7 Minute Briefing

SAR Jessica

1. Background

Jessica was an 88-year-old woman who died in August 2023.
Jessica had multiple long-term health conditions, including Type 2 diabetes, COPD, diverticulitis, chronic leg ulcers, increasing frailty, and reduced mobility. In the months prior to her death, she was receiving supportive and palliative care at home due to increasing breathlessness and fatigue.
Jessica consistently expressed a clear wish to remain at home and not move to a hospice, hospital, or care home.

2. Brief History and Key Events

From August 2021 onwards, Jessica had increasing health and care needs and lived with different family members at various points. She experienced significant frailty, weight loss, pressure damage, and poor hygiene, with repeated reports of lacking clean clothing or bedding. District Nurses and Hospice at Home staff visited regularly and documented concerns about neglect and the home environment. There were concerns about informal care arrangements, including whether family members were able to meet Jessica's needs between care visits. When concerns about hygiene, nutrition, and living conditions escalated safeguarding concerns should have been consistently re-escalated

3. Agency Involvement

Although many agencies were involved, the SAR identified that working was often parallel rather than coordinated, with limited use of formal multi-disciplinary team (MDT) meetings to bring together agency concerns and shared risk information.

4. Areas for Development

The SAR identified several key areas for learning:

- Safeguarding concerns should be consistently escalated or revisited when adults with complex needs situations deteriorate.
- There was sometimes an over-reliance on recording concerns within shared systems. Formal safeguarding referrals should have been initiated by professionals
- Agencies should come together to form a shared, holistic understanding of risk, particularly regarding neglect.
- Partners should challenge when care plans are not working, for example when there is repeated evidence of poor hygiene and unmet needs.
- When mental capacity is assumed, capacity and safeguarding decisions should always be evidenced together when risks escalate.
- Informal carers should be supported and/or challenged in relation to what is realistically expected of them.
- Multi- Disciplinary Team meetings should be used in complex cases to effectively coordinate care and to escalate any concerns.

5. Positive Practice

- ✓ Jessica's voice and wishes were consistently heard.
- ✓ Adult Social Care responded appropriately to safeguarding referrals, particularly regarding potential financial abuse and applying Making Safeguarding Personal principles.
- ✓ Unpaid carers were identified and offered carers' assessments and support promptly.
- ✓ GP services provided regular reviews, continuity of care, and a timely referral to District Nursing when Jessica became housebound.
- ✓ Hospice at Home staff demonstrated exceptional compassion and commitment, frequently going above and beyond to support Jessica's dignity and comfort.
- ✓ End-of-life care was recognised and put in place, including anticipatory medication and increased care visits.

6. Key Messages

- ✓ Respecting a person's wishes does not remove the duty to safeguard when neglect is evident.
- ✓ Safeguarding concerns should be revisited and re-escalated when circumstances change.
- ✓ Recording concerns is not enough –completion of formal safeguarding referrals remain everyone's responsibility.
- ✓ Care plans must be actively reviewed, especially when evidence suggests they are not working.
- ✓ Mental capacity assessments should be clearly linked to safeguarding decisions.
- ✓ MDT working is essential in complex end-of-life and family-supported care situations.
- ✓ Professional curiosity in this case meant practitioners and managers asking "Is this care good enough?", even when their intentions are kind.

7. Further Information

Practitioners are reminded that a formal referral should be made if they have a safeguarding concern
https://www.safeguardingcambspeterborough.org.uk/concerned/professionals-reporting-a-concern/
Multi-agency safeguarding training Multi-Agency Safeguarding Training | Cambridgeshire and Peterborough Safeguarding Partnership Board
Mental Capacity Act resources Mental Capacity Act Resources | Cambridgeshire and Peterborough Safeguarding Partnership Board