Susan

A Safeguarding Adults Review

Overview Report

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1. Introduction

1.1 Susan was a 58-year-old female of white British origin. Susan had a stroke when she was 37 years old leaving her with physical disabilities and communication difficulties (right sided paralysis, left sided weakness and expressive dysphagia). Susan was a wheelchair user who was supported by her mother and other family members including her son. Susan's son had a diagnosed psychotic illness that was well managed when he took his medication. Susan's mother (also known as 'grandmother' in this report where reference is in respect of Susan's son) was also a huge support to Susan's son, ensuring that he took his medication and attended his appointments. Susan's son became unwell following the death of his grandmother who was no longer around to support him and, added to his grief, he apparently did not take his medication.

1.2 Susan's son seriously assaulted her causing significant facial injuries. Susan's son was arrested; it was soon realised that he was suffering from psychosis, he was assessed and detained under the Mental Health Act. Adult Social Care referred the case to the Safeguarding Adults Board for consideration of a Safeguarding Adult Review in respect of the physical abuse Susan suffered. Susan died 18 days later in hospital from unrelated physical health causes.

2. Process and Scope and Reviewer for the SAR

2.1. The Terms of Reference, including decision making, scope and methodology for the SAR can be found in Appendix 1. The review set out to cover a three-month period prior to the death of Susan. TSAB commissioned an independent reviewer to chair and author this SAR[1].

3. Family Involvement in the Review

3.1. A key part of undertaking a SAR is to ensure that families are integral to the review process. Families can provide views and insights that professionals may not have. A more complete picture of the person is often available from families who can provide a unique perspective. Discussions were undertaken with the Mental Health Trust about whether it would be possible for Susan's son to be involved. It was agreed on discussion between Susan's son and his key worker that, as he had no recollection of events and that he was still receiving inpatient rehabilitation, there would be no benefit to the review, neither would it be in his interests to have any involvement in the review process at this time. Other family members did agree to be involved via a call but declined the offer to meet with the author face to face. The family were supported by the Safeguarding Manager from the local authority who had been supporting the family post incident. Their views and thoughts are included throughout this report where they are relevant to learning.

[1] Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of TSAB and its partner agencies.

4. History and Background

4.1. Susan's family members discussed Susan's earlier years with the author. There were just the two siblings, but their parents were from larger families so there was a sizeable extended family who were all very close.

4.2. Susan was described as 'boisterous' as a child. As an adult Susan worked in retail. Susan met her partner and had her son when she was 26 years old. Susan's family reported that her partner was violent to her and other family members; he was not from the UK. Family told the author that they believed that he is living in his country of origin. Susan, her son and the family had no contact with him, and he did not feature in the son's life. Mental Health records show that he the father of her son left the home when he was about six years old. It does not appear that any of the professionals knew this information or how it had affected Susan or her son. Professionals were not aware of Susan's son's dual heritage. His ethnic status is recorded as White British. It is therefore not clear if his dual heritage had any impact on him culturally, however the violence from when he was a child may have impacted on his mental health according to research.[2,3]

4.3. Susan had a stroke when she was 37 years old; Susan's son was 11 at this time. The stroke happened on a Boxing Day; Susan did not come home from rehabilitation until the following March. The family were told that Susan had a blood clot in her leg that had moved and caused the stroke. During this time, Susan's son was looked after by Susan's mother. It is very likely therefore that this is where the bond between grandmother and grandson developed. This extended separation from his only parent may have added to his childhood trauma. Susan's mother continued to play a large part in her daughter and grandson's life, supporting practically and emotionally. It can therefore be seen why both were devastated at her loss, three months before the assault. Susan had always been clear that she did not want professionals involved in her care and support and so it was her family, mainly her mother who were her carers.

5. Events leading up to the death of Susan

5.1. The below represents a descriptor of key events in order to support learning; analysis and learning are provided in section six.

Assault two years prior to scoping period

5.2. For the reasons discussed above, Susan did not come to the attention of any services other than the GP for general healthcare. This was the reason for the relatively short scoping period for this review. Albeit that Susan's son is not the subject of this review, his care and support will be referenced where it is relevant to the impact his illness had on his mother, specifically when his grandmother had died, and he became Susan's closest carer.

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[2] Morgan C, Gayer-Anderson C, Beards S, Hubbard K, Mondelli V, Di Forti M, Murray RM, Pariante C, Dazzan P, Craig TJ, Reininghaus U, Fisher HL. **Threat, hostility and violence in childhood and later psychotic disorder: population-based case-control study.** Br J Psychiatry. 2020 Oct;217(4):575-582. doi: 10.1192/bjp.2020.133. PMID: 32778182; PMCID: PMC7525109. https://pubmed.ncbi.nlm.nih.gov/32778182/

[3] Dvir Y, Denietolis B, Frazier JA. **Childhood trauma and psychosis**. Child Adolesc Psychiatr Clin N Am. 2013 Oct;22(4):629-41. doi: 10.1016/j.chc.2013.04.006. Epub 2013 Jun 18. PMID: 24012077. https://pubmed.ncbi.nlm.nih.gov/24012077/

5.3. During the information gathering for this review, it became apparent that there had been a previous significant incident that was more or less a mirror image of the incident that this review considers. That has therefore been brought into the scope of this review to identify if there was any learning that might have been afforded to the contemporary incident.

5.4. Two years prior to the scoping period for this review, police were called on two separate occasions two days apart to the home of Susan and her son. Grandmother had been staying with Susan as there were concerns that Susan's son was becoming mentally unwell. It was reported by a family member to the police that Susan's son was having what was described as a psychotic episode. Police and the mental health crisis team attended the home. The result on the first of these occasions was to leave Susan's son at the property with a view that the mental health team would follow up. There had been no direct threats of violence, and the police did not record any offences.

5.5. Three days later Susan's son was threatening violence to family at the address. This was Susan and her mother. On this occasion Susan's son was arrested for assault. There were no visible injuries and neither victim wanted to pursue a prosecution and withdrew any consent to support police action. Again, what the family wanted was for Susan's son to get help. On this occasion Susan's son was detained under the Mental Health Act. This therefore satisfied the family that he was getting the help he needed.

5.6. The police submitted a Public Protection Notification (PPN)[4] to adult social care, which was good practice, in recognition of the risk to both Susan and her mother. It was clear from social care records that Susan's son had been assessed under the Mental Health Act and that he had been detained. There was a safeguarding case opened by the local authority in respect of the Susan and her mother. A telephone call was made to the family and was taken by grandmother due to Susan's communication difficulties. Susan's mother was very clear that this was an isolated incident and was solely due to her grandson's mental health illness and that it was out of character for him. Susan's mother also stated that they did not require any help and support at that time and would seek support in the future should they need it. It is recorded that the criteria were not met for a safeguarding enquiry and the case was closed as it was deemed that, as Susan's son had been detained, that the risk had been removed. The only other agency that was involved once the safeguarding was closed, apart from the Mental Health NHS Trust, was the GP practice; they had not been notified about the safeguarding referral but did know that Susan's son had been detained.

Death of Susan's Mother

5.7. There were several issues that had happened around the time of, and as a result of the death of Susan's mother.

5.8. The first issue that arose was the fact that Susan's benefits had always been paid into her mother's account. Now that her mother had died, Susan was unable to access her money. With the support of her son and with Susan's agreement checked by the Department for Work and Pensions, that he could speak on her behalf, the benefits were updated to be paid

[4] **Public protection notice (PPN)** is an information-sharing document that records safeguarding concerns about an adult or child. PPNs are shared with partner agencies to inform a multi-agency response. https://hmicfrs.justiceinspectorates.gov.uk/glossary/public-protection-notice/

into Susan's bank account. Another family member of Susan's was granted carer's allowance a month later in respect of the caring role for Susan.

5.9. Susan's son made complaints to the social housing landlord and the GP practice about the fact that two family members were living at the property he had always shared with his mother and that they had been there since the Covid pandemic. The call to the GP is recorded as having Susan agreeing with what Susan's son was saying in the background whilst on the call. He stated that the family members needed to move out as they were not financially contributing to their living costs. It is not clear why this had not been raised before; Susan's son only raised it after the death of his grandmother. He appeared to be agitated about the arrangements for bedroom allocation; he did not make any contact with the police as had been advised by the landlord. The GP made a referral to the social prescriber link worker and advised Susan's son to contact Citizen's Advice. It is not clear how any of this was resolved but this was four weeks before the incident. Family members told the author that they were not living with Susan and that they visited every day to offer care and support to Susan. Family members informed the author that it was on one of those visits that they found Susan with the injuries.

5.10. Susan's son, who had been under the care of the mental health psychosis team had begun to default his appointments. Despite several attempts to try and engage with him this had been unsuccessful from two months before the death of his grandmother. Susan then sent a message to the mental health team to say that her mother had died and that her son was not wanting to engage with the team at that time. There had been further plans to try and meet with him but there was no attempt to do this recorded. 20 days before the assault, the Mental Health NHS Trust psychosis team had written to Susan's son and informed the GP that they were discharging him back to the care of the GP.

5.11. One week before the assault, a family member called adult social care from another area of the UK concerned that Susan's mother had passed away and detailing the needs of Susan since her stroke and that her mother had previously been supporting her. It was stated that Susan was living with her son but that he had mental health issues, and the caller was not aware if he was taking his medication. The family member had stated that Susan had said that she would like carers to come in and consented on the phone. The referral was progressed for assessment. The next day the referral was assessed by the Early Intervention and Prevention team with a further call to the family member. These details included the difficult family dynamics of family members living with Susan and that there was no clear picture of Susan's son's current mental health. The family member called adult social care back to inform the social worker about the fact that the stairlift was broken, this was duly dealt with between social care and the landlord. The focus of this information seemed to have been more about care and support needs and the faulty stair lift rather than concerns specifically about any risk from Susan's son, what his mental health issues were and the difficult family dynamics that were being reported. It was agreed that a Care Act needs assessment would be undertaken; this was placed on a holding list for allocation, suggesting no identified risk or urgency was required.

Susan is assaulted by her Son; she dies 18 days later from unrelated natural causes

5.12. There was no further contact with agencies until the police were called when Susan had been seriously assaulted by her son. As stated in the introduction Susan's son was arrested, assessed and detained under the Mental Health Act. Susan was taken to hospital by

ambulance where she received sutures to her facial wounds. She returned home the same day to the care of family members.

5.13. It is noted that this was a much more serious attack than the incident two years previously and therefore, post incident, the police made referrals to the local domestic abuse support service, Adult Social Care and MARAC[5]. There was a Section 42[6] enquiry started and the safeguarding team within the local authority began to build a relationship with Susan and her family. The immediate risk from her Son was managed due to his detention.

5.14. Susan was completely devastated and shocked about the attack at the hands of her son. None of the family were able to understand how it could have happened. Susan now stated that she did not want any support from carers and would prefer to be left alone to recover with the support of her family. She did agree to support with a housing move to a ground floor property and stated she did not want to live with her son any longer. Susan agreed to have a pendant call button and be supported by a safety plan and therefore a safeguarding enquiry was opened. Initially Susan declined support from domestic abuse support services, but later agreed.

5.15. Seven days later a district nurse visited to remove Susan's sutures. No concerns were recorded. Susan stated that she only had the wounds that the sutures were being removed from and no other skin damage.

5.16. Within the following four days, at some point, Susan and the family member became very unwell with a vomiting and diarrhoea bug. As a result of this all visits that had been arranged were cancelled, these were the social care Occupational Therapist, the social worker and the domestic abuse support services. The family member reported to the social work safeguarding manager that Susan had a fall at the weekend and that they were managing well despite being unwell. Susan did not change her mind regarding general social care support and confirmed this with the Early Intervention and prevention social worker. The case was closed to that team, but the safeguarding enquiry remained open.

5.17. Two days later the domestic abuse support worker contacted Susan again, the family member confirmed that Susan remained very poorly and would call to rearrange visit when Susan was better. The GP record does not show that anyone contacted the GP regarding the illness they were suffering from. The following day Susan's case was heard at MARAC. It was agreed that in order to prevent Susan becoming overwhelmed with professionals at this time, it would be better for the local authority safeguarding team to coordinate contact with other professionals. This was not to say that other professionals would not be involved but that coordination would happen through the Adult Safeguarding Team so that contacts and visits would not become overwhelming.

5.18. On the same day as the MARAC, the family member called the GP as Susan was in a lot of pain in her foot. The GP visited and was not sure if it was due to a fracture from the fall or a

[5] **MARAC** A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator.

[6] **The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. 2014 HM Government The Care Act 2014; https://www.legislation.gov.uk/ukpga/2014/23/resources

blood clot. The GP arranged attendance at Accident and Emergency and an ambulance was called. The call to the ambulance service via NHS 111 made no mention of any diarrhoea and vomiting bug or any concern for Susan other than regarding the pain in her foot and that a category four (four hour) response time would be satisfactory. There was a validation call from a clinician in the Emergency Operations Centre to Susan whilst she was awaiting an ambulance to be dispatched. During this call the family member advised there had been no deterioration since the GP had visited earlier in the day. The ambulance arrived within the response time for category four.

5.19. The Ambulance crew reported that Susan had been doubly incontinent and appeared drowsy. Some concerns were noted with the property in that it was messy, cluttered and had an unpleasant odour. The crew also noted a strong smell of alcohol in the property; however, Susan denied any use of alcohol. Susan told the Ambulance crew that she had been urinating in her chair for the past 3 days as she had been unable to mobilise. The ambulance crew offered a referral to social care for needs assessment. The family member related that they were awaiting an assessment and a falls pendant. The family may have misunderstood the assessment process as social care had closed the case for assessment.

5.20. Susan had a very low blood pressure, and three crews were required to support her in improving her blood pressure and to safely extract her from her home.

5.21. On arrival in the emergency department, tests showed that Susan had a blood clot in her leg and was dehydrated due to the diarrhoea and poor intake since she had been unwell. Extensive pressure ulcers were noted to thighs and buttock which were dressed. A safeguarding alert was raised by the hospital in relation to the pressure ulcers and apparent self-neglect/neglect as she had dried faeces on her in addition to the pressure ulcers.

5.22. Over the next four days, Susan deteriorated. During that time, several investigations were carried out to understand why Susan was becoming so unwell. Results showed a blood clot in the leg and an Acute Kidney Injury possibly due to dehydration from the diarrhoea and vomiting. Brain scans also showed atrophy of the brain indicative of dementia. This had not been previously known about and at that stage it was not for acute intervention and diagnosis due to how unwell Susan was becoming. As Susan became more ill, it was decided that clinically Susan would not survive resuscitation or any surgery. Susan continued to receive active treatment up to the ceiling of what was available but sadly died four days after admission. The police, on behalf of the coroner, investigated the cause of death and identified that it was not related to the recent assault by Susan's son but due to other natural causes.

6. Learning themes to be addressed

Impact of mental illness on Susan and Family

6.1. It was acknowledged very soon after the assault by Susan's son on Susan that led to this SAR, that there was learning for the Mental Health NHS Trust regarding the discharge of Susan's son back to the care of the GP due to not being able to engage with him on appointments and contacts.

6.2. An early learning review as well as a tabletop review by the Mental Health NHS Trust concluded that the discharge back to the GP was not appropriate. This was particularly so

given the known information of the death of his grandmother who was considered to be a protective factor, his carer and was the person who visited every day to encourage him to take his medication. This coincided with a change to Susan's son's care coordinator three months previously which he had not been happy about. Other identified learning was that changes in the teams had an impact on how the whole team supported each other, that there were no recordings of this case being discussed in team huddles or supervision although staff know that it was discussed, and diaries indicated supervision had taken place. The learning review resulted in an extensive action plan which this SAR will ensure is completed and that actions have made a difference to people in receipt of services.

6.3. It is therefore for this SAR to consider the multi-agency learning that comes from the information and discussions undertaken. Most of the learning in this area comes from the fact that other services were not aware of the safety net that the grandmother provided. Some of this could have been known in future planning on the previous discharge from detention following the incident two years prior.

6.4. After the previous incident, conversations by social care took place with grandmother only via telephone. She spoke on behalf of herself and Susan as victims of the assault. As a person with significant protected characteristics[7], including difficulties communicating on the phone, best practice would have been to visit to ensure that there was agreement between mother and daughter about what support they could have and what support was needed rather than relying on information from Susan's mother alone. The case was closed without any conversation with Susan. Whilst speaking to the grandmother was good practice, not communicating directly with Susan is not in line with Making Safeguarding Personal[8]. It is of note that all later interventions regarding safeguarding were respectful of the need to include the person in their own protection and safety plans.

6.5. On discharge of Susan's son from hospital, apart from the mental health community team, the only other service involved was the GP practice. The subsequent discharge letter to the GP did not identify any current or specific ongoing risks to family and no action for the GP to take. The discharge summary did identify Susan's son could become agitated (no indication as to trigger) and can become stressed at home leading to becoming paranoid and that could affect his medication compliance (does not indicate how this might manifest). Susan's son was to be followed up by the mental health community team. The discharge summary at that time indicated no immediate action for the GP 'usual care'.

6.6. This information was therefore not giving the GP the impression that there was a risk to Susan as the impression was that the mental health team had discharged a person who was well from hospital and that he was to continue with ongoing support from the community team. With no other agencies involved at that time, there was no one else who had knowledge that Susan's son was dependent on his grandmother to keep him well and recognise and act on

[7] In the **Equality Act 2010**, nine characteristics were identified as 'protected characteristics'. These are the characteristics where evidence shows there is still significant discrimination in employment, provision of goods and services and access to services such as education and health. Disability is one of the nine protected characteristics.

[8] **The Making Safeguarding Personal (MSP)** initiative began as far back as 2009 by the Local Government Association and Association of Directors of Adult Social Services[8] to ensure outcome focussed, person centred responses to adult safeguarding, rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process.

any decline. It is also noted that grandmother was 83 years old with no contingency arrangements for her advancing age; she died two years later.

6.7. When family members began to make contact about the behaviour of Susan's son two years later, the nuances of this were not picked up. Information within these conversations was clear regarding Susan's son's mental health issues and now being Susan's main carer. The family dynamics were discussed as well indicating that Susan's son was now a sole carer for his mother. These concerns were shared by the family with Adult Social Care, it is not clear why there were no conversations by the family with the GP or the mental health team other than Susan's son making contact regarding the issue of his agitation at family members living in his and Susan's home. It was not picked up that this was not the case and that Susan's son may have been misinterpreting their being there regularly and that this could have been paranoid behaviour.

6.8. No information appeared to be discussed about the mental health issues, what they were and what the impact of the diagnosis would be on Susan's son's behaviours and on his family members, in particular his mother who was a wheelchair user and had difficulties with communication. His diagnosis of schizoaffective disorder was likely to have been delusional beliefs, that he may be being controlled, hearing voices and other psychotic type symptoms that could cause his behaviour to be a risk to himself and others. The hospital discharge letter to the GP two years earlier did have the diagnosis in the text but there was no relapse trigger plan to identify what future triggers may be. Unlike that letter, the discharge letter from the community mental health team two years later, albeit that the internal investigation showed that this discharge was inappropriate, was more robust and listed all of the triggers and how to manage different stages of illness. It informed the GP that Susan's son had disengaged from services and that the GP was to continue to monitor physical and mental health and provide prescribed medication.

6.9. This issue of discharge back to a GP for a person with a psychotic illness, has arisen nationally in an inquiry into murders in Nottingham[9]. There is to be a public inquiry, and it is therefore likely that there will be national action on this issue that the Board will need to be aware of. It is noted that the circumstances of the person were different but the impact was significant in Susan's case.

6.10. There were several reasons why this was not identified as being more of a critical situation than it was. The information regarding the issues two years earlier were not seen on the social care system due to the migrated record and there had been no intervention from social care as the family had declined help and support at that time.

6.11. It is also the case that the conversations regarding the practicalities of issues within the home took over, so it was a pragmatic decision to identify that the repair of the stair lift was important and the issues regarding Susan's son's illness drifted from conversations.

6.12. The result of the telephone conversations was that there were no time critical issues, the stairlift issue was communicated to the social landlord and the social care assessment, identified as section 9 care needs assessment and not section 42, safeguarding, was put on

[9] https://www.cqc.org.uk/publications/nottinghamshire-healthcare-nhsft-special-review-part2

hold as was the situation at the time, whilst awaiting allocation. There were contacts whilst the case was 'holding', however none of these resulted in a visit.

6.13. Family members did not appear to know who else to contact if there were concerns about Susan's son's mental health illness and could not have foreseen that the assault would be as severe as it was or as imminent as it was. This is not unusual in that families often see Adult Social Care as a first point of contact for many issues; this therefore leads to learning.

6.14. It was less than a week later that the assault on Susan happened.

6.15. The learning here could be identified as the requirement to be able to check out information on receipt of concerns with issues being triaged in a multi-agency safeguarding hub[10]. To argue this though, it would have to have been seen that the information from family would have been seen to be at a level of consideration for S42 safeguarding decision making; this was not the case. It would be the case that to do this the SAR would be applying hindsight bias in that we are now aware of how unwell Susan's son was, the risk that he posed and that he had been discharged from mental health services. Had the issue of concern been recognised as safeguarding then that may have involved a contact with the mental health team and the GP to triangulate the family concerns. The main learning within this section is for the mental health trust and as stated before that has already been recognised and actions accordingly taken.

6.16. Learning for social care relates to the fact that the previous safeguarding concern was hidden, and that the mental health 'issues' were not followed up with anyone who had any professional knowledge of what those issues might be and what risk Susan's son may pose if he was unwell. Care is needed on migration of systems that flags or alerts are visible on new systems, and mental health issues need to be explored so that risk may be understood.

Being professionally curious

6.17. The second main area of learning comes from understanding why professionals in this case were not more professionally curious to understand how this family were managing both pre and post the assault on Susan.

6.18. Of the story and Susan's journey above, the following areas that could have been subject to more curiosity were considered:

Elements where curiosity and information sharing/ discussion might have been applicable	Organisation
Was there any risk to Susan as a wheelchair user by placing a hold on needs assessment?	Adult Social Care
Why did Susan's son stop engaging with mental health teams?	Mental health GP

[10] **Multi Agency Safeguarding Hub (MASH)** provides triage and multi-agency assessment of safeguarding concerns - in respect of vulnerable children and adults. It brings together professionals from a range of agencies into an integrated multi-agency team. https://www.hants.gov.uk/socialcareandhealth/childrenandfamilies/safeguardingchildren/childprotection/mash

As a major protective factor for son, what were trigger plans for death of elderly grandmother?	Mental Health
What was impact on family when mother and son's main carer died?	Mental Health GP Adult Social Care
When son was agitated about family living issues what was behind this? Had family members moved in? Was Susan being exploited?	GP Adult Social Care Social Landlord
When family members called social care with concerns, what type of mental health issues were being reported? What do mental health teams know of this person? Is this a safeguarding concern or needs assessment concern? Who else might hold information?	Adult Social Care
How was Susan and her family member coping when both unwell with diarrhoea and vomiting given carer and wheelchair user were affected? Had they contacted the GP?	Domestic Abuse Services, Adult Social Care, Occupational therapy
Why was Susan in such a neglected state on the day she was admitted to hospital?	GP Ambulance
Why did family not seek help for illness and fall?	Ambulance service GP Adult Social Care

6.19. The term professional curiosity was originally developed in children's safeguarding reviews in the early noughties [11]. As more work was undertaken regarding safeguarding adults, the concept quickly moved across to safeguarding adult practice too. There are very few reviews that do not mention professional curiosity with multiple safeguarding children and adult boards providing training, guidance and briefings on the subject. TSAB has also undertaken a large amount to work on the idea of being professionally curious.

6.20. The recent Second Analysis of Safeguarding Adults Reviews[12] cites 44% of all SARs undertaken between 2019 and 2023 showing an absence of professional curiosity as part of the learning. The analysis put this within the direct practice domain. This SAR has looked deeper into this concept to understand and consider why, despite the high profile of the term and concept, SARs are still finding that there is a dearth of curiosity shown in practice

6.21. At the workshop session with practitioners for this SAR, time was given to understanding what the framework for professional curiosity might look like as well as the barriers to practicing in a naturally curious way.

[11] Dickens J, Cook L, Cossar J, et al. (2023) **Re-envisaging professional curiosity and challenge: Messages for child protection practice from reviews of serious cases in England.** *Children and Youth Services Review* 2023: 107081. https://www.sciencedirect.com/science/article/pii/S0190740923002761

[12] Preston-Shoot. M, & Braye. S, (2004) **Second national analysis of safeguarding adult reviews** Local Government Association, June 2024 https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

6.22. The possible solutions have come from the workshop, research (IBID),[13] and guidance[14]. The first issue is one of definition, practitioners at the workshop wondered whether the description makes it sound too complex. What it means in general is asking more 'why' questions to understand the fuller picture. Susan's life and story were not particularly complex but did leave difficulties to be faced. Asking more than the obvious questions needs more time and in many cases time to build a relationship with the person that a professional wants to know more about. Fear is also a factor, will probing too deeply stray into the Human Rights of privacy and right to family life? Also is there enough resource within teams to allow for time or is the workload so overwhelming that time is actually of the essence to proceed to the next call or assessment?

6.23. This is therefore where senior management and leaders come into the picture. The guidance mentioned above asks questions of senior leaders and managers regarding resources and supervision models. Time is needed, time for reflection, supervision and peer support. Is hot desking a barrier where there are no longer corridor and cross desk conversations between professionals? Would co located services and regular professionals huddle type meetings lead to more professional curiosity and understanding of how other agencies work? When there were less resourcing and staffing issues within organisations, it was not unusual to find that practitioners would not be rushing so much from one meeting to the next, allowing for more networking time. It is also the case that as there are more and more online meetings where no travel time is needed, meetings are literally back-to-back, sometimes for a whole day, this leaves no time for self-reflection on work and conversations undertaken in the preceding hours. This SAR will make recommendations to address wider issues to enable more opportunity for professional curiosity and ensuring that each partner organisation plays their part in disseminating the concept rather than it needing to be practitioner and team led.

Effective/Good Practice

- Professionals responded immediately to the needs of Susan post incident, they were mindful of the shock and raw emotions of the incident and allowed Susan to take the lead as this what she wanted.
- The mental health trust reviewed instantly the issues that the incident raised for them and put together an action plan for change.
- The GP practice knew the family well
- The social landlord responded to the need for repairs of the stair lift.
- The Ambulance Service arranged to take Susan and her son in different ambulances and to different hospitals post incident.
- MARAC and Safeguarding referrals were made appropriately

Learning

- Recognition of increased risk for those with disabilities who lose their longstanding care arrangements should ensure that assessments are undertaken in a timely manner
- Signposting to appropriate services is an important function of the Adult Social Care Front Door.
- Understanding of the nature of mental health issues is important to understand if there is any risk

[13] Victoria Burton, Lisa Revell, **Professional Curiosity in Child Protection: Thinking the Unthinkable in a Neo-Liberal World,** *The British Journal of Social Work*, Volume 48, Issue 6, September 2018, Pages 1508–1523, https://doi.org/10.1093/bjsw/bcx123

[14] Research in Practice Strategic Briefing (Dec 2020) **Professional curiosity in safeguarding adults** https://www.researchinpractice.org.uk/media/z5nl0yiw/adults_professional_curiosity_sb_web.pdf

- On receipt of concerns expressed by family, it is important to triangulate that information with professionals who may have more details.
- Ensuring that safeguarding concerns are shared appropriately and flagged on systems where possible ensures that future risks may be assessed more readily and accurately.
- Being professionally curious is of utmost importance in order to understand below surface issues
- Understanding declining of support services is important to identify risk factors.

7. Summary and Conclusion

7.1. In summarising the learning from this review, it is useful to use a model for a whole system approach used in other adult safeguarding research literature (see figure 1). This model shows how each domain interlinks with the next around Susan.

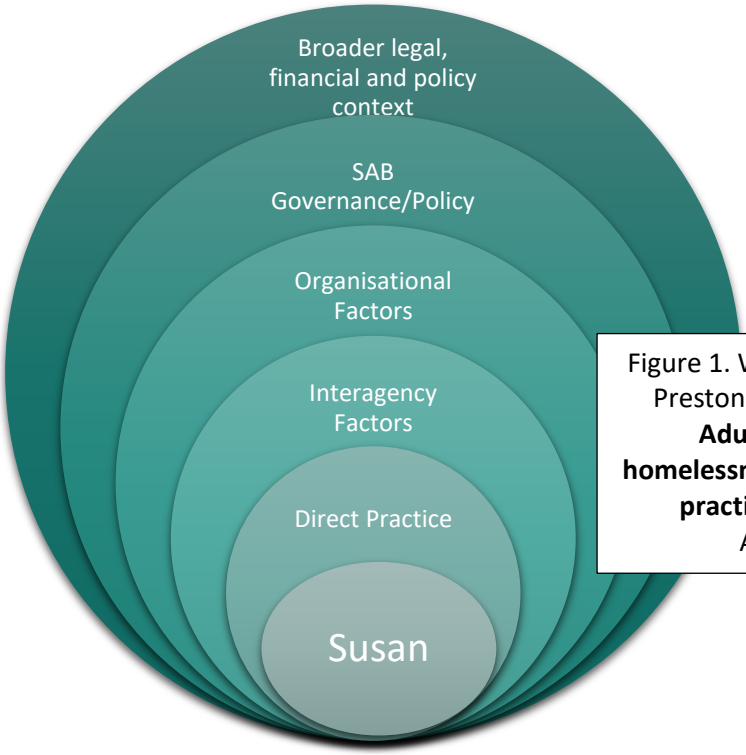

Figure 1. Whole system model from Preston Shoot, M. Shoot (2020) **Adult safeguarding and homelessness A briefing on positive practice** Local Government Association. Pp 8

7.2. Susan's life was not one that was particularly complex although she did have challenges within it that she managed well with the support of her family. As a woman who had been the victim of previous abuse from her partner and then suffering from a stroke that left her with communication difficulties and physical disabilities there were many protected characteristics that professionals needed to consider when working with her. Generally, practitioners were mindful of her protected characteristics and, by listening to her, ascertained her wishes. Direct practice with Susan was generally good.

7.3. Being more professionally curious may have led to questions regarding her change of decision post assault concerning support that she needed or wanted. That may then have led to an opportunity to discover that Susan was becoming unwell and was unable to care for herself even with the support of her family member. Professional curiosity may also have led

to suggestions that medical help be sought post fall and when unwell.

7.4. Improved interagency working could have highlighted the risk that Susan's son may pose when he became unwell, and use of historic information flagged between agencies may have improved that essential communication.

7.5. The wider organisational factors have come from the fact that records can become 'hidden' when systems migrate to new ones with information then not readily visible. The most significant
organisational factors have come from the learning review in the Mental Health NHS Trust; this SAR acknowledges that the learning was significant. It cannot be known whether if Susan's son had not been inappropriately discharged or follow up had been more assertive, the assault could have been prevented but there may have been opportunities to assess his mental health more readily. The death of his grandmother who was a significant member of the family was neither prepared for nor acted on.

7.6. Whilst professional curiosity is seen in this review as being largely absent and could be considered as falling under the direct practice domain, using the learning from the workshop and research, on this occasion it is being considered under organisation factors as well as policy and broader national context. That is due to the fact that supervision, peer support and time for reflection come within those organisational factors. It is suggested also that with difficulties in funding, recruitment and retention across statutory agencies, many practitioners are overwhelmed with volumes of work and large caseloads which lead to lack of time and space to be professionally curious. TSAB have tried addressing the direct practice issues, now it is time to look at the wider picture to enable a professionally curious workforce.

8. Recommendations

1. Recording Systems

- TSAB should seek assurance from all partner agencies, that where there is migration to new electronic record systems, that there is clarity regarding how to access safeguarding risks and information from historic information and that new record systems should be proactively checked to ensure previous safeguarding information is visible.

2. Professional Curiosity

- TSAB to include professional curiosity as a focus of Safeguarding Adults Week in November 2024.
- TSAB to ensure that the new Professional Curiosity briefing is disseminated to as many practitioners as possible.
- TSAB should seek to engage managers at all levels in enabling professional curiosity in the workforce wherever possible. Organisations should be requested to share any examples of tools and good practice that enables a professionally curious workforce.

3. Triage of Assessments

- TSAB should require organisations who have telephone triage systems that assess risk in the process of referral management, to ensure that those with disabilities and communication issues are prioritised to ensure that the risk

assessed is accurately based on the current need of the person. (Actions could include updating policies to consider risk of telephone triage for those with communication difficulties).

4. Flagging of previous safeguarding

- TSAB should ask that organisations use safeguarding concern flagging on record systems to ensure that cumulative risk is instantly visible.
- Where Adult Social Care may record only section 42 progression as criteria for a safeguarding flag, that this is amended to include where criteria met for Section 42 but does not progress for other reasons e.g. person refuses intervention or risk has been removed.

5. General Learning Briefing

- TSAB should assure itself that the learning from this review is disseminated as widely and diversly as possible. TSAB should consider providing for different audiences and learning styles.

Appendix 1

TEESWIDE SAFEGUARDING ADULTS BOARD
Safeguarding Adults Review
SUBJECT CASE 2/23 SUSAN
Terms of Reference and Scope

1. Introduction

A Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a 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) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A 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).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SARs "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and TSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and

empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Agency Review Reports/ Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary known from referral and scoping.

Susan, a white British 58 year old female was violently assaulted by her son, she sustained significant injuries as a result. This was a prolonged attack lasting approx. 15 minutes and could have led to Susan being killed.

At the time of the incident Susan's son was mentally unwell and following his initial arrest he was assessed under the MHA 1983 and was formally detained under s2 MHA. At the time of the MHA being requested Liaison Psychiatry deemed him to be presenting as Psychotic and was openly responding to auditory hallucinations.

Susan's son has a diagnosis of schizo-affective disorder. He had not been engaging with the psychosis team and therefore his case was closed 3 weeks prior to the incident occurring. It

does not appear the team were aware of the recent bereavement of his grandmother and that he had stopped taking his medication. Susan/family had noticed a deterioration in Susan's son's mental health over the past month and had tried to get support through the GP.

The assessing doctors as part of the MHA assessment that was carried out expressed concern that Susan's son's schizo-affective disorder, untreated given his history of violence when unwell, was of significant concern.

Susan's son was previously detained under s3 MHA in June 2021 following an assault on his grandmother. Susan's son is s117 eligible. At the time of the incident, he was not in receipt of any support having been closed due to non-engagement.

Following the incident, Susan managed at home with the support of her sister; she declined any other formal support. Susan and her sister became unwell with Norovirus approximately 2 weeks later. Susan was admitted to hospital with a noted swelling to her foot thought to be an injury from a previous fall. On Admission Susan was diagnosed with acute kidney injury and cellulitis of her foot. Susan deteriorated over the next few days and died four days following admission. Cause of death on post-mortem was found to be acute peritonitis and a perforated duodenal ulcer.

3. Decision to hold a Safeguarding Adults Review

A SAR Referral was made by the social worker following the initial incident. The Safeguarding Adults Review Sub-Group of the Safeguarding Adults Board met to consider the case for review. The SAR Decision Support Guidance was used to determine that the criteria for a mandatory SAR was met. It was noted that although Susan died due to natural causes, she was seriously harmed both physically and emotionally as a result of the assault, which prompted the SAR Notification. The chair of the Board endorsed this decision to proceed with a mandatory SAR.

4. Scope

The scope of the review will cover contact and assessments agencies had with Susan and her son in terms of his caring role, his movement to live with his mother post the death of his grandmother, from June 2023 until Susan passed away in August 2023. This also covers the period of time post incident to identify how agencies worked together to support and safeguard Susan post this significant trauma. Information will also be sought from agencies regarding background information, key events and interventions at any point prior to the scoping period (including the time surrounding the death of Susan's mother).

5. Methodology

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

TSAB elected to use a methodology that engages frontline practitioners and their line managers. Chronologies collated during the scoping phase along with analysis of practice from each agency, reviewed by the author to identify where learning was emerging within the agreed key lines of enquiry. Agencies are asked to review their own involvement and provide a brief report of their learning and recommendations. A reflective workshop will be undertaken using an appreciative enquiry approach. The workshop will focus on understanding the strengths in the current systems and working towards identifying any areas for further improvement.

6. Key Lines of Enquiry to be addressed

The following case themes that will be addressed and are not in any order of priority or importance.

6.1. Death of the mother of Susan

- Please analyse any information and interventions that your agency had around the time of the death of Susan's mother. Include in your analysis what your agency understood of the impact that this may have on the family.

- Please critically discuss what worked well and what might have worked better.

6.2. Support for Susan pre incident

- What assessment and support were in place following the death of Susan's mother who was her carer?
- What assessment or understanding of risk was undertaken when your agency was aware that Susan's son had moved to live with his mother?
- Please thoroughly analyse practice in this area to include what you would have noticed if support for Susan had worked well.

6.3. Support for Susan's son as carer

- How equipped was Susan's son to be the main carer for his mother?
- What did practitioners understand of any risk to Susan when he was mentally well?
- How did son's eligibility for s117 aftercare support him and in particular in his caring role and relapse recognition/prevention?
- What relapse plans were in place for Susan's son, including recognition of relapse triggers and action plans?
- Please thoroughly analyse practice in this area to include what needed to happen and what good practice looked like/would look like.

6.4. Support for Susan post incident

- What assessment and support were in place at home post incident?
- What was understood regarding the care and support needs of Susan?
- What was understood about the level of care that family were able to give in support of Susan's activities of daily living especially when she and her carer became unwell.

- Please thoroughly analyse practice in this area to include what needed to happen and what good practice looked like/would look like.

6.5. End of life care

- Please analyse any blocks and barriers to understand Susan's presentation during her hospital admission that led to her being placed on end-of-life care.
- If her condition had been known about, could she have been treated?
- Please analyse enablers and constraints to understanding the gravity of her presentation.
- Please thoroughly analyse practice in this area to include what needed to happen and what good practice looked like/would look like.

6.6. Safeguarding system

- How well did the multi-agency safeguarding system protect Susan from harm and/or further harms?
- Please analyse the practice and decision making within your agency and across agencies in respect of referrals or any other safeguarding concern your agency is aware of. Please include what needed to happen and what good practice looked like/would look like.

6.7. Protected Characteristics

- How did practitioners' evidence that Susan received equitable care and reasonable adjustments that were made respect of protected characteristics as described within the Equality Act (2010)

7. Independent Reviewer

The named independent reviewer commissioned for this SAR is **Karen Rees.**

8. Organisations to be involved with the review:

The following organisations will be asked for Agency Reports:

- Police
- Department for Work and Pensions (DWP)
- Emergency Duty Team (EDT)
- GP
- Domestic Abuse Support Services
- Ambulance Service
- Hospital NHS Foundation Trust
- Borough Council
- Social Housing
- The Mental Health NHS Foundation Trust.

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family, involve them in the review and share findings with them prior to publication. TSAB has contacted Susan's family via a point of contact within the local council to inform the family of the SAR; they will be invited to take part in the review. The author will decide with, support of Board and those currently working with Susan's son if his involvement will be beneficial to the learning.

Project Plan dates:

1.	Initial planning meeting	01/02/2024
2.	Governance Group initial meeting & Terms of Reference agreed	6th March 1pm – 2pm (Microsoft Teams)
3.	Agency Report authors' briefing	6th March 4pm – 5pm (Microsoft Teams)
4.	Agency reports returned by	10th May
5.	Review of Agency Reports by Author	13-15May
6.	Distribution of pre workshop document and Agency Reports	10th June
7.	Family meeting	17th June (TBC - afternoon)
8.	Learning and Reflection Practitioners' Workshop (F2F)	18th June 9.30am – 4.30pm (River Tees Watersports Centre)
9.	First Draft Overview report to all workshop attendees and Panel (Governance Group)	26th July
10.	Follow up meeting with Workshop attendees (Virtual)	6th August 12.30pm – 4.30pm (Microsoft Teams)
11.	V2 Overview report to Panel (Governance Group)	14th August
12.	Panel (Governance Group) meeting (1)	20th August 10am – 12pm (Microsoft Teams)
13.	V3 Overview report to Panel (Governance Group)	28th August
14.	Panel (Governance Group) meeting (2) to finalise report and build recommendations (recommendations to be agreed electronically)	4th September 1pm – 2.30pm (Microsoft Teams)
15.	Final Report to Board and learning briefing circulated to Board members	27th September
16.	Final Report and learning briefing to Board for sign off	9th October 9.30am – 10am (Microsoft Teams)