September 2024

SAFEGUARDING ADULTS REVIEW

Adult B

PREFACE

‘Local Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult.’

S.44 Care Act 2014

In 2022 the Suffolk Safeguarding Adults Board (SAB) considered the case of Adult B, who died in October 2021. Adult B had been known to a number of agencies and identified as being at risk of abuse and neglect however the SAB determined the criteria for a Safeguarding Adults Review (SAR) had not been met.

The purpose of a SAR is to determine what the relevant agencies and individuals involved might have done differently, that could have prevented Adult B’s death. This is so lessons can be learned from the case and those lessons applied in practice, to prevent similar harm occurring again.

The following review has been prepared by Diana Stroh, a former police safeguarding investigator, with over twenty years’ experience in joint-agency working, and eldest daughter of Adult B.

“Suffolk’s safeguarding professionals persistently failed my dad, when they had the information to support statutory safeguarding reviews into his care between May 2018 and his death in October 2021. As a former safeguarding professional myself, I find this collective behavior worrying and potentially unsupportive of vulnerable adults in need of safeguarding.”

Whilst this Safeguarding Adults Review may not have been produced by more conventional means it, nevertheless, follows recognized principles of research, information-gathering and, on the whole, objective analysis into the structures, actions and outcomes of agencies involved in safeguarding Adult B.

INTRODUCTION

Adult B was 88 years old at the time of his death. He'd been a widow since 2000 after his wife of 47 years died following a short battle with cancer. Adult B moved from the Woodbridge area shortly after her death, to a large three-bedroom bungalow in Bramford.

He had two adult daughters that lived in the area.

Adult B had previously worked for Suffolk County Council.

Adult B didn't have any other family based in Suffolk and, whilst on good terms with a small group of neighbours in his age-range, was reluctant to forge friendships beyond this. He would describe himself as a private person.

One of these neighbours, Mrs M, offered ad-hoc cleaning for Adult B, whilst his immediate neighbours offered basic welfare support on an informal basis.

Adult B self-managed a number of medical conditions through prescription medication.

He was first diagnosed with dementia in early 2018 after a referral from his eldest daughter.

Adult B received live-in care from his eldest daughter, Ms D, between December 2013 and May 2018.

He received care from his younger daughter, Mrs J, from May 2018 until his death in 2021.

Adult B first came to the attention of agencies in 2018 during this significant change in his care provision and a diagnosis of dementia.

In February 2021 he again came to the attention of agencies after showing signs of self-neglect, injury-inducing falls and a further decline in his mental state. Adult B initially accepted an offer of local authority support but subsequently declined this.

Adult B died in hospital on the 16th October 2021. He'd been admitted after suffering a fall at home and wasn't discovered for several hours. At the time of his death agencies were involved in a crisis period, responding to allegations of neglect and financial abuse raised by Adult B's eldest daughter.

A s.42 review (Care Act 2014) was commenced after Adult B's death and a subsequent request for a s.44 review was refused in May 2022.

TERMS OF REFERENCE

This report will focus on events from January 2018 and will specifically examine,

- The circumstances and events surrounding Adult B's death.
- How legislation, policy and guidance informed the provision of care provided to Adult B, including duties under the Care Act 2014.
- Whether there were opportunities for the agencies to have worked more effectively with regard to Adult B to safeguard him and others.
- Information sharing, communication and coordination of multi-agency care, including referrals, assessments and reviews.
- Whether there are lessons to be learnt from the circumstances of this case, about ways in which local professionals and agencies worked together to safeguard Adult B.

NARRATIVE SUMMARY

Adult B was a widower, having lost his wife to cancer in 2000. He'd lived alone in a large three-bed detached bungalow since his wife's death, having been emotionally unable to remain in the home he'd shared with her.

He visited his wife's grave once a week for eighteen years, until unable to do so due to failing health.

Adult B had been a self-sufficient individual for much of his life and was competent in a wide range of D.I.Y. skills. He took up wood-working hobbies following his retirement and created a fully equipped workshop in his garden where he spent many happy hours making objects and gifts for family and friends.

Since the 1990s Adult B had regularly visited his sister, Mrs M, in Australia. These annual trips usually occurred between February and April.

On the whole Adult B appeared to take a pro-active attitude to his own health and managed his medication effectively for many years. Main long-term health concerns included angina and arthritis.

In late 2013 Adult B's eldest daughter Ms D moved in with Adult B in what was meant to be a temporary measure. It was discovered Adult B's health and his ability to care for himself had not been as effective as previously thought, and Ms D became his live-in carer, in the absence of any alternative options.

This led to a dramatic, and unplanned, change in Ms D's personal plans, a situation still affecting her to this day.

In August 2017 Ms D raised concerns over Adult B's ongoing memory loss with his GP and he was diagnosed with dementia in early 2018.

In April 2018 Adult B returned home from his annual trip to Australia, suffering from a severe urinary tract infection (UTI). He'd also suffered a fall and subsequent chest infection.

Ms D was suitably concerned about his physical and mental presentation to raise concerns with his GP.

At the same time Adult B's younger daughter, Mrs J, became uncharacteristically involved in Adult B's care.

Just days after his return from Australia, and without warning, Adult B issued an eviction notice on Ms D. The notice contained a number of unsubstantiated allegations and failed to acknowledge Ms D's role as Adult B's main carer.

Adult B appeared unaware of the eviction order when asked and was unable to identify suitable plans for his care following Ms D's departure. He was still being treated for the UTI and was refusing to take his regular medication as prescribed.

Having previously supported Ms D with concerns over Adult B's health and wellbeing, his sister Mrs M arrived in the UK to focus on establishing the value of Adult B's bungalow and other assets. Mrs M was also unable to identify suitable plans for Adult B's care following her return to Australia.

Concerned about the impact of potentially significant changes in Adult B's personal circumstances, Ms D reported safeguarding concerns to the police, which were then referred to the local authority adult safeguarding team. These included concerns over potential neglect, domestic and financial abuse.

Ms D was later advised by a representative of Suffolk's Adult Care services, in August 2018, that Adult B had 'full' mental capacity and didn't require any professional support.

At the same time Adult B made significant changes to his will, leaving Mrs J the main beneficiary. He also changed his burial arrangements, requesting to be buried in a newly-purchased plot rather than be laid to rest with his wife.

In December 2018 Ms D wrote to the police safeguarding lead claiming she believed Adult B to be at risk of financial abuse. She was unaware of the changes to his will at the time. Suffolk Constabulary failed to respond.

In January 2021 Adult B claimed he 'sits all day in the same position watching the TV.'

On the 13th February 2021 Adult B was seen in A&E for a minor head injury following a fall.

On the 22nd February 2021 Mrs J contacted Adult B's GP surgery to report he was not eating and appeared confused, that he lacked an appetite and wasn't drinking enough. His dementia was considered by the GP but not discussed with Mrs J.

On the 23rd February 2021 Adult B was seen in A&E for another fall where he lost consciousness. He was referred for a FAB review.

On the 24th February 2021 Mrs J was contacted by Suffolk Adult Care Services (ACS) and stated Adult B's condition had deteriorated with him becoming more forgetful. Mrs J also stated Adult B was not consistently maintaining personal hygiene, including a failure to change his incontinence pads.

On the 7th April 2021 Adult B was referred to Community Memory Assessment Service, by his GP. Mrs J advised the Service Adult B's memory problems were 'all new to her' despite Adult B having been diagnosed with dementia in 2018.

Adult B was seen by a member of the CMAS Team on the 19th April 2021 and diagnosed with Dementia in Alzheimer's disease.

It was noted on the letter to the GP that Adult B wasn't taking any of his evening medication. It was also noted that Adult B was not suitable for medication in relation to his diagnosis due to 'poor balance and unsteadiness in his mobility'.

Adult B was advised of this diagnosis on the 9th August 2021. Whilst he'd initially agreed to carers assisting him when seen in A&E in February, Adult B later declined any assistance from ACS.

On the 12th October 2021 Adult B was admitted to hospital after suffering a fall. He was not discovered for several hours.

Adult B's eldest daughter, Ms D, was advised of this by concerned neighbours, when they were unable to contact Mrs J.

Upon seeing Adult B's condition, Ms D made an immediate safeguarding referral to the Director of Suffolk's ACS.

Adult B died in hospital on the 16th October 2021.

The Director of ACS was advised of this by Ms D.

On the 25th October 2021 it was agreed, at a Multi-Agency Safeguarding Hub (MASH) hearing, that the criteria had been met for an enquiry, under s.42 of the Care Act 2014, to ascertain Adult B's views 'in relation to the concerns raised by his daughter'.

The report stated Adult B had not been spoken to in over two years and it was felt appropriate to do so in light of his recent Alzheimer's dementia diagnosis.

A copy of the MASH report was forwarded to Ms D on the 26th October 2021.

On the 30th October 2021 Ms D made a complaint to Suffolk Constabulary, alleging her sister, Mrs J, had abused Adult B and suspected her of doing so to fraudulently obtain his money, when Mrs J refused to communicate with Ms D regarding their executor obligations.

On the 1st November 2021 Ms D made a further complaint to police, after receiving malicious communications from one of Mrs J's neighbours, attempting to intimidate her.

The police ignored these complaints.

On the 3rd November 2021 Ms D received correspondence from an ACS representative, stating a s.42 enquiry would investigate Adult B's care needs up to his death.

On the 8th November 2021 Ms D was arrested on suspicion of harassment, following a complaint from Mrs J. The complaint was dropped after it was discovered Mrs J was refusing to disclose information Mrs D was lawfully entitled to. Mrs J was instructed by police to disclose the required information.

Subsequent legal investigations identified Adult B had changed his will to benefit Mrs J and her immediate family, in August 2018.

On the 11th February 2022 Ms D received correspondence from an ACS representative, stating '…the safeguarding enquiry was closed as inconclusive as there was no evidence from the information gathered that your father was at risk of neglect or financial abuse'.

The correspondence went on to state '…any assessment would have been conducted in line with the guidance given in 2014 Care Act and could only have been carried out with the actual person's consent if they had Mental Capacity'.

In April 2022 Ms D made a complaint to the Suffolk Safeguarding Partnership (SSP), requesting a Safeguarding Adults Review (SAR) be conducted, in accordance with s.44 of the Care Act 2014, stating the s.42 review had been unlawfully conducted after Adult B's death.

In May 2022 Ms D received correspondence from an SSP representative stating her referral '…did not meet the criteria for a Safeguarding Adult's Review'.

In July 2022 Ms D made a complaint to the Local Government and Social Care Ombudsman. The Ombudsman concluded '…the Council's safeguarding investigation was as robust as it could have been...' and refused to conduct an investigation into Ms D's complaint.

ANALYSIS AGAINST THE TERMS OF REFERENCE

The following findings have been produced following the methodical analysis of available evidence, including formal reports, medical records and correspondence, alongside relevant legislation, regulation, policy and guidance. The findings have been categorized according to the terms of reference identified.

TOR 1. The circumstances and events surrounding Adult B's death

Adult B died in hospital, four days after suffering a fall at home on the 12th October 2021. He wasn't discovered for several hours. The cause of Adult B's death included Alzheimer's dementia and a lower respiratory tract infection. He was initially diagnosed with dementia in early 2018.

His dementia, taking into account information from Adult B's medical records, may have played a significant part in Adult B's cognitive understanding of his care needs over the three year period leading up to his death, and affected how Adult B responded to offers of support from professionals and informal support networks.

Adult B had been prone to respiratory infections for a number of years and, eight months before his death, suffered two falls requiring A&E attendance, one for a minor head injury. It was also recorded that Adult B was not eating or drinking appropriately and not consistently maintaining personal hygiene at the time. His main carer was also expressing concerns on how to cope with Adult B's needs.

In April 2021, Adult B agreed to carer assistance from the local authority but, shortly afterwards, declined this assistance. Available evidence suggests the authorities lacked the suitable professional curiosity to further consider Adult B's needs and the efficacy of his support network in light of the information being provided. There also appears to be little consideration having been given to potential disguised compliance by those close to Adult B and, specifically, Mrs J, who was later found by police to have withheld information from family members.

On the 12th October 2021 Adult B was admitted to hospital. His eldest daughter, Ms D, after seeing Adult B's neglected condition, made a safeguarding referral to the Director of Adult Care Services.

On the 16th October 2021 Adult B died.

A week later, on the 25th October 2021, a multi-agency safeguarding panel agreed Adult B met the criteria for a s.42 (Care Act 2014) review.

While it's not possible to say Adult B's death was predictable or preventable, the circumstances of his death highlight a number of concerns about the way the agencies worked together to safeguard Adult B, including responses to self-neglect and a deterioration in his mental health, leaving him vulnerable to abuse.

Care Act 2014, s.42

The Care Act 2014 requires a local authority to make statutory enquiries, or cause others to do so, where it has reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and as a result of those care and support needs is unable to protect themselves against the abuse/neglect, or the risk of it.

The principle behind S42 is the promotion of wellbeing, and prevention, and therefore does not apply to deceased individuals.

The legislation doesn't state a s.42 enquiry should be undertaken to establish the mental capacity of the person concerned.

Nor should it be assumed that someone with full mental capacity is immune from abuse or neglect.

Adult B was first referred to the local authorities, by Ms D and the police in 2018, during a significant period of upheaval and ill-health. Adult B was being treated for a UTI and displaying signs of delirium at the time, with his younger daughter, Mrs J, forcibly taking control of Adult B's care needs, having expressed little interest prior to this.

There was also evidence to indicate Adult B was not taking his medication as prescribed and that he had recently suffered a fall and chest infection whilst staying with his sister, Mrs M, in Australia. He had previously been diagnosed with dementia, following a referral to his GP in August 2017.

Despite the referral alleging Adult B was at risk of neglect and financial abuse, it's unclear whether the agencies involved treated this referral as a s.42 review.

It was concluded, in August 2018, that Adult B had 'full' mental capacity, and did not require local authority intervention, which appeared to conflict with information available at the time.

In February 2021 it was established that Adult B's mental health was declining, with evidence of self-neglect identified and his carer struggling to cope. Section 10 of the Care Act 2014 places a duty on local authorities to assess the support needs of carers, and yet there's no evidence to suggest this was considered in relation to Mrs J.

Local authority assistance was offered and initially accepted by Adult B. However, few, if any, enquiries appear to have been made after this assistance was rejected, to establish whether Adult B was able to make suitable choices concerning his care.

On the 12th October 2021, Ms D made another safeguarding referral to the local authority, after Adult B was admitted to hospital having suffered a fall and laying undiscovered for several hours, and showing signs of neglect.

Adult B died on the 16th October 2021.

On the 25th October 2021 a multi-agency safeguarding panel agreed the criteria for a s.42 review had been met, and recommended this be conducted, however, Adult B was already dead by this time with the panel apparently unaware of this.

On the 3rd November 2021, Ms D received written confirmation that a s.42 review was to be carried out to '…investigate the care needs leading up to your father's death.'

Ms D was later advised, in February 2022 that the '…safeguarding enquiry was closed as Inconclusive…'

Opportunities to conduct appropriate s.42 reviews in 2018 and early 2021 appear to have been missed by the authorities, with the emphasis being on mental capacity rather than safeguarding, despite strong evidence to indicate Adult B was at risk from neglect and abuse.

The s.42 enquiry, conducted following Adult B's death, should be considered unlawful.

Recommendations: Legislation, Policy and Guidance

The Care Act 2014 sets out a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. S.42 of that Act imposes an obligation on the local authority to make appropriate enquiries if it believes an adult is experiencing, or is at risk, of abuse or neglect. On three separate occasions obligations under s.42 of the Care Act 2014 appear to have been mistakenly applied by the agencies involved in Adult B's case.

The Board should ensure that those who may have cause to carry out a s.42 safeguarding enquiry have the suitable training and support to do so in accordance with relevant legislation.

<u>Care Act 2014, s.44</u>

The Care Act 2014, s.44 states a Safeguarding Adult Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support if there's a reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult and the adult has died and the SAB knows or suspects that the death resulted from abuse or neglect.

It goes on to state each member of the SAB must co-operate in, and contribute to, the carrying out of the review with a view to identifying the lessons to be learnt from the adult's case and applying those lessons to future cases.

Ms D, believing the criteria for a s.44 review had been met in Adult B's case, made a referral to the SAB in April 2022.

In May 2022 she received a response from the SAB, stating her referral '…did not meet the criteria…'

The response went on to state the SAB was '…satisfied by the County Council's assessment both of what happened and by your father's capacity to take his own decisions…'

This seems to suggest some sort of review was carried out but not necessarily a s.44 review as was the obligation of the SAB in Adult B's case.

Enquiries in 2018, focused on Adult B's mental capacity rather than the risk of abuse or neglect, and there's little evidence to suggest any enquiries were carried out in early 2021, when Adult B was presenting with neglect issues.

There's also little evidence to suggest relevant authorities considered a s.10 (Care Act 2014) carer's assessment with Mrs J, in April 2021, who was disclosing an inability to cope with Adult B's condition at the time.

The multi-agency report, dated 25th October 2021, had confirmed Adult B's case met the criteria for a s.42 review, and recommended one be undertaken, albeit the panel was unaware of Adult B's death at the time.

However, those undertaking the subsequent s.42 review *were* aware and described the review as being to '…investigate the care needs…' leading up to Adult B's death. As previously identified, a s.42 review can't be lawfully conducted on a dead person, indicating a lack of legislative understanding.

The SAB response in May 2022, again, referred to Adult B's capacity to '…take his own decisions…' as a factor for not conducting a s.44 review, indicating a further lack of legislative understanding.

The purpose of a s.44 review is to establish whether the authorities involved could have worked together better to safeguard the adult concerned, after that adult has died, to ensure a learning culture can be applied to future cases, with evidence suggesting in Adult B's case that the criteria for a s.44 review had been met.

Recommendations: Legislation, Policy and Guidance

The Care Act 2014 (s.44) sets out a clear legal framework for when a Safeguarding Adult Board must conduct a formal review into cases where an adult with care and support needs has died and there's a concern as to how the authorities worked together to safeguard the adult, knowing or suspecting abuse or neglect was a factor in the adult's death. The SAB in this case appears to have mistakenly failed to conduct a s.44 review in accordance with its statutory obligations, focusing instead on mental capacity to negate the need for a review.

The Board should ensure that its members, and its relevant partners, who may have cause to consider, approve and conduct a s.44 Adult Safeguarding Review have the suitable training and support to do so in accordance with relevant legislation.

<u>Mental Capacity Act 2005</u>

The Mental Capacity Act applies to anyone working with individuals who may be suffering from impairments or disturbances in the function of their mind or brain that may compromise their ability to make decisions. These impairments could be temporary or permanent.

Unwise decisions do not in themselves demonstrate a lack of mental capacity, and it's a matter of assessing the individual's ability to make a decision, rather than the decision itself, when working with people suffering from mental health issues.

Assessing a person's capacity to make decisions about care arrangements and interventions is crucial and the Act does not prevent the authorities from making their own decisions about the interventions they offer or the manner in which they're provided but, rather, when a person has been assessed to potentially lack capacity in relation to a particular decision, it sets out a process for ensuring the individual's part of the decision-making process is undertaken subject to certain considerations under the 'best interests' test.

Case law suggests “The purpose of the best interest test is to consider matters from the person’s point of view” (Aintree University NHS Hospitals Trust v James, 2013).

People with dementia may lose mental capacity and be unable to make some decisions. The mental capacity of someone with dementia can also be subject to change, short-term or long-term, and depends on the complexity of decisions being considered.

The Mental Capacity Act requires professionals to take this into consideration when supporting an individual to make decisions.

In the case of Adult B there appears to have been limited attempts to assess his ability to make decisions, including decisions about his care needs, despite his dementia diagnosis in 2018.

The local authority stated Adult B had ‘full mental capacity’ just months after he was diagnosed, and was facing a significant reduction in supportive family care.

In early 2021 the local authority offered Adult B care support, after a documented decline in his mental health, linked with his dementia, and evidence of self- neglect. However, Adult B’s subsequent decision to refuse the care support was not queried.

Opportunities to discuss Adult B’s decision-making abilities with his support network may also have been missed when the authorities failed to consider a carer’s assessment at the time.

As Adult B’s mental health deteriorated his ability to make decisions and his mental capacity would have been likely to fluctuate and become increasingly variable. Assessments of Adult B’s capacity appear to have been brief, if conducted at all, and failed to consider all relevant information, with capacity seemingly used to excuse the need for professional involvement in Adult B’s care.

Decisions about whether a person has, or lacks, capacity should be person-centred and thorough, and should not be made simply to support a course of action, or inaction, that the authorities wish to follow.

Recommendation: Legislation, Policy and Guidance

Adult B’s decision-making capacity was certainly impaired in some areas, with evidence to show a deterioration in his mental state due to dementia, and self-neglect issues. The authorities appear to have considered Adult B’s mental capacity in relation to their own needs rather than looking to support the individual concerned.

These fluctuations in his mental state could have called into question Adult B’s ability to make decisions about various aspects of his wellbeing, including his ability to self-care.

The Board should ensure that staff across health and social care in its area, have suitable training and support in relation to assessing mental capacity, in accordance with relevant legislation and recognized guidance.

Professional Curiosity

Professional curiosity is about having the capacity and communication skills to explore and understand what is happening with an individual or family. It is about using proactive questioning and challenge. It is about understanding your own responsibility and knowing when to act, rather than making assumptions. It is about not taking things at face value. (Norfolk Safeguarding Adults Board)

In Adult B's case the authorities appeared to show a bias towards their own desired outcomes, rather than Adult B's individual needs, filtering out potentially relevant information and opinions that suggested Adult B may be at risk of abuse or neglect.

The authorities also appeared to focus primarily on Adult B's perception of his care needs, such as accepting his account of 'getting old' to justify dementia symptoms, whilst apparently ignoring the views and opinions of his wider support network, thereby potentially missing important information regarding his actual safeguarding needs.

There appeared to be a lack of awareness on the part of the authorities to effectively apply professional curiosity skills in Adult B's case, with a pre-conceived bias that he had mental capacity potentially clouding judgments, and evidence to the contrary being dismissed.

In 2018 the authorities considered Adult B to have full mental capacity, but resisted the opportunity to explore the significant changes in his care provision that would have identified him as being more vulnerable to abuse and neglect.

A continued resistance to establish the bigger picture was also apparently missed in early 2021, when Adult B agreed to care support but then declined it. There's evidence to suggest that had suitable professional curiosity been shown at this time, the authorities may have identified financial abuse and coercive control, being perpetrated by Mrs J.

Had a carer's assessment been conducted with Mrs J, the authorities may also have been made aware of her own potential self-care vulnerabilities, which may have identified additional support needs for Adult B, and Mrs J's suitability to care for him.

Recommendation: Legislation, Policy and Guidance

Professional curiosity is a regular theme within Safeguarding Adult Reviews and relies upon a number of factors to be effective, including the courage to challenge and question the 'status-quo', within a well-managed, transparent professional setting.

The Board should ensure that staff across health and social care in its area, and relevant partners, have suitable training and support to best understand the concept of professional curiosity and the courage to apply it effectively.

TOR 3. Multi-agency Working, Information Sharing, Coordination of Care

Many people with care and support needs will require the input of a number of services in order for their needs to be met. Effective coordination is vital to ensure the individual, at the centre, benefits from a partnership of support around them, including statutory agencies, voluntary groups, friends, family and carers.

Partnership is a core principle of safeguarding adults, to protect them from abuse, neglect and self-neglect. The Care and Support Guidance, issued under the Care Act 2014, states,

“Partners should ensure that they have the mechanisms in place that enable early identification and assessment of risk through timely information sharing and targeted multi-agency intervention.”

Communication between agencies, the service user, informal networks, family, friends and carers is an important way of ensuring that everybody involved in supporting an individual has a consistent and shared understanding of their needs, and is a vital part of maintaining openness and trust and the management of risk.

Information sharing is not just about the authorities sharing information internally, it’s about listening to the views of everyone involved in someone’s care, to ensure a common purpose and effective safeguarding provision across the board.

In the case of Adult B there’s little evidence to suggest multi-agency working, information sharing or the coordination of care worked effectively to safeguard him.

There was no single professional or agency identified as being the point of contact for anyone wishing to raise concerns or provide information into Adult B’s health and wellbeing and this may have led to poor information sharing and communications.

In 2018 the authorities dismissed claims that Mrs J had forcibly taken over Adult B’s care to gain access to his finances and manipulate him whilst he was mentally and physically impaired.

Instead the authorities displayed a lack of professional curiosity and an apparent misunderstanding of relevant legislation, to claim Adult B had full mental capacity, when available evidence from Adult B’s GP suggested otherwise.

The authorities again displayed a lack of professional curiosity and information sharing, in early 2021, when offering Adult B care support that was initially accepted, and then declined. Wider enquiries with relevant people in Adult B’s life, at this stage, could have identified potential financial abuse that meant Adult B was at risk of further neglect.

Initial offers of condolence by senior staff, to Ms D, following Adult B’s death in October 2021, were later replaced by silence and, later still, threats, as Ms D sought to establish how and why her father had died, when the authorities had been aware of concerns going back to 2018.

Ms D’s concerns about Adult B, remained consistent throughout this time and were based, not just on personal issues, but a significant level of former professional experience conducting police safeguarding investigations. And, yet, the authorities sought to dismiss Ms D’s concerns, by failing to engage with her in a professional and respectful manner, including at one point Ms D being accused of having ‘unfinished business’ with the local authority, in 2022.

Recommendation: Multi-Agency Working, Information Sharing, Coordination of Care

Communication between agencies, service users and their wider support networks is an important way of ensuring that everybody involved in supporting an individual has a consistent and shared understanding of that person's needs, risks and proposed interventions.

The Board should consider the identification of a lead professional in the context of s.42 and s.44 Care Act reviews, who can act as a central point of information and communication, to facilitate effective and transparent multi-agency decision-making.

TOR 5. Lessons to be learned from this case review

The Suffolk Safeguarding Partnership's website states,

'Sections 42…and 44 of the Act underpin the work of the Suffolk Safeguarding Partnership, and set out ours and our partners collective responsibilities around

- protecting individuals and investigating instances of abuse
- the role of the Safeguarding Adults Boards, and
- conducting Safeguarding Adults Reviews'

Information, and evidence, highlighted within this review indicate statutory obligations under s.42 and s.44 of the Care Act 2014 were not, or wrongly, applied, while loosely focusing on mental capacity rather than safeguarding concerns.

The authorities involved also showed a collective lack of professional curiosity when safeguarding concerns were raised in 2018 and 2021, thereby failing to comprehend Adult B's needs, and potential risks, appropriately.

Recommendations within this, and previous, reviews have focused on suitable training to ensure staff undertaking relevant statutory responsibilities are properly equipped to do so.

Previous review findings have also identified similar issues including,

- Clear gaps in knowledge and understanding of relevant legal frameworks, meaning opportunities for intervention may be missed
- A lack of definitions, tools and inconsistent thresholds for safeguarding intervention
- A lack of timely and dynamic assessment both of self-neglect and mental capacity
- No clear pathways from referral to intervention

Despite previous findings, it seems gaps in relevant knowledge and skills still remain.

It's the suggestion of this review that the impact of learning from previous case reviews is evaluated and monitored by the Board, and a focus made on determining appropriate training to support adult safeguarding practitioners.