Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Safeguarding Adults Review

August 2019

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1. Introduction

In October 2018 Mary and Graham (pseudonyms are used to protect anonymity) a married couple both in their 80s, died approximately 2 weeks apart in the home they shared together in Leicester. Mary died first, followed by Graham a few weeks later. There is no indication that either death resulted from abuse or neglect and there was no requirement under the Care Act 2014 to undertake a review of this case. Nonetheless, Leicester Safeguarding Adults Board (SAB) chose to undertake this review. It was thought that a review of Mary and Graham's circumstances prior to their death could provide useful insights into self-neglect, individuals we find it difficult to engage with, and the way in which organisations work together. By promoting effective learning and improvement action, Leicester Safeguarding Adults Board (LSAB), aims to prevent future deaths or serious harm occurring.

2. Summary of learning themes

This review explores a number of themes that emerged from the analysis of professionals' contact with Mary and Graham:

- Coercion and control in elderly couples
- Engaging with people we find difficult to engage
- Assessing risk
- Practitioner access to historic records
- Male victims of domestic abuse
- Mental capacity, self-neglect and mental health
- Agency thresholds and working together

3. Context of Safeguarding Adults Reviews

One of the core duties of a Safeguarding Adults Board (SAB), under Section 44 of the Care Act 2014, is to review cases in its area (in this instance, Leicester) where an adult with needs for care and support (whether or not the Local Authority was meeting these needs):

- has died and the death resulted from abuse and neglect, or
- is alive and the SAB knows or suspects that they have experienced serious abuse or neglect

Importantly, Safeguarding Adults Reviews (SARs) are about how agencies worked together to safeguard adults; they are in their nature multi-agency reviews. For a review to be mandatory in legislation, there must be reasonable cause for concern about how the SAB, its members, or others with relevant functions worked together to safeguard the adult.

4. How this case met the Safeguarding Adults Review criteria

It was the view of Leicester SAB's Review Subgroup and Independent Chair that, at the time of commissioning this review, that they were unable to determine whether this case met the criteria for a mandatory Safeguarding Adults Review (SAR) under the Care Act 2014. However, it was agreed that there may be useful learning for the safeguarding partnership and therefore a SAR was commissioned under Section 44(4) of the Care Act 2014, which allows for a non-mandatory SAR to be undertaken in the following circumstances:

'*An SAB may arrange for there to be a review of any other 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)*.'

At the time of commissioning the review, unclear elements about whether a mandatory SAR was met were:

- It was difficult to determine whether or not Graham had needs for care and support. A GP referral in 2016 related to 'memory issues' however he was never assessed by the Mental Health Nurse Specialist for older people or the Consultant Psychiatrist, Mental Health Services for Older People. It was acknowledged that it was possible he had needs for care and support that were not apparent to agencies involved, but that this could not be confirmed.

- In terms of Mary, there may well have been needs for care and support related to her previous diagnosis of Persistent Delusional Disorder. It was not clear how accessible this information was to frontline staff attempting to engage with Mary in recent years, or the impact it might have had on their ability to engage with her.

- The cause of death for Graham and for Mary was unknown. Whilst (from information available at the time) it appeared unlikely that either death had resulted from abuse or neglect, without this being confirmed it remained difficult to determine whether either or both individuals had been adequately safeguarded.

The Coronial Inquests into Mary and Graham's deaths subsequently concluded that their deaths were from natural causes.

5. Succinct summary of case – (written by Lead Reviewer)

Leicester Safeguarding Adult Board (SAB) initiated this Safeguarding Adult Review (SAR) in December 2018. It followed an incident when a man came into a police station to report that he had concerns about his elderly neighbours. He had not seen them for 2 – 3 weeks. Officers attended the scene and found the bodies of two elderly people – Graham (aged 87

at the time of his death) and Mary (aged 82 at the time of her death). There were no suspicious circumstances and a file was sent to the Coroner. Police officers described the premises as being dirty and there was no food in the property at all. There was no gas or electricity supply to the premises and candles had been used for light. There were no cooking facilities. There was a disability seat on the toilet which was damaged. At the time of death neither party was registered with a GP. The bank account had not been accessed for some time and held a large sum of money.

No cause of death could be established for either of the couple and what happened to them will never be known, although the Coronial Inquests concluded that their deaths were due to natural causes.

The couple had been known to Housing over a long period. The involvement with Housing was characterised by:

Failure to pay rent

No response to attempted written communications

Failure to allow access for essential works, including gas checks

Failure to allow access to professionals (mental health, adult social care) who were asked to see them in response to concerns raised

Unauthorised adaptations to property

Accumulations of rubbish leading to complaints from neighbours

Verbal abuse and threats e.g. of legal action

Housing staff regarded the couple as vulnerable and were concerned about possible domestic abuse/ coercion of Graham by Mary, based on their experience of limited contacts with them.

There had been referrals to mental health services and to adult social care, but the couple did not engage and relevant professionals were unable to access them in order to make assessments of potential needs and possible risks. Although Mary had a history of a psychotic illness that had led to an admission for assessment under Section 2 of the Mental Health Act 1983 in 2005, the mental health referrals relating to her were not deemed urgent or worrying enough to justify action in the absence of consent. Attempts to find a way of dealing with the situation using the then complex case panel (now defunct) and using the Vulnerable Adult Risk Management (VARM) process did not identify ways to intervene, work with, or support the couple. The GP had identified safeguarding concerns when Mary blocked access to Graham in 2016 after expressing concerns about his memory, but the fundamental issue was seen as mental health, not taken further as a safeguarding concern,

and mental health services failed to get access and were unable to assess either person separately.

6. Methodology

Leicester SAB is committed to supporting the Research in Practice for Adults (RiPfA) and Social Care Institute for Excellence (SCIE) SAR Library. The SAR Library is focusing on collating 'systems' findings by considering enablers or barriers to good practice that have influence beyond a single case. Systems findings identify explanations for why things have happened and considers learning that can be generalised.

In order to achieve its goal of identifying systems findings, the methodology for this review split the review into two parts. The first part of the review involved a trawl of information going back 10 years asking agencies to confirm (i) whether the couple were known to them and (ii) whether there was any indication during that time that Graham or Mary had needs for care and support under the Care Act 2014 (whether or not the Local Authority was meeting those needs).

Once commissioned, the Lead Reviewer reviewed the scoping period and draft terms of reference for the individual agency reports. Agencies known to Graham and Mary were asked to complete individual agency reports with a detailed scoping period of 3 years (plus summary information going back to 2005). Individual agency chronologies were requested and provided as part of agency reports. See Appendix i for a short, combined chronology of key events.

Information from the initial referral, board manager report, trawl information, family, and single agency reports was then pulled together by the Lead Reviewer. An opportunity was provided for the Lead Reviewer to interview practitioners involved and their first line managers. The Lead Reviewer chose not to interview practitioners involved with this case "as they would be unlikely to add to the information received". This first part of the review helped to clarify and determine 'what' happened (**CASE FINDINGS**) as well as begin to explore the 'why'.

Subsequently. the Lead Reviewer supported Leicester SAB's Review Subgroup to determine terms of reference, and to identify delegates for the second part of the review which involved a 'learning event'. Local safeguarding leads, service providers, specialist and generic frontline posts including social care, health, housing, and police were invited to the learning event, which was facilitated by the Lead Reviewer. This event considered, in a wider context, the themes and issues identified in the first part of the review, with a view to identifying systems learning in order to consider the barriers and enablers of good practice (**SYSTEMS FINDINGS**).

A fortnight after the learning event, the Lead Reviewer met with the Review Team to reflect on systems findings from the learning event and begin to draft recommendations for change (**RECOMMENDATIONS**).

7. Terms of Reference

Terms of reference for the individual agency reports were written to enable individual agencies to explore their contact with the couple. They were as follows:

i. What impact did Graham's gender and age have on agencies recognising him as a potential victim of domestic abuse and subsequent access to risk assessments and support offered to him? Was domestic abuse considered as a reason for practitioners being unable to engage with Graham?
ii. How readily available to practitioners was Mary's 2005 diagnosis of persistent delusional disorder? If this was not readily available, what impact did not knowing about this diagnosis have on practitioners' ability to engage with Mary and subsequently with Graham?
iii. Was Mary and / or Graham's mental capacity considered when agencies were trying to engage with them? How well was the Mental Capacity Act 2005 applied?
iv. Was the Vulnerable Adults Risk Management (VARM) process applied appropriately? How well did it work?
v. What impact did Graham and Mary's interdependency, the support and care they provided for each other, have on agencies' understanding of each of their needs?
vi. Explore how appropriate it would have been to make and receive joint or individual referrals for support for Graham and Mary.
vii. Identify good practice.
viii. Where known, reference local audits, inspection findings, or internal reviews involving your agency where similar themes have been identified. Case details should not be provided, but a brief overview of relevant themes should be noted.

The subsequent learning event provided an opportunity for the partnership to consider the potential systemic issues identified through the individual agency reports. The three-hour event involved eleven practitioners from across the local authority, health, and police, and was facilitated by the lead reviewer. Terms of reference for the event were as follows:

i. We are aware that coercion and control can be missed in interpersonal relationships of the elderly. We would like to explore why this might be. For example, does coercion and control "look" different in older people? Do older people have different attitudes to or understandings of what we might regard as coercion and control? If so, what are the implications for practitioners working with older adults?
ii. When coercion and control is identified in interpersonal relationships of the elderly, the inherent risks of serious harm (physical or psychological harm that is difficult or impossible to recover from) is not always acknowledged / focused upon. Why might this be?
iii. What prohibits us from thinking in more detail about why we have been unable to engage with an older individual (or a couple)? Are there ways of increasing the chances of engagement or of "working around" failure to engage?
iv. What conversations do we need to have when people seem to be at risk but are not engaging with agencies and do not have a clear need or condition that brings them into the remit of individual statutory services?

v. When working with elderly couples and coercion and control and/or other violent behaviour is identified:
    a. do we know what options are available to us in relation to:
        i. support services
        ii. adult safeguarding options including mental capacity
        iii. identifying and managing risk
        iv. the criminal justice system
    b. How do these different approaches interact with each other? Does going down one route (i.e. safeguarding) rule out another (i.e. criminal justice) and vice versa?

vi. What stops us from accessing information within our own organisations/systems? Think both about difficulties accessing recent/current information as well as information that was available to us 5, 10, 15 and 20+ years ago. Is there an assumption from other agencies that this information is readily available to you?

8. Engagement with family

A family member provided background information for the review which very helpfully gave the review team some context and insight into Graham and Mary's lives. It was agreed with the family member that this personal information would not to be shared in the report itself. The family member did not want to be further involved in the review, but asked to be notified once the report is complete.

9. Review team

The Review Team consisted of members of Leicester Safeguarding Adults Board's Review Subgroup, which included senior safeguarding representatives from the following agencies:

- Leicestershire Police
- Leicestershire Partnership NHS Trust (LPT)
- Leicester City Council, Community Safety
- Leicester City Council, Adult Social Care
- Leicester City Council, Housing
- Leicester Clinical Commissioning Group
- University Hospitals Leicester

Older Mind Matters Ltd was commissioned by Leicester SAB to lead the review, and the Lead Reviewer was Dr Susan M Benbow, MB, ChB, MSc, FRCPsych, PhD, GMC 2382872 Director of Older Mind Matters Ltd, Visiting Professor, University of Chester, Psychiatrist and Systemic Psychotherapist, bringing with her both expertise and independence.

10. Review timeline

Care Act 2014 statutory guidance identifies that Safeguarding Adults Reviews should be completed '*within 6 months of initiating it, unless there are good reasons for a longer period being required*[1]'. In this instance, recruiting an independent reviewer, allowing 6-8 weeks for good quality single agency reports to be written, and including a learning event to explore systemic learning all took additional time, but were felt to be important aspects of the review methodology.

The result was that the review took 8 months from commissioning, to the Overview Report being drafted. All agencies worked well together to ensure this review was completed within a reasonable timeframe, so that learning can be progressed whilst it remains current.

REVIEW TIMELINE	
Milestone	**Completion Date**
Date of deaths	October 2018
Referral heard at Review Sub Group	06.11.2018
Trawling letters issued	08.11.2018 & 21.11.2018
Trawl returns	23.11.2018 & 29.11.2018
LSAB Review Subgroup recommendation to commission a SAR	11.12.2018
Recommendation put to LSAB Independent Chair	20.12.2018
LSAB Chair agrees to commission SAR	21.12.2018
Notify HM Coroner of intention to commission SAR	27.12.2018
Updated Board Manager Report drafted and circulated	02.01.2019
Methodology agreed, including draft terms of reference for IMRs	08.01.2019
SAR independent lead reviewer/facilitator/author commissioned	March 2019
Board Office initiate engagement with family	March 2019
Independent lead reviewer/facilitator/author reviews terms of reference for IMRs	March 2019
Agency reports (IMRs) requested	18.03.2019
IMR returns received	09.05.2019
Review team reflect on learning so far + confirm terms of reference for the learning event	11.06.2019
Learning event takes place	27.06.2019
Review team post learning event reflection and draft recommendations	10.07.2019
Overview Report drafted	August 2019

[1] Department of Health (2017). Care and support statutory guidance
[online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed 21 August 2019].

11. Findings from single agency analysis and reports

Taken from Leicester City Council (LCC), Housing, agency report dated May 2019

Case Finding *What happened?*	**Systems Finding** *Why did this happen?*	**Recommendation** *How are we going to improve things?*
Health and Social Care not attending VARM		For non-attendance, escalate situation to Social Care Divisional Head. Send minutes and actions.

Taken from General Practitioner agency report dated May 2019

Case Finding *What happened?*	**Systems Finding** *Why did this happen?*	**Recommendation** *How are we going to improve things?*
Access was not gained to assess the patient's mental health and what support they required.	Patients refused to allow access and threatened health professionals	If all usual options have been exhausted then referrals/re-referrals to the local authority should be considered with updated information of options tried. Escalation process should be followed if there is disagreement over outcome of safeguarding referral.
Patient [Graham] was not seen alone without presence of Mary	Wife [Mary] attended all appointments with him and engaged on his behalf	Staff to create opportunities for patients to be seen alone, should they wish to where there are safeguarding/DVA concerns.

Taken from Leicester City Council, Adult Social Care (ASC) agency report dated May 2019

Case Finding *What happened?*	**Systems Finding** *Why did this happen?*	**Recommendation** *How are we going to improve things?*
The VARM (Vulnerable Adults Risk Management) process did not work as effectively as it could have when initiated	Human error on the part of an ASC worker resulted in attendance not being scheduled within ASC. No systematic feedback to	Ensure the revised VARM guidance is fully understood by staff in LCC This will maximise the likelihood of a constructive multi-agency discussion taking place with relevant partners including sharing

leading to a missed opportunity for multi-agency risk reduction planning	partners not in attendance.	the outcome with those not present.

Taken from Leicestershire Partnership NHS Trust agency report dated May 2019

Case Finding *What happened?*	**Systems Finding** *Why did this happen?*	**Recommendation** *How are we going to improve things?*
Graham was initially allocated an outpatient appointment rather than home visit.	The information in the referral letter was not reflected in the decision making.	When information provided in referral letters suggests a reluctance to engage and previous disengagement home visits should be considered.

Individual agencies also provided action plans which provided information about how these recommendations were going to be progressed including the desired outcome, how change will be achieved, a named action holder, and an agreed timeframe for completion. These actions will be overseen by the Leicester SAB Review Subgroup until they are achieved.

12. Further analysis (written by Lead Reviewer)

In this section, the Lead Reviewer with support of the review team, will provide an analysis of the key themes identified in this review.

Questions from the original terms of reference

Intersectionality of gender and age in relation to recognition of domestic abuse and subsequent access to support. Including was domestic abuse considered as a reason for practitioners being unable to engage with Graham?

This is an interesting question and is discussed below in relation to coercion and control. Practitioners at the learning event were clear that we may well accept some behaviours in older couples that we would question in younger couples, and that behaviours of women towards men may not be seen in a similar way to the behaviours of men towards women. Practitioners highlighted a potential gender bias from professionals in relation to domestic abuse that may have been exacerbated by generational and age issues

Similarly, practitioners may have different expectations of a long partnership involving people in their later years and have concerns about being disrespectful if they question aspects of that relationship: after all, it has endured. Yet domestic abuse is domestic abuse and standards should not be different for later life partnerships than those involving younger couples. Respectful professional curiosity should assist staff to ask questions sensitively and confidently. This might be an issue to take account of in training in relation to domestic abuse.

How readily available to practitioners was Mary's 2005 diagnosis of persistent delusional disorder?

This was not readily available and her history prior to that was even less available but it seems that she had a history of contact with mental health services going back as far as the 1970s. Had this information been known then some issues might have been understood differently. See the themes of joint working and systemic factors below.

Was Mary's capacity considered when agencies were trying to engage with her?

The Mental Capacity Act (2005) Code of Practice refers to the two-stage assessment of capacity, namely:

'Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)

If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?' (page 41, Code of Practice)

It sets out four questions to consider when assessing mental capacity:

'Does the person have a general understanding of what decision they need to make and why they need to make it?
Does the person have a general understanding of the likely consequences of making, or not making, this decision?
Is the person able to understand, retain, use and weigh up the information relevant to this decision?
Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?' (page 41, Code of Practice)

The starting point is the presumption that an adult has capacity, unless there are reasons to suspect otherwise. It is clear that in this case capacity was presumed rather than assessed in respect of both Mary and Graham. In fact, because the couple didn't engage with services,

there was little opportunity to assess capacity, and capacity was presumed from how they presented. Yet there is evidence that Mary probably had an ongoing psychotic illness that potentially could have affected some aspects of her decision-making and Graham was thought to be developing cognitive impairment/ possible dementia. There was also little opportunity to see Mary and Graham separately.

Was the Vulnerable Adults Risk Management (VARM) process applied appropriately? How well did it work?

There has been much discussion at Panel and at the practitioners' event around whether the couple met the criteria for the VARM process and whether there is a 'gap' that used to be filled by the complex case panel. The consensus is that they did meet the criteria for VARM, considering in particular self-neglect, possible domestic abuse/ coercion, lack of engagement with services, hoarding, and living circumstances.

A previous complex case panel had not made headway and, unfortunately, the VARM process did not help in this case. Partly this was because Adult Social Care were not present at a meeting called by Housing due to an administrative error. Inviting a range of agencies to be involved in the VARM process may give access to possible interventions that may otherwise not be considered. There is learning about the VARM process to take into the ongoing review of the process.

What impact did Graham and Mary's interdependency, the support and care they provided for each other, have on agencies' understanding of each of their needs?

Agencies were unable to see Graham and Mary separately (apart from on one occasion when Housing staff saw Graham on his own although Mary was in the background) and unable to assess either together or separately. In cases of suspected coercion and/or domestic abuse it is particularly helpful to see people separately and in a safe place. It may be coercion is misidentified as co-dependency. Without bringing the information together and being able to assess Graham and Mary, agencies were unlikely to be able to understand the couple's needs, separately or jointly.

Explore how appropriate it is to make and receive joint referrals for support

Practitioners have to be realistic and when a couple is close and the partners inter dependent that has to be acknowledged. However, we also need to recognise that people are individuals and may have their own individual needs. Is it possible to assess people separately and together, whether they are referred jointly or as individuals? This links with the discussion at the practitioners' event about trying to be both creative and flexible.

Thematic analysis

The analysis that follows is organised into themes and incorporates discussion from the practitioners' event.

Theme 1: Coercion and control

Housing staff were concerned in the case that Graham may be subject to coercion and control by his Mary. The Home Office definition of coercive behaviour, taken from Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework (2015)[2] is as follows:

'Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another.'

The terms of reference for the learning event asked:

We are aware that coercion and control can be missed in interpersonal relationships of the elderly. We would like to explore why this might be.

For example, does coercion and control "look" different in older people? Do older people have different attitudes to or understandings of what we might regard as coercion and control? If so, what are the implications for practitioners working with older adults?

Practitioners felt that coercion and control in older adults doesn't necessarily look different, but (and we acknowledged the risk of stereotyping older adults) it may be 'normalised' by professionals and the individuals involved, in that:

- practitioners may accept some behaviours in older people that maybe they wouldn't accept in younger adults
- Some older people don't want to complain/ make a "fuss"
- If the genders had been reversed (i.e. male to female coercion/ control) or if there had been children in the household practitioners would probably have been more likely to challenge
- Is there possibly a generational difference in understanding what constitutes abuse perhaps relating to ideas of "duty" within a marital relationship?
- Was coercion misinterpreted as co-dependency in this couple?
- Behaviour is sometimes explained away as quirky or eccentric or perhaps as a lifestyle choice, instead of looking for and asking about the reasons. This connects with

[2] See https://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship [Accessed 26 Sept 2019].

professional curiosity. It seems likely that some or even much of Mary's behaviour may have related to psychotic beliefs and/ or experiences.

- No single agency had the whole picture
- Agencies didn't work together and pool the knowledge that they had about the couple

A second question relating to coercion and control was:

When coercion and control is identified in interpersonal relationships of the elderly, the inherent risks of serious harm (physical or psychological harm that is difficult or impossible to recover from) is not always acknowledged / focused upon. Why might this be?

Do we for example, prioritise other issues (i.e. health issues) that the couple may be experiencing? Do we privilege some risks over others?

Important points in relation to this include:

- Behaviour is sometimes explained away as quirky or eccentric or perhaps as a lifestyle choice, instead of being curious and looking for/ asking about the reasons.
- Risk assessments used with older adults may focus more on physical health risks rather than psychological, social and relational risk
- Similarly risk assessments focused on domestic abuse may not fit for older couples (see Bows (2019)[3] and Benbow, Bhattacharyya and Kingston (2019)[4])

Braye, Orr and Preston-Shoot[5] have written about autonomy and protection in self-neglect work and some of their comments are relevant here. They note that '*the right to make unwise decisions … become(s) a mantra often repeated'* and they refer to '*concerned curiosity demonstrated through authoritative but respectful questioning'*. They also highlight the tension between respecting autonomy and duty of care/ protection.

Theme 2: Engaging clients who services find difficult to engage

This couple had a pattern of non-engagement with agencies/services. The terms of reference for the learning event asked:

[3] Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. British Journal of Social Work (2019) 49, 1234–1253

[4] Older adults and violence: An analysis of domestic homicide reviews in England involving adults over 60 years of age. Ageing & Society 39 (6): 1097-1121.

[5] See Braye, Orr and Preston-Shoot (2017) Autonomy and protection in self-neglect work: the ethical complexity of decision-making. Ethics and Social Welfare 11 (4): 320-335 for more discussion of these issues.

What prohibits us from thinking in more detail about why we have been unable to engage with an older individual (or a couple)? Are there ways of increasing the chances of engagement or of "working around" failure to engage?

Practitioners reflected:

- Do professionals use appropriate language to engage people? Is the language we use sometimes off-putting?
- Where did this couple go during the day? Could the people who were seeing them have offered some support or could an appropriate individual have endeavoured to see them in an alternative setting, where they felt more comfortable?
- Need for flexibility in who sees them and where
- They engaged with some homeless services: could this have presented an opportunity?
- There is a need for imagination in approach – on the back foot if in the person's home – seize any opportunity – persevere – be creative (continuity of relationship with one worker?)
- One person described a good practice example of seeing a woman in X-ray where she made a disclosure – it was the only way to see her on her own

Theme 3: Joint working and creativity

No single agency was aware of the bigger picture with the couple and that meant that need could not be assessed and risk could not be assessed. There is a big question about how we work together. The terms of reference for the learning event asked:

What conversations do we need to have when people seem to be at risk but are not engaging with agencies and do not have a clear need or condition that brings them into the remit of individual statutory services?

Practitioners noted:

- We need to try to understand views of authority and respect – are the right people doing the talking e.g. someone might respect the GP rather than a worker from adult social care? Or they might respect and relate to someone from voluntary services? There is a need to identify the most appropriate agency to engage and that may not be the one we would expect – there may be a need to explore alternative avenues.
- When working with complex cases or with people we find difficult to engage how do we avoid fatigue? Peer reviews on complex cases might be helpful, supervision, reflective practice, or perhaps other ways to encourage staff members to ask for help/ ideas.
- How do we prevent silo working?

- The VARM that took place in respect of the couple at the heart of this SAR was interdepartmental rather than multiagency – we don't have to know the people concerned to be helpful in creative thinking but we tend to think if I don't know them then what's the point in going? VARM could be seen as a way of problem solving rather than merely a way of information sharing. (Although there is value in simply bringing information together and sharing it with partners).
- High risk panel used to exist and was useful for cases that didn't 'fit'.
- Complex case meetings took place at one time but were replaced by VARM
- Governance for VARM? (is it audited?) (Subsequently we learned that it is, and that the audit is feeding into the current review of VARM.)
- Possible multi agency risk management is being explored currently

There was discussion about whether the couple in this case would have met criteria for VARM (and we need to beware hindsight bias) but there was a strong consensus that they would have met the criteria. The Leicester, Leicestershire & Rutland Safeguarding Adults Thresholds Guidance Version 6 Updated July 2018 is helpful in setting out a framework for decision making and also states that:

'If, at the point of referral there is insufficient information to apply safeguarding thresholds then further enquiries should be made to gather this information'. (page 1)

This is an important caveat and is likely to be highly relevant in working with people who are not engaging.

Two other points made at the learning event are relevant here:

- Language differences between agencies – what information is needed to meet agency thresholds? What makes a case hit threshold? (This is about agencies understanding each other.)
- Quality of referral to make sure we meet threshold – emphasise the important points.

Accessing information in order to be able to share it with partners is relevant here and the terms of reference for the learning event asked:

What stops us from accessing information within our own organisations/systems? Think both about difficulties accessing recent/current information as well as information that was available to us 5, 10, 15 and 20+ years ago. Is there an assumption from other agencies that this information is readily available to you?

It was clear that agencies held different information about the couple in this SAR and that information was not brought together. Mary's history of a psychotic illness was in the GP records and LPT records but not known to other agencies; the unusual behaviour of sending blank audiotapes at significant expense to Leicestershire Police together with non-understandable letters was not known to the GP or to mental health services (but suggested mental ill-health); Mary's ideas about household appliances being bugged had been documented in the past but was not known to Housing who may have taken a different view on why perfectly good white goods were being trashed/ thrown away had they known about her history. There was discussion about how information is transferred to new electronic systems and from one electronic system to another, along with a recognition that some information needs to be retained and flagged so that it can be readily accessed in future.

Theme 4: Systemic factors

Another question raised in the terms of reference for the practitioners' event was:

When working with elderly couples and coercion and control and/or other violent behaviour is identified:

a) do we know what options are available to us in relation to:
(i) support services
(ii) adult safeguarding options including mental capacity
(iii) identifying and managing risk
(iv) the criminal justice system

b) How do these different approaches interact with each other? Does going down one route (i.e. safeguarding) rule out another (i.e. criminal justice) and vice versa?

The discussion was more about working together and involving other agencies in a joint response than about how one approach might rule out others: points included:

- Need to know other agencies' eligibility criteria and boundaries
- Would a multi-agency safeguarding hub bring information together?
- Use different electronic records – some staff can access partner agencies' systems
- The value of chronologies: chronologies bring information together but involve work! (This is about the value of taking a long view – cross sectional experience of this couple at one point in time may not have suggested the risks they were facing but when looked at longitudinally the situation looks different and that perhaps is one reason why Housing staff were so concerned about them: they had the longitudinal involvement.)
- Joint systems are helpful and facilitate information sharing.
- Global consent is helpful – and consent can endure until you opt out

- Language differences between agencies – what information is needed to make a case hit threshold?
- Quality of referral to make sure we meet agency thresholds
- If a referral is made and then is turned down what happens next? The discussion noted that the referrer needs to be a plan for what they might try next if concerns are ongoing.
- An informal telephone conversation is not the same as a referral – make a formal referral if you want a response.
- Who feels they have responsibility to take action and how do they involve others?

Had this been a younger couple then would criminal justice options have been more likely to be pursued? (For example, in response to the lock changing incident and Mary's aggressive behaviour towards staff etc.) There were several occasions when police involvement could have been considered and the criminal justice pathway might have opened up options that were unavailable to healthcare and social care pathways.

Theme 5: Assessing risk

This was a theme running through all the themes above, particularly joint working and systemic factors. Points made at the practitioners' event included:

- How do you assess risk, if you don't see people?
- If we haven't got consent, we can't access information – if they're not engaging, we don't have consent and can't assess risk to decide whether this is a high-risk situation.
- Why wasn't Adult Social Care contacted following VARM? (And following on from this how do we make sure that it doesn't happen again?)
- Did adaptations to the property make it unsafe? Was the work an example of taking advantage of vulnerable adults?

There are no easy answers to these questions, but being creative in engaging people, sharing information including key information from the past, and working together with partners are all part of the context for assessing risk – this requires time and support which is challenging when services are under pressure.

This couple could have been understood as self-neglecting. Self-neglect is included in the Care Act 2014 categories of abuse or neglect relevant to safeguarding adults with care and support needs. It often presents a complex challenging human rights issue for practitioners because of the need to balance respect for an individual's autonomy with the practitioner's duty of care requiring them to protect that adult's health and wellbeing. Whilst there is no generally agreed and accepted definition of self-neglect, it is described in Leicester, Leicestershire & Rutland's Safeguarding Adults Thresholds Guidance.

Three areas are generally regarded as characteristic of self-neglect: these are

- Lack of self-care
- Lack of care of one's environment
- Refusal of assistance that might alleviate these issues.

Mary and Graham certainly showed signs of the second and third of these. In this context there might be a belief that an individual is making life choices and lifestyle as a choice may be given priority over vulnerability and risk. It is generally accepted that interagency communication, collaboration and risk-sharing are core to working with people who self-neglect.

Theme 6: Good Practice

Housing went above and beyond their responsibilities in trying to help this couple over a long period of time and in trying to see Graham separately from Mary: staff should be congratulated for their persistent tenacious endeavours and compassion,

In house Adult Social Care safeguarding training includes use of the VARM process and consideration of the relationship and potential signs of domestic abuse.

The VARM process was under review at the time that this SAR was being conducted and issues relating to VARM were fed into that review process as the SAR progressed.

13. Systems findings (written by Lead Reviewer)

In this section, the Lead Reviewer with support of the review team, will outline systems findings identified in this review.

The Vulnerable Adults Risk Management (VARM) process

Case finding: The VARM process did not work in this case.

System finding: Some agencies did not attend due to individual error (not a systems issue) but the systems issues identified from this review were:

- That there is no clear escalation process for non-attendance.
- Nor is there contact with agencies who did not attend (i.e. not sending meeting minutes out to non-attenders etc).
- VARM can be seen as a way of bringing people together for knowledge only whereas it should also be seen as an opportunity to pool expertise.
- We also need to take into account what information is known/accessible and what historic information may not be available to agencies.

Interpersonal domestic abuse/ coercive control

Case findings: 1. Possibility that interpersonal domestic abuse against elderly male victim was missed by some practitioners.

2. Mary and Graham were not seen separately despite domestic abuse / coercive control being a potential (but unconfirmed) factor in their relationship.

System finding: Practitioners may accept (and not question) behaviours in older people that they would not accept (and would question) in younger people: there is a need to be alert to possible gender bias that may be exacerbated by generational and age issues.

Engaging with people we find it difficult to engage with

Case finding: Individual agencies and the partnership struggled to engage with this couple.

System finding: People we find it difficult to engage with may need a particularly creative and flexible approach involving thinking 'outside the box'.

This is likely to involve using people they trust and are in contact with rather than insisting on a particular agency/ practitioner, and seeing them in places where they feel comfortable which may not be their home or the practitioner's office.

It is also likely to involve continuity of relationship.

Information sharing

Case findings: 1. Key information not passed across and/or not recorded. Key information not included in professional referrals.

2. Mary's previous diagnosis of mental ill health was not passed on.

System finding: 1. Referrers don't always know the language of their partner agencies, their thresholds for intervention / action, and what information is needed to meet the partner agency's thresholds.

2. Historical information is not always available, either (i) immediately or (ii) at all. Not all safeguarding partners are aware that this is the case. So when practitioners are told there is "no information" they are not aware that there could be historical information, but it is not available.

Risk assessment and management

Case finding: Risk wasn't assessed.

System finding: There was a pattern of making referrals, failing to see the couple and taking no further action.

If people do not engage, that fact is likely to increase risk rather than mitigate it and alternative approaches to the situation need to be considered by bringing relevant agencies together.

Good practice

Case finding: Housing went above and beyond their responsibilities in trying to help this couple over a long period of time and in trying to see Graham separately from Mary: staff should be congratulated for their persistent tenacious endeavours and compassion.

System finding: Housing may have felt a responsibility/ "loyalty" to the couple because they were working with them over a long time. They had first-hand experience of the difficulties and took ownership of the problem. Knowledge of vulnerabilities/family circumstances at an early stage helped to mitigate risks and instigated the need to have a co-ordinated response from services rather than merely a bureaucratic approach following established procedures.

Housing were keen to think outside the box and delay action on processes rather than staff being process driven.

Senior management were engaged at an early stage.

14. Multi-Agency Recommendations (written by Lead Reviewer)

In this section, the Lead Reviewer with support of the review team, will make recommendations about how to address the systems findings identified.

The Vulnerable Adults Risk Management (VARM) process

At the time of this review there was already an ongoing review of the VARM process and the following learning was fed into the ongoing VARM review:

- Need for a clear escalation process
- Minutes should be sent to agencies which did not attend meetings.
- Meetings should be held in venues chosen to facilitate the attendance of key people.
- Need to be clear what information is available/ accessible to agencies.

- Meetings to consider alternative possible pathways eg using the criminal justice system if appropriate.
- VARM offers a way of bringing people together to pool expertise and address difficult situations rather than simply bringing together people who have experience of the situation to share what they know. This suggests that statutory agencies should always be invited.

These points have been fed into the VARM review as the SAR has progressed and therefore an additional recommendation is not required but they are included here for completeness.

Recommendation 1: Interpersonal domestic abuse/ coercive control

Awareness-raising across the safeguarding adults partnership: Encouraging the representation of older people (including older male victims) in case examples for domestic abuse training and awareness-raising that takes place across the safeguarding adults partnership.

Recommendation 2: Engaging with people we find it difficult to engage with

Promoting across the safeguarding adults partnership, the benefits of a 'problem-solving' or 'creative thinking' way of working with people we are struggling to engage with. Embed this way of working into multi-agency safeguarding adults work when we are finding it difficult to engage with people (including VARM).

Recommendation 3: Information sharing

3.1 Promote the use of professional and appropriate challenge across the safeguarding adults partnership (including use of the 'Resolving Practitioner Disagreements and Escalation of Concerns' policy).

3.2 Safeguarding adults partners to be reminded that important historical information needs to continue to be available long term across referrals and closures and across changes in personnel and systems. Where this is not possible, assurance to be sought that partners have a mechanism in place to identify this both internally and externally.

Risk assessment and management

An additional recommendation on risk assessment and management is not required as the systems issues are addressed in the review of the VARM process and the recommendation above relating to information sharing.

Good practice

An additional recommendation arising from Housing's good practice is not required as it is addressed in the recommendation around engaging people we find difficult to engage, and the changes to the VARM process.

Combined Chronology of KEY events (written by Lead Reviewer)

Timeline

Date	Agency	Details
1970s	LPT	Mary: Evidence suggesting previous mental health history and treatment at a Psychiatric Hospital.
1990s	LPT	Mary: Seen by consultant psychiatrist but diagnosis unclear.
June-July 2005	LPT	Mary had admission to mental health unit under the Mental Health Act 1983 (Section 2) and diagnosis of persistent delusional disorder recorded. She expressed beliefs that house bugged by neighbours, bogus policeman visited her house, believed a member of her family had been murdered. Reports of aggression towards others including Graham. Self-discharged when Section expired. Refused aftercare.
2005-2009	Housing	Joint tenancy of bungalow. Repeated non-compliance with access to property to carry out gas safety checks, asbestos removal, and non-response to letters.
Early 2009	ASC	Visit by social worker – entry denied. Social worker referred to psychiatry and Community Psychiatric Nurse visited property but failed to gain access. ASC no further action.
2009-2015	Housing	Technical eviction for rent arrears. Joint tenancy ended. Sole tenancy in Graham's name.
Summer 2009	ASC	Housing contacted ASC concerned about Mary's

		mental health and possibility Graham controlled/ abused by Mary. Social worker referred to psychiatry again. Letter from consultant psychiatrist: Mary does not engage with mental health, not in a crisis at present, she declines assessment.
Autumn 2009- 2010	Housing	Multi-agency meeting set up. Injunction to carry out gas safety check and asbestos removal.
June 2010	Police	Mary: vulnerable adult report submitted. Unusual communications with Leicestershire Police over period of time. Refused access to officers. Concerns about mental health of both Mary and Graham.
Late 2010	ASC	No community care needs or welfare issues. Remains a housing issue.
Early 2013 to spring 2013	ASC Housing ASC	Referral from housing re eviction. Referred to complex and enduring case panel meeting. Visits continue to fail access. Case closed. Eviction warrant withdrawn. Visits continue to get no access - issues of self-neglect, need to establish if both have community care needs. Not possible to establish needs, level of risk.
May to July 2013	ASC Police ASC	Neighbours report strange behaviour to Police. Not registered with GP. Police submit vulnerable adult report, both social services and mental health

		team contacted. Complex case meeting to be held. Professionals unable to assess. Without GP no route into mental health services.
2014-2015	ASC Police Housing ASC	Failed visits continue. VARM approach suggested. Eviction approved late 2014 (rent arrears). Eviction notice served April 2015 after drilling locks to gain entry. Evicted 1/7/2015, "disappeared off the radar", believed to go into B&B. Closed case Dec 2015: no social worker task to undertake.
Spring to autumn 2016	GP ASC GP LPT	Registered with GP – Graham forgetting things, would like memory test. Referred to mental health but then missed appointments with GP and declined further intervention when finally seen. Mental health nurse reported to GP that Mary refuses access to Graham-GP identifies safeguarding issue. GP and nurse talk with social services: mental health assessment is a health responsibility but mental health can't get access. No indication of safeguarding issues other than non-engagement. GP refers to Mental Health Services for Older People.

		Letters sent to Mary and Graham re appointments. Graham fails to attend outpatient appointment. Further letters follow. Outcome of MDT discussion CPN to contact GP and social services – no contact made with couple. Referral closed Sept.
Late 2016	Housing ASC	Direct let approved and community care grant for various essential items. ASC assessment requested – declined by Mary. No evidence of needs or concerns about capacity. No risks to safety. No further action.
2017 to early 2018	Housing ASC Housing ASC Housing	Moved into property. Neighbours complain about rubbish in couple's garden. Access continues to be refused. August: Housing refer again to ASC. ASC record for information only – "unless there are serious concerns that would warrant intervention against their wishes." October referred again – facing legal action for rent arrears. Case closed – no further action unless needs identified and consent given. Failed access continues. Gas capped off Jan 2018. Unauthorised adaptations to property noted.

April 2018		VARM meeting not attended by ASC due to admin error.
Summer-autumn 2018	Housing	Failed access visits continue
Autumn 2018	Police	Neighbour reports to Police concerns about elderly neighbours – not seen for 2-3 weeks. Officers attended and found Graham and Mary deceased. Causes of death could not be identified at post mortem examination: Coronial Inquests later concluded deaths due to natural causes.

Appendix ii – key to acronyms/ abbreviations

ASC	Adult Social Care
B&B	bed and breakfast (accommodation)
CPN	community psychiatric nurse
GP	general practitioner
IMR	individual management review
LCC	Leicester City Council
LPT	Leicestershire Partnership Trust
LSAB	Leicester Safeguarding Adults Board
MDT	multi-disciplinary team
RiPfA	Research in Practice for Adults
SAB	Safeguarding Adults Board
SCIE	Social Care Institute for Excellence
VARM	Vulnerable Adult Risk Management