or failed to identify unmet needs.

There were concerns about Hoarding and Self-Neglect, and it was unclear if alleged incidents of Domestic Abuse had been shared between partner agencies. There was also a suggestion of services being declined on behalf of the Subject by her husband.

The criteria for a Safeguarding Adult Review were discussed and it was agreed that these were met.

The decision was taken that this case should go forward for a Review in Rapid Time in accordance with Walsall Safeguarding Adult Board procedures.

5. Review in Rapid Time

Attendees:

- West Midlands Police
- Black Country Integrated Care Board (Black Country ICB)
- Black Country Healthcare Foundation Trust (BCHFT)
- Black Country Women's Aid
- Walsall Council – Adults Social Care (ASC)
- West Midlands Fire Service
- Walsall Healthcare Trust (WHT)
- Walsall Safeguarding Partnership Interim Business Manager
- Walsall Safeguarding Partnership Interim Case Review Coordinator
- Walsall Safeguarding Partnership Chair

This case was considered under Walsall Safeguarding Partnership's recently introduced Review in Rapid Time process.

The Chair of WSP Safeguarding Adult Board chaired the meeting and began by explaining the process. The first issue to be addressed was to confirm the scoping decision that the criteria for a SAR as laid out under Section 44 of the Care Act 2014 had been met.

It was agreed that the Subject:

- had care and support needs,

- there was reasonable concern how partnership agencies had worked together to safeguard her,
- Condition 1 was met as subject had died,
- There were unresolved concerns as to whether her death resulted from abuse or neglect.

It was further noted that there are a range of SAR methodologies available, and that a Review in Rapid Time was one option. At the conclusion of the meeting, it would be determined whether all relevant learning had been identified via the Review in Rapid Time process or an alternative form of review was required, and this could include a traditional SAR methodology.

As the initial referring agency, ASC provided a summary of their concerns that prompted a referral and supplemented this with material from their written submission requested subsequent to the scoping discussion.

The good practice of the Mental Health Support Worker was acknowledged, with their excellent record keeping being noted as well as their being an effective conduit to other services. It was also noted however that over time 'CD's hoarding and the resulting cluttered environment had become normalised, professional curiosity could have been stronger, and whilst there had been liaison with the Fire Service, concerns about the conditions hadn't been escalated.

It was noted that single agency learning had been identified by ASC and already acted upon, and there was multi-agency learning in terms of the need for stronger protection planning.

It was acknowledged by Black Country Women's Aid that whilst they would not have been able to work on a 1:1 basis with 'CD', they could have offered advice in a multi-agency context. An update was also provided regarding their Independent Domestic Abuse Advisor service.

The West Midlands Fire Service submission highlighted internal learning that was being addressed and that when issuing equipment as had been the case with 'CD', better information sharing with agencies such as ASC and any relevant caring agency was needed. They have introduced an improved data system that allows more effective checking of any previous contact with someone.

They had been in contact with 'CD' but not all messages left on her mobile phone were followed up. There were smoke alarms in the house, and when checked there was charge in the batteries. During the subsequent investigation, neighbours reported that 'CD's smoke alarms regularly sounding but they had not heard anything on the night of the fire.

The fact that the Fire Service had been involved was noted as a positive.

West Midlands Police detailed their involvement with 'CD', including evidence of good inter-agency working between themselves and the Subject's GP.

The submission by Black Country ICB highlighted good practice by the GP prioritising face to face appointments for the Subject but despite this she had on occasions declined certain tests / investigations. There were gaps in her records where it was not always evidenced that issues of domestic abuse had been discussed with her. It was asked whether there was any evidence of controlling behaviour by her husband at meetings such as medical appointments but evidence provided in agency submissions indicated that 'CD' was usually accompanied by her Support Worker rather than the husband. His wellbeing as a carer for a challenging partner was also discussed.

The supportive approach of the GP was also noted by WHT but at one outpatient appointment when 'CD' appeared agitated, this was not fully investigated and was perhaps indicative of a lack of professional curiosity.

It was also noted that the support provided to 'CD' regarding her mental health had not been consistent throughout the period under consideration and that her cluttered home environment and daily life could have been viewed as Self-Neglect. 'CD' had not been referred to the Walsall Self-Neglect Panel, and a question was asked whether the process here is comparable to the VARM (Vulnerable Adult Referral Mechanism) process in Sandwell. (It was suggested that if a person in similar circumstances in Sandwell declined visits from such as a Fire Safety Officer, they would have been referred to VARM). It was agreed that such a referral would probably not have changed the outcome as agencies were communicating with her and other visits were taking place.

Learning / Recommendations:

- Walsall Safeguarding Partnership to produce a learning briefing that highlight the benefits of protection planning and multi-agency meetings, thus reducing the risk of missed opportunities to safeguard vulnerable individuals.

- Recognising the key role of the Fire Service in tackling cases of Hoarding and Self-Neglect, a meeting has been held with a WMFS representative who confirmed that they attend both the subgroup and the Self-Neglect and Hoarding Panel. This enables issues such as the sharing of relevant information to be regularly reviewed.

- Walsall Safeguarding Partnership to work with partner agencies to promote awareness of the Mental Capacity Act, and in particular to highlight the need to record the outcome of capacity assessments.

- The complexities apparent in the relationship between 'CD' and her husband were acknowledged. Her mental ill-health and behaviours had at times placed significant pressure on their relationship, and it was noted that he continued to act as her carer. Walsall SAB will consider how best to remind colleagues of the importance of concerned curiosity when considering family relationships.

- Walsall Safeguarding Partnership to produce learning materials to remind colleagues that where there is a possibility of familiarity with a person's situation leading to diminished professional curiosity, regular supervision can assist in maintaining vigilance.

- As a general and recurring theme in SARs locally and nationally, the need for proactive and concerned curiosity was recognised when working with adults with care and support needs.

Conclusion

In summarising the discussions, it was the consensus view that the criteria for a SAR had been met and that the Review in Rapid Time process had identified all the likely relevant learning and that it was not necessary to commission any further review.

An Action Plan to address the learning points will be produced.