Essex Safeguarding Adults Board

RUTH

SAFEGUARDING ADULT REVIEW

A REVIEW COMMISSIONED BY ESSEX SAFEGUARDING ADULTS BOARD INTO THE CASE OF RUTH, A 61 YEAR OLD FEMALE WHO SUFFERED AN INCIDENT OF SERIOUS ABUSE IN 2018

CASE SUMMARY
OCTOBER 2020

Essex Safeguarding Adults Board

Learning from Essex Safeguarding Adult Reviews

Case Summary – Ruth

On 16th October 2018 Ruth was admitted to Hospital, after being found unresponsive by family members at the family home. Ruth's father, Edwin, was also admitted to hospital having taken an overdose of Benzodiazepine. Ruth was brought into hospital by ambulance with police in attendance following an act of primary poisoning by Edwin. Although both were very ill for some time, both Ruth and Edwin survived.

Ruth was a 61-year-old woman who suffered a traumatic brain injury, following a horse-riding accident in 1975, aged 18. In March 2013 she underwent a total hip replacement and during her recovery, suffered a stroke resulting in left sided weakness. Ruth's sibling, Owen, described Ruth as being a bright, fun loving girl. Owen stated that after the accident Ruth was transferred to a geriatric ward and family members were told that her chances of surviving more than a year were remote.

Ruth's family refused to give up on her and brought her home when she was well enough. Ruth's father Edwin was described as a very formidable man who refused to give up on Ruth. During the review Owen described how their parents had taught Ruth how to eat, swallow, drink and go to the toilet again. They had also helped Ruth to stand and get out of the chair and the family home had been adapted to help care for Ruth.

Ruth's mother carried out most of her care until Edwin retired in 1990, when he then took over Ruth's care. The family had employed nurses to look after Ruth during the night so that they could look after her during the day. An incident happened not long after night nurses started helping Ruth, where jewellery went missing from the family home. This made the family lose any trust in outside people, deciding to look after Ruth themselves. Edwin had stated that you "can't pay people to care". This appears to have then continued throughout Ruth's life and although outside help was sometimes accepted, the family carried out most of the care themselves.

Ruth's stroke greatly reduced the amount of movement that she had, and this added considerably to the pressure on the family, with Ruth requiring 24-hour care. A carer was found for Ruth who started taking Ruth to a Day Centre in 2010. Ruth was described as really enjoying the time at the Centre and that she specifically enjoyed being with other people and singing. Owen described Ruth as being 'head strong' and was happy to indicate to people what she wanted to do and whether she was enjoying herself.

After two months the carer left as they became pregnant and Owen took over personal assistant duties. This evolved over eight years with Owen taking on more of the responsibility. Owen stated that he started easing off his work commitments so that he could spend more time with Ruth and visit places that she enjoyed.

Ruth started attending another Day Centre in July 2018, which provides a service to people with learning disabilities. Ruth attended one day a week and whilst there enjoyed several activities including the choir, hand massages, painting, drawing, puzzles, and on occasions using the multi-sensory room.

Owen described learning, about a year before, that their father, Edwin, had been diagnosed with prostate cancer, which later spread to his bones. Edwin was receiving hormone injections every month. Edwin was in his late 80's and had also suffered a heart attack and had a pace maker fitted. The family had begun to consider how they would continue caring for Ruth longer term. They had made a decision to convert the garage into an annex and had applied for funding. The community Occupational Therapist had been involved with the family and had advised on possible grants to apply for.

Edwin was described by professionals as being a very strong individual who appeared to be 'old school'. He believed that the care for Ruth was his responsibility and that no one else could look after his daughter as well as he could. Throughout the review period agencies raised concerns regarding the manual handling of Ruth, mainly by Edwin. Edwin explained during Police interviews that he was unable to cope with Ruth anymore and that he did not feel that he could leave the burden of care to anyone else.

Findings and key themes

Person Centred Care and seeing Ruth as an individual

Ruth attended a Day Centre one day a week and full assessments of need were completed with both Ruth and her family. The Day Centre appear to have put Ruth at the heart of her care, and it is documented that Ruth's views were obtained on all occasions. Staff at the Day Centre stated that Ruth had settled in and that she enjoyed activities such as singing and playing games with staff. Ruth's activities changed depending on her mood, but Ruth appears to have been at the heart of making those decisions.

Ruth was involved with Adult Social Care (ASC) for several years, although the personal budget agreement started in August 2010. Prior to this date Ruth's support needs were funded by her family. Within the timeframe for this review, documentation indicates that annual reviews took place regarding Ruth's personal budget, although the focus of Social Worker visits was on finances and not Ruth. Most of the assessments were completed without speaking with Ruth to ascertain whether she was happy with the care package. Additionally, on a couple of occasions Ruth was not present during the review process. Professionals failed to carry out Mental Capacity Assessments and therefore did not make Best Interest Decisions of behalf of Ruth. Instead decisions were made for Ruth by her father Edwin.

There is evidence to suggest that professionals considered Edwin an expert as he had looked after Ruth since her accident and as such, they did not feel that they could intervene.

Carers assessments and contingency planning
Although Ruth's family provided the majority of her care for many years, there is limited documented evidence that carers assessments were considered by professionals or offered to family members. An assessment was offered in 2010 but this was declined by Edwin. Those agencies involved with the care planning for Ruth were not aware of her father's ill-heath, despite being Ruth's main carer. Professionals failed to identify the need for contingency planning for Ruth's future care, due to her parents advancing years and Edwin's deteriorating health, which would impact on the family's ability to continue to care and support Ruth. In addition, consideration should have been given to offering Owen, Ruth's brother, who was acting as Ruth's PA, a carer's assessment.

It was identified throughout the review that Edwin could be very strong minded and that he had set views on how to look after Ruth. Professionals should, however, have been mindful of the strong sense of obligation they felt towards their daughter and the difficult decisions about having to ask for help and support.

Safeguarding concerns and supervision
Throughout the review period agencies raised safeguarding concerns about the manual handling of Ruth, mainly by Edwin. A safeguarding concern was closed in 2017 and dealt with under case management. If the referral had progressed through the safeguarding route this might have established a more robust way of exploring the issues. A further safeguarding concern related to a moving and handling issue was raised by the Occupational Therapist (OT). The decision to close the safeguarding case appears to have been premature, especially as it had been identified that the family did not follow up with the recommendations for adaptions.

A further concern was raised regarding Edwin refusing to change Ruth's wheel chair, even though it had been identified as being unsafe. It appears that there was a lack of joined up working and a general acceptance that Edwin was putting the welfare of Ruth first.

Following a further assessment in May 2018 a decision was made that the OT would continue to work with Edwin and other family members in relation to the concerns raised about manual handling. They appear to have missed the fact that Ruth's brother Owen had requested additional help whilst Edwin was in hospital and then failed to consider this upon his return home.

A lack of formal clinical supervision for OT's was identified during the review and the practitioner's event. There was, however, no evidence that the lack of supervision had an impact on the safeguarding concern raised about Ruth's care. It was also identified that there was a lack of OT's, which appears to be a national problem. A lack of Senior OT support, available for OT's was also identified and has subsequently been recruited.

Time for adequate case reflection for complex cases remains a challenge due to the fast pace of the urgent work and the high caseloads and workloads of staff. Practice meetings have been set up for OT's to provide opportunities for peer discussions and guidance regarding complex cases and professional issues.

Recommendations

Recommendation 1
Adult Social Care to assure the Director of Adult Services that assessments are being completed in an adequate manner where a person-centred approach is being considered and followed up. This may involve the review of the assessment form to make sure that all visiting social workers apply a person-centred approach when discussing personal budgets and that the views of the person are considered and documented.

Recommendation 2
Agencies have identified the lack of understanding of their staff surrounding the application of MCA and Best Interest Decision making. The findings in this review need to be shared with staff, and prior to that, teams need to be advised again of the policies on assessing capacity and evidencing those assessments and Best Interests Decisions where appropriate. Consideration of providing additional training regarding MCA and Best Interests Decisions. To consider how an audit can be completed to provide assurance that capacity issues are addressed in every case to include observational visits of how the MCA and safeguarding principles are embedded within practice.

Recommendation 3
Adult Social Care to assure themselves that professionals are aware of the importance of carers assessments and contingency planning where the carers themselves have significant needs and these needs may impact on the care and support that they give. It is also important to identify the changes in carers personal circumstances and that It is to be reinforced that all professionals have a responsibility to update lead professionals where changes in a person's circumstances might have an impact on their ability to care for others with care and support needs.

Recommendation 4
OT's to receive clinical support for all cases, particularly complex and difficult cases. Workers are to be allowed the time and the space for reflection on cases.

Recommendation 5
Essex Safeguarding Adult Board to seek assurance from other agencies and departments in the following areas:

- awareness of the 6 safeguarding adult principles,
- clarify individual responsibilities within the Care Act
- understanding of the management of processes to report and respond to concerns/complaints, including escalation.
- Staff have the skills and competencies to hold difficult conversations with family members.