Safeguarding Adults Partnership Board Practitioner Briefing

Safeguarding Adult Review - Dorothy

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)

SAR

It is important to note that this is not a recent case and a lot of practice and procedures have changed since the time of death. An action plan is in place to address the recommendations raised within the SAR report. This briefing is written to support the learning for professional with a view to improving future safeguarding practice

Dorothy

The name Dorothy is a pseudonym used within this briefing to anonymise and protect both the identity of the adult at risk and her family members.

Background

Dorothy was a 77 year old female who died in January 2019. At the time of her death she lived with her daughter Faye 47 years, in Peterborough.

After being found unresponsive by her family, Dorothy was admitted to Peterborough City Hospital on 24th January 2019 and died on the same day. She had a large open wound from an untreated breast cancer tumour which had become necrotic with metastatic deposits throughout both lungs. The state of Dorothy's health was unknown to health agencies, or any other professional before 24th January as she had not sought any medical support.

Dorothy displayed hoarding behaviours and the Peterborough Housing Association Cross Keys Homes attempted to support Dorothy to address this due to the fire risk that was posed to the other residents residing in the properties either side of Dorothy and Faye. In February 2018, Peterborough City Council Homelessness team became involved as Dorothy and her daughter were facing homelessness as a result of possible eviction by Cross Keys Homes.

Both agencies made further attempts to support Dorothy and Faye to clear the property but had limited success.

Other agencies who had very limited interaction with Dorothy and Faye in the years before Dorothy' death were Adult Social Care, bailiffs from the County Court and Cambridgeshire Fire and Rescue Service.

This case review is focused on the period of time from November 2016 when Cambridgeshire Fire and Rescue Service attended the property of Dorothy and subsequently made a referral to Peterborough Adults Social Care, until Dorothy's death in January 2019.

Contact was made with Adult Social Care on seven occasions during the review period in relation to either Dorothy or Faye, as well as a number of referrals made previous to the review period. Dorothy was deemed to have capacity following these earlier referrals and the concerns referred to Adult Social Care did not meet the safeguarding criteria.

Key Learning Points for Professionals

All agencies involved agreed that the needs of Faye had been overshadowed and as such, any opportunity to support her had been missed. She should have received an assessment in her own right and her case could have been managed by Adult Social Care under their complex case management process. The process would have included a professionals meeting which could have included her GP and possibly a mental health representative. This should have been supported by clearer recording allowing for Faye to be considered as a separate individual.

Adult Social Care could have been clearer to both the other professionals and Dorothy and Faye themselves regarding their role and the support they may have been able to offer. The records did not suggest that sufficient attempts to engage both women had been made.

It was also agreed that further investigation by Adult Social Care should have been undertaken following the referral received in November 2018 when it appeared that eviction of Dorothy and Faye was imminent, and then again in January 2019 when the bailiffs suggested they would not go ahead with an eviction without the presence of Adult Social Care.

There was an absence of health agencies in this case. Dorothy had been displaying severe hoarding behaviour for many years: she had been rehoused in 2007 for this reason. However, there were no indications from the records considered as part of this review that she had been offered mental health support for this behaviour. When discussing this at the facilitated agency meeting, the agencies agreed however that such specialist support was not available at the time and remained unavailable now. Available support for people who display hoarding behaviour is now discussed at the district led Hoarding Panels. These groups bring together safeguarding partner agencies across the county to consider what support might be appropriate in each individual case. The Panels have facilitated closer working relationships and a shared understanding of hoarding. There have also been incidences where funding has been used from the Disabled Facilities Grant to aid with clearing clutter from a property.

In February 2018, the Homelessness Team made a referral to Adult Social Care which was supported by photographs of the property. This referral was not recorded on Adult Social Care records and it is reasonable to have expected the Homelessness team to have contacted Adult Social Care due to the lack of response from them. All agencies present at the facilitated agency meeting agreed that all referring agencies should be aware of their responsibility to follow up referrals with Adult Social Care if they do not receive a response.

Further Information

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

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

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

Hoarding
https://www.safeguardingcambspeterborough.org.uk/2019/03/01/hoarding/

Multi-agency Protocol for Working with People with Hoarding Behaviour
https://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/hoarding/

Self-Neglect
https://www.safeguardingcambspeterborough.org.uk/adults-board/adult-abuse-and-neglect/self-neglect/

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/

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

The Lived Experience of the Adult
https://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/lived-experience-of-the-adult/

April 2021