Louise Safeguarding Adult Review 6 Step Briefing

The Background

Louise was an 87-year-old lady who had lived in a supported housing scheme for 20 years and was first noted to have cognitive problems in 2013, over the following 7 years her abilities declined. Louise had a friend called Trevor who supported her, and he was the registered Lasting Power of Attorney (LPA) for both health and finance for Louise.

Louise would always say she did not need help even when observation suggested she was struggling. Various agencies were involved in her care and support. Professionals tried to engage Trevor to help him to provide care and support for Louise, but this was often rejected. Professionals raised safeguarding concerns during the time frame under review, but all cases were closed without enquiry, as there was no evidence of intentional neglect.

In December 2019 Louise was admitted to hospital, severely malnourished and with significant pressure ulcers. She initially improved, but sadly deteriorated and died on 6th January 2021.

Safeguarding Concerns

- Louise was cared for by Trevor who had Lasting Power of Attorney for finance and health. There were concerns expressed by agencies that he was not acting in her best interests.
- After neighbours expressed concerns about her, the GP attended and found her with severely overgrown toenails that were digging into her skin, she appeared frail, financial concerns were recognised, and the GP found Trevor very controlling.
- The podiatrist found that Louise's feet were very neglected, and she was very confused and restless. Her toenails were 5-8cm long, curled over and very thick and growing into her flesh. The chiropodist noted these were the most neglected feet seen in 25 years of practice.
- Louise was unaware of her needs and showed signs of dementia.
- Trevor was routinely reluctant to allow services into the home and sometimes became aggressive.
- There was evidence that Trevor was struggling as there were concerns around Louise's personal care and her weight was reducing.

The Incident

In December 2019, 111 were contacted and reports of Louise having bed sores that were itching and bleeding were made. The urgent response team attended and noted that Louise was unresponsive except to pain, was severely dehydrated and possibly suffering from sepsis. The paramedics noted that Louise appeared extremely malnourished, emaciated, incontinent and confused. Louise was admitted to hospital. Despite attempts to treat Louise, and evidence of improvement around 23rd December, she deteriorated and died on 6th January 2020.

The Review

This Safeguarding Adult Review (SAR) concerns the effectiveness of inter-agency practice in relation to engagement and care of an 87-year-old woman. The Southampton Safeguarding Adults Board Case Review Group recommended that this case met the criteria for a Statutory Safeguarding Adult Review and this was agreed by the Southampton Safeguarding Adults Board (SSAB). The period covered by this review is from 1st January 2012 until the date of Louise's death, on the 6th January 2020.

Good Practice

The review identified the following good practice:

- Several agencies were supporting Louise.
- Agencies frequently raised concerns with Adult Social Care.
- The Older Peoples Mental Health Service (OPMH) and the Community Independence Service (CIS) showed tenacity and continued to visit, despite Trevor trying to stop them.
- OPMH and CIS demonstrated professional curiosity and concern and made enquiries about the Lasting Power of Attorney (LPA).
- The community services responded well at critical times and showed tenacity with trying to gain entry.
- The hospital found a private podiatrist to treat Louise's toenails urgently.
- A podiatrist responded quickly and provided treatment to Louise.

Findings

- Louise was a lady who was showing signs of increasing cognitive impairment for over 6 years and her difficulties were known by various agencies. She was able to present well superficially, even when there was evidence that she was clearly suffering and unable to manage, however this was never challenged.
- Trevor was seen by various agencies as a friend or carer, and when he became her LPA for both health and finances it was accepted without question. When some professionals showed curiosity about the legality of this, the OPG said there was nothing to indicate concern. Although Trevor was not allowing services access to Louise, it was assumed that as he had the LPA, he had the legal right to do this.
- Practical application of the Mental Capacity Act was a critical part of this story. There did not appear to be evidence of assessing understanding and using critical enquiry to ensure Louise was able to make the decisions she was being asked to make. Knowledge of the legal duties of the LPA, how to challenge this, and the role of the Court of Protection was lacking, together with cohesive multi-agency discussion.
- Safeguarding referrals were made, and agencies tried to raise concerns, but they were closed without enquiry. The reason of "neglect not being intentional" was not challenged by ASC senior managers.
- There is some evidence of multi-agency communication by phone and email, but there is no evidence of "round table" professional meetings. The evidence suggests that most communication was one way and decisions were made by ASC, without multi-agency involvement.
- When admitted to hospital, there was no referral to adult safeguarding and Louise's death certificate listed the cause of death as '1a Malnourished; 1b Self neglect 1c. Dementia'. The term "self-neglect" appeared to be used without any investigation (at that time) to establish if this was correct. A report-based inquest confirmed self-neglect on the final death certificate.
- All professionals would benefit from improved knowledge regarding what constitutes neglect and self-neglect alongside the criminal offence of coercion and control.
- The care, support and protection of Louise should have been better. Professional curiosity, correct application of the Care Act 2014 and better understanding and practical application of the Mental Capacity Act 2005 and Lasting Power of Attorney could have improved her life and potentially changed the outcome.

Useful links for Best Practice

- Louise Full Report and Recommendations
- 7 Minute Briefing Mental Capacity
- Gaining access to an adult suspected to be at risk of neglect or abuse
- Mental Capacity Guidance – Bournemouth University
- One Minute Guide to Self-Neglect
- 4LSAB Multi-Agency Safeguarding Adults Escalation Policy
- Care Act factsheets - GOV.UK (www.gov.uk)
- Find out if someone has an attorney, deputy or guardian acting for them - GOV.UK (www.gov.uk)