Safeguarding Adults Partnership Board Practitioner Briefing

Safeguarding Adult Review – Mark

What is a Safeguarding Adult Review (SAR)?

According to Part One Section 44 of the Care Act 2014 Safeguarding Adult Boards (i.e. Cambridgeshire and Peterborough Safeguarding Adult Partnership Board) must undertake a Safeguarding Adult Review (SAR) when:

1. An adult in its area with care and support needs (i.e. an adult at risk) has died as a result of abuse or neglect whether this was known or suspected before the adult died and there is concern that partner agencies could have worked more effectively to protect the adult.
2. An adult in its area with care and support needs (i.e. an adult at risk) has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a Safeguarding Adults Review is to **learn the lessons** about how professionals and organisations work together, and to consider how the learning can be used to improve practice for others in the future.

(Adapted and Taken from Care Act 2014 and Cambridgeshire and Peterborough Safeguarding Adult Partnership Board Website)

Mark

The name Mark is used as a pseudonym within this briefing to anonymise and protect the adult at risk's identity and wider family.

Background

During his adolescent years Mark was hit with a cricket bat, whilst playing cricket, that led to brain injury. Mark had suffered from mental health difficulties for most of his life and was diagnosed as having Hebephrenic Schizophrenia. Mark was placed in a care home in Cambridgeshire in 2009 by another local authority's NHS Trust and had a Deprivation of Liberty Safeguard (DoLS) in place. He continued to have support from the care coordinators/ social workers, from the other local authority's NHS Trust and as Mark was living in Cambridgeshire, responsibility for his mental health care needs fell to the local mental health services of Cambridgeshire and Peterborough Foundation Trust (CPFT).

The care home described Mark as a complex man who liked to dress so that he looked smart. Although he did have the capacity to choose what to wear, he would not have the capacity to enable him to cross the road safely. Due to his medication, Mark suffered from severe constipation and acute abdominal issues and as a result was prescribed strong laxatives.

During November 2019 Mark was escorted to the hospital three times by his carers with chronic constipation. Mark was unable to wait for long periods of time, due to his medical condition and could be uncooperative and try to leave the hospital. On 26 November 2019 Mark died, and the cause of death was given as Bronchopneumonia, Ileus and Paralytical Megacolon noting a Clozapine effect.

Key Learning Points for Professionals

Areas for Improvement Identified within the SAR

- **Deprivation of Liberty (DoLs)**

Except for the care home none of the agencies who were treating Mark were aware of what was written within the DoLs. *It may have been helpful to know what was written within the DoLs to support Mark in his care and treatment and to guide and support further assessments and reviews*

- **Completing Mental Capacity Act Assessments (MCA)**

In terms of his treatment and GP attendance there was no evidence of capacity assessments or Best Interests' assessments taking place. These *assessments would have informed the GP surgery, clinic and psychiatrists about Mark's capacity and if it was ascertained that he lacked capacity, then would advise what would be the best interests for him in terms of treatment*.

During the several admissions into hospital neither an MCA assessment nor a Best Interests Assessment was undertaken by the hospital *which may have advised medical staff about Mark's capacity to remain in hospital as well as supporting his treatment needs*.

These were missed opportunities for supporting Mark's chronic and acute health needs for when he was constipated and then later when he needed emergency treatment.

- **Sharing Information**

None of the agencies were able to access each other's recording systems for sharing information given that access to electronic systems was precluded outside of certain organisations. *A type of multi-agency meeting, in Mark's case may have been helpful, to share information, given that he was a man with very complex issues and needs*

- **Assessment**

There were times, recorded within the chronology, when the care home contacted the GP and HUC with serious concerns about Mark's health deteriorating and in response the GP's gave telephone consultations and suggestions as to what to do to support Mark. The agencies at the facilitated multi-agency event felt that *these were missed opportunities for when Mark could have been physically examined that might have provided a different assessment of the situation and invoked an alternative response from the doctor*.

- **Recording**

Limited information was provided by the care home, CPFT and the other local authority's DoLs team as to who the social workers / care co-ordinators for Mark were or where they were located. *In terms of sharing information and contacting relevant services for support and working together agencies should record clearly what agencies are involved with the adult at risk, what their roles are and what their contact details such as an address, email and main line telephone number.*

Not all the records of the agencies involved in Mark's case had clear descriptions of events and treatment with a rationale for the actions /activities recorded and of the outcomes. *Making sure that events are recorded and that records are clear, concise, explanative, have a rationale*

and avoid jargon is essential not only in terms of recording events and concerns but also for sharing information and for overall accountability.

- **Lived Experience of the Adult**

The signs, to agencies working with Mark, were that he did not say that he was in any pain and that he continued to eat normally. However, health agencies at the meeting felt that given Mark's medical condition of a distended abdomen and a potentially perforated bowel he would have been in pain. *In terms of the 'lived experience of the adult' and making safeguarding personal it was suggested that professionals should think about wider observations surrounding an adult at risk and to note any changes in behaviours that are unusual for them.*

Areas of Good Practice Identified within the SAR

- **Physical Health**

It was good practice, that in terms of Mark's general physical health he was attended to on a timely basis and when he injured himself medical records show that he was given appropriate medical treatment

- **Communication and Working Together**

The communication between members at the Clozapine clinic was good as was the continued contact and support from the clinic with the staff at Mark's care home. The care home effectively communicated with agencies and asked for changes in the way Mark was treated, to accommodate his needs whilst at the same time enabling Mark to agree to and allow the treatment

The nurse from the GP practice had a good relationship with the care home and with Mark and visited many times to see him and to administer treatment.

It was highlighted as 'good practice' when the pharmacy refused to change Mark's drug regime without a GP's letter highlighting the changes. This prevented potentially incorrect amounts of medication being dispensed but also highlights that *when changes are made to medications for patients the pharmacy should be informed.*

It was good practice that the care home always made sure that Mark had his 'hospital passport' with him when going to hospital that contained useful information about his mental health history that was kept in a red packet. *It is important that documents such as hospital passports are kept up to date for informing health professionals about patients with complex social and health needs.*

- **Advocacy**

It was good practice that Mark had an advocate who visited him at the care home to explain his DoLs and to ascertain if he was still happy to be at the care home. In terms of Making Safeguarding Personal, *where possible an advocate should be considered to support those people with care and support needs in their understanding and decision making*.

- **Risks Associated with Medication**

At the facilitated multi-agency event attendees outlined that it was good practice that professionals present at the event knew about and recorded the potential side effects of Mark taking Clozapine. It was good practice that the reduction of Clozapine was immediately put into action once the new psychiatrist became aware of the potential life-threatening issues for

Mark due to severe constipation that could have resulted in the possibility of having a perforated bowel

Recommendations

1. The NHS has prepared informative **leaflets** for both professionals and people with learning difficulties (easy read leaflets) to explain about constipation, how to avoid being constipated and what to do if people are constipated. This is available on the Safeguarding Partnership Board's website https://www.safeguardingcambspeterborough.org.uk/adults-board/adult-abuse-and-neglect/constipation-and-people-with-a-learning-disability/

2. Professionals, where possible, should consider undertaking assessments in the presence of the person concerned to provide opportunities to **examine, observe and ask** the individual about their experiences and feelings.

3. When a person is deemed to have 'capacity issues', agencies should consider undertaking a '**Mental Capacity Act assessment'** and if necessary, a '**Best Interests' assessment'**.

4. Agencies who work with adults at risk who have complex needs should consider noting, in a prominent place, on their records about **the lived experience of the adult** and what the individual behaviours and issues are for them.

5. A&E departments across Cambridgeshire & Peterborough to review their current policies and procedures to ensure they are meeting their equality duty for adults with complex needs and behaviours when presenting in crisis, to ensure an **appropriate pathway** is enabled to meet their needs including reasonable adjustments where appropriate, to ensure urgent care access is available when required.

6. The safeguarding partnership to design a **hospital passport** for use in all the hospitals across the Peterborough and Cambridgeshire region

7. When undertaking assessments, safeguarding enquiries and support plans with an adult at risk professionals **should always consider the use of an advocate**. If a person is deemed to lack capacity or maybe the subject of a DoI's a different type of approved independent advocacy service should be considered for supporting the adult at risk.

8. Accurate, succinct and timely **recording** of events is essential for safeguarding adults at risk. (i) the care home is to review their record keeping procedures and to keep all assessments and records of events on service user's individual files (ii) all professionals to make accurate, timely, succinct records of all events in relation to service users on their data bases (iii) Managers to have regular oversight and 'sign off' of practitioner's records as part of single agency monitoring / auditing and within supervision (where held).

Further Information

Adult Safeguarding Partnership Board Website
http://www.safeguardingcambspeterborough.org.uk/adults-board/

Multi-Agency Policies and Procedures
https://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/

Mental Capacity Act
https://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/deprivation-of-liberty-safeguards-dols/

Lived Experience of the Adult Guidance
https://safeguardingcambspeterborough.org.uk/adults-board/cpsabprocedures/lived-experience-of-the-adult/

Safeguarding Adult Reviews
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/sars/

Multi-Agency Safeguarding Training
http://www.safeguardingcambspeterborough.org.uk/availabletraining/

Virtual Briefings (SWAYS)
https://safeguardingcambspeterborough.org.uk/home/virtual-briefings-sways/

Leaflets, Resource Pack, Training slides, Virtual Training and Useful Information
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/leaflets/
https://www.safeguardingcambspeterborough.org.uk/adults-board/resources-for-practitioners/

Constipation Information

https://www.safeguardingcambspeterborough.org.uk/adults-board/adult-abuse-and-neglect/constipation-and-people-with-a-learning-disability/

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