Safeguarding Adults Partnership Board Practitioner Briefing

Safeguarding Adult Review - Simon

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

Simon

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

Background

Simon was a 90 year old man who died in 2017. He was born in France and English was his second language and as his health deteriorated he would often speak limited words in French. He was a sociable and well respected business man who ran the family electrical business and had a wife, son, daughter in law and grandchild.

Simon started to become known to a number of agencies around 2008 and in 2009 he was admitted to hospital for the removal of a frontal lobe meningioma (brain tumour). The operation left Simon with acquired dementia and he suffered from cerebrovascular disease and experienced an epileptic seizure. Simon also had a history of pressure ulcers, kidney disease and his mobility and ability to swallow deteriorated progressively over time. Simon died in hospital having developed pneumonia secondary to aspiration caused by his poor swallow response.

His wife, son and daughter in law cared for Simon along with carers who his visited his home twice a day. There were also a number of other professionals involved in Simon's care and support needs including; general practitioner (GP), hospital staff, district nurses, older people mental health team, speech and language therapists, occupational therapists, dietetic teams and social care.

The Author of the SAR notes that between 2014 and 2017 professionals identified a number of increasing concerns for Simon in relation to; tissue viability, being drag lifted by family members, poor nutrition, lack of pain relief being administered and the family refusing necessary supportive equipment. On many occasions agencies deemed that care provision for Simon was to increase. However, these additional services were repeatedly declined by the family.

The family expressed that they felt that there were too many professionals involved, the additional care would be too expensive and they did not want their house looking like a hospital. Simon's wife also felt that by accepting increased support this would be perceived as a reflection of her inability to effectively care for her husband.

Key Learning Points for Professionals

- **Safeguarding an Adult At Risk**

The SAR highlights that four safeguarding referrals were made, in respect of Simon, and it was 'good practice' that adult social care, allocated social workers who completed investigations, liaised with agencies, identified risks and undertook assessments. Furthermore, when poor moving and handling techniques were reported and equipment refused social care spoke to the family. However, the Author noted that social care were repeatedly unable to determine neglect of Simon and the allegations made by professionals remained unsubstantiated.

The Author suggested that there was a 'conflict… determining the difference between what the family perceived as safe and well and what agencies perceived as safe and well'. The Author highlighted that the family 'needed to know' from social care where the 'boundaries lay' for them being able to make legal decisions for Simon and what the potential consequences of their actions or inactions might mean. *Agencies should openly discuss and explain to family members what keeping an AAR safe and well means and make clear that if the AAR is not kept safe and well what might happen, whether that is further intervention or potential legal redress.*

- **Mental Capacity Assessments (MCA)**

Agencies failed to undertake full MCAs to ascertain whether Simon could make informed decisions in relation to his care and support needs. The Author indicated that 'Simon's right to autonomy was not considered by agencies and assumptions were made based upon Simon's presentation or status, for example, he was not very verbal, he was asleep, he appeared confused and it was thought that he lacked capacity to make that decision.' This meant that there was no lead agency to coordinate services or a clear care plan as to how decisions had been made, resulting in the family members and agencies making all of the decisions that regularly affected Simon.

If an MCA had been undertaken information in relation to Simon's past expressed wishes and feelings would have been taken into account and consideration given to who would be the best person to represent his views. Agencies should have considered whether an ***advocate*** working on Simon's behalf would have been beneficial to support Simon's views and working with the family and services to address his care and support needs.

- **Lasting Power of Attorney (LPA)**

Agencies did not discuss the possibility of the family looking into the process of an LPA which would have had legal implications and standards set for the family for them to potentially be able to support Simon's welfare and financial needs. Having an LPA would mean that the family would be legally making 'best interest decisions' for Simon both as an individual and a family member. *Professionals should be aware of what the lasting power of attorney means and of the procedures and processes involved with the Office of Public Guardian when supporting an adult at risk.*

- **Carer Assessment and Care Plans**

In Simon's case there were a lack of clear agency care plans being completed, recorded and put into place both in relation to him living in the community and prior to discharge from hospital stays. These were missed opportunities in terms of providing co-ordinated care and support for Simon with his best interests taken into account and could have supported the family's understanding of agency involvement and assistance available whilst ensuring commitment and compliance. If the care plan had then not been followed then intervention and legal redress could have been sought and if necessary agencies and/or the family held to account to ensure that Simon was safe and well.

- **Roles and Responsibilities in Safeguarding**

The Care Act 2014 is clear that '**Safeguarding is every agency's joint responsibility**' in terms of sharing information for safeguarding purposes, undertaking assessments where there are safeguarding concerns and working together to safeguard an AAR. Unfortunately in Simon's case it was identified that there were a number of concerning situations where agency's should have undertaken assessments and made safeguarding referrals to the MASH (Multi-Agency Safeguarding Hub) but did not. The Author also made reference to safeguarding referrals being made to the MASH that should have been undertaken as a safeguarding inquiry (Section 42) particularly in relation to Simon's mental capacity.

For accountability and safeguarding purposes it is vitally important that all agencies and professionals record; assessments, care plans, work completed with the AAR, liaison with the family and other agencies and note safeguarding concerns. In Simon's case there were many incidents that were not recorded and not shared that would have helped to ensure that he was safe and well.

- **Identification of Neglect**

From 2014 and over the years there were safeguarding concerns raised by agencies in respect of Simon possibly suffering from neglect. However agencies did not identify what 'neglect' for Simon looked like nor recorded their safeguarding concerns as potentially being 'neglect'. *Professionals should consider if an AAR is experiencing neglect and evidence what the signs and indicators are for that individual, whether it be lack of; care, food, treatment, equipment, cleanliness and medication and record the perceived impact on them*.

- **Domestic Violence and Financial Abuse**

The SAR Author noted that 'Domestic Abuse' can; encompass familial abusive relationships, include neglect and disguised compliance, be intentional and/or unintentional and include coercion and control. In Simon's case there was evidence of; unexplained injuries, bruising and swelling, nutritional concerns, lack of access to services for him without his family being present, concerns about him being drag lifted and not being given pain relief by family

members and refusal from the family for necessary equipment. *Professionals need to understand what Domestic Violence is and to be Professionally Curious to 'rule in or rule out' potential domestic violence, whilst being confident and having 'respectful uncertainty' in order to challenge what is said to them. Professionals need to be able to make appropriate referrals to the police and social care if an adult at risk might be experiencing domestic violence.*
The Author noted that there was no evidence that agencies considered the possibility of financial abuse in Simon's case. The family paid for private carers but would not accept additional care for Simon, due to 'not being able to afford the costs'. However, when a financial assessment was finally completed this showed that the care would have been funded by continuing health care. *Professionals should be aware of what 'financial abuse is' and consider if an AAR is being financially abused by family members, friends or other people known to them.*

- **Care and Support**

It was good practice that the care needs of Simon were continually assessed and a continuing health care (CHC) assessment was completed. However, the Author noted that implementing the CHC assessment was 'thwarted' due to (i) the lack of appropriate moving and handling equipment in the home to enable care staff to safely manage Simon's care needs (refused in the home by the family) (ii) the inability of care agencies to provide carers in that location and (iii) a lack of continuity to progress matters (CHC team) and delays from care providers in providing costings.

- **Making Safeguarding Personal – The Lived Experience of the Adult at Risk**

There was little evidence of professionals seeking or trying to understand what Simon wanted, what life was like for Simon and what his wishes and feelings were. This was often thwarted with the perception of professionals that he was not able to understand what was being said due to his presentation (being asleep, no verbal and potentially not having capacity) and this perception was reinforced by his family who continually spoke and made all the care and support decisions for him. The Author noted that Making Safeguarding Personal needed to be better understood by professionals and that the support of an advocate should have been considered. Additionally professionals should have sought an understanding as to the reasons why the family were reluctant to accept care provision and were refusing, at points, to engage with agencies.

Practitioners should always communicate with the adult at risk and ascertain their thoughts, feelings and wishes; though at the same time professionals should find out the reasons why services are being declined and weigh up what the risks of significant harm are for that individual if services are not implemented or are withdrawn. Professionals need to hear the voice of the AAR and not let stronger voices such as family members over impose.

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/

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/

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

Pressure Ulcer Guidance
Practice Guidance on Pressure Ulcers | Cambridgeshire and Peterborough Safeguarding Partnership Board (safeguardingcambspeterborough.org.uk)

Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership
https://www.cambsdasv.org.uk/website

Office of the Public Guardian and Lasting Powers of Attorney
https://www.gov.uk/government/organisations/office-of-the-public-guardian

https://www.ageuk.org.uk/information-advice/money-legal/legal-issues/power-of-attorney/

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