Learning from Carol's Safeguarding Adult Review

Hillingdon SCP safeguarding children partnership

Hillingdon Safeguarding Partnership

Hillingdon safeguarding adults board

Ruth Shill

Introduction

Please try to stay focussed and engage with the session - turn off emails and phones if you can

The slides will be shared

Please add any questions to the chat, we will come to these at the end

Some of the content of this session is difficult, this reflects the circumstances of the adult concerned – if you need to take a minute then please do

Temperature Check

Can you please complete the form appearing in the chat?

What is a Safeguarding Adults Review?

Section 44 Care Act: A SAR must be undertaken where

- there is concern about how organisations worked together to safeguard an adult, and
- the adult has died, and it is suspected or known that the death resulted from abuse or neglect, or
- The adult has survived serious abuse.

There is discretion to undertaken a SAR even if the above criteria are not met.

The purpose of a SAR is to learn from the adult's situation to improve other people's safety in future.

SARs are different from a coroners inquest, a police investigation, and a safeguarding enquiry pursuant to s.42.

Methodology

Desktop review of all available documentation

Interviews with family members

Reflective meetings with frontline practitioners and operational managers

Police undertook an internal review of the criminal investigation and shared the outcome with the Review Team

Who was Carol?

Carol was a 77 year old white female who lived with her long-term partner of 35 years

Carol worked in a café for years and had been an outgoing and sociable person

She cared for and accommodated her grandson in his teenage years

As her health deteriorated, she became socially isolated and dependent on her partner

Carol's family believed she had dementia for at least a year prior to her death

Carol was in receipt of no care and support at home and her partner was believed to be providing support

What Happened?

In Oct 2021, LAS attended Carol's home and had significant concerns about unmet care needs and unmanaged risks

Hospital raised a safeguarding concern alleging "extreme neglect", and they reported to the police

Widespread Moisture Associated Skin Damage, likely caused by exposure to urine and faeces for days or weeks prior to admission

Carol never regained consciousness. She died on 26th October from Bronchopneumonia and Stroke

Police closed their investigation with no further action in Nov 2021

Safeguarding Enquiry ran from Nov 2021 – Feb 2022. Neglect concerns were unsubstantiated

Overarching Areas of System Learning

Lived experience

Supervision and management oversight

Legal literacy

Partnership working

Lived Experience

In June: poor personal hygiene, neglected home environment, smell of urine, and indication of confusion.

In August 2021 a professional visited the home to speak to Carol and found home conditions to be "*probably the worst*" they'd ever seen.

Carol was noted to have poor personal hygiene

Carol's partner was experienced as intimidating, hostile and domineering.

Carol told the social worker the dog was biting her – injuries were visible.

Carol's partner said he was meeting all her care and support needs and declined outside help

If Carol or her partner told you she didn’t want any outside help, how might you proceed?

What might you say? What might you ask? What might you be considering?

Key Practice Messages:

Lived Experience

Effective assessment requires consideration of the lived experience of adults and their families

What is life like for the person I am here to help?

Critically reflect on the meaning and implications of all the information available

Explore contradictions and inconsistencies between different sources

Supervision and Management Oversight

Feeling considerable discomfort in Carol's home. Wanted to leave as soon as possible

Very poor conditions in the home made them uncomfortable

Feelings of intimidation and hostility from Carol's partner

What was seen and smelt was contrary to what Carol and her partner said

Barriers to sharing difficulties and emotional reactions in supervision

People aspire to ‘professional distance’

Sometimes people believe that emotions equal weakness

Beliefs that they are supposed to be unaffected

Supposed to feel comfortable in uncomfortable situations

Self-protection against secondary trauma

Key Messages for Practice: Supervision and Management Oversight

- Support critical reflection on all information available to professionals
- Enable practitioners to critically reflect on their feelings and experiences during encounters with service users
- Support professionals to challenge service users, families, and other professionals
- Promote a culture of openness, support and curiosity, and encourage engagement in complexity
- Clarify the purpose and focus of safeguarding enquiries and support timely conclusions
- Support use of the escalation where needed

Legal Literacy

Mental Capacity Act 2005 – professionals need to know when to doubt capacity and to have awareness and understanding of crimes under section 44

Care Act 2014 – practitioners need to discharge legal duties to carers and establish whether informal carers are able and willing to provide the care that is needed

Care Act 2014 – there is a duty to consider suitability of representatives and to arrange advocates where there is no appropriate person

Care Act 2014 – there is a duty to assess someone's needs even when they refuse an assessment if they are at risk of abuse, neglect or self neglect

Mental Capacity: "Learning from SARs: A report for the London Safeguarding Adults Board" (2017)

LEARNING FROM SARS:
A REPORT FOR THE LONDON SAFEGUARDING ADULTS BOARD

SUZY BRAYE AND MICHAEL PRESTON-SHOOT
18th July 2017

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*"much of the learning in the SARs was about **missing or poorly performed capacity assessment, insufficient scepticism and respectful challenge** of decision making"*

*"the majority of the evidence…points to **fundamental flaws** in how the **Mental Capacity Act is understood and applied** in practice"*

Mental Capacity Act 2005, Principle 1:

"A person must be assumed to have capacity unless it is established that he lacks capacity"

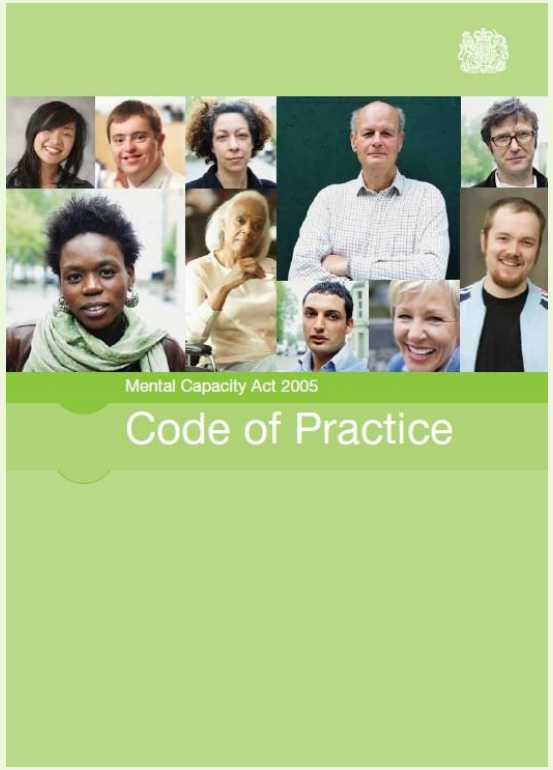
The **assumption of capacity** *"is* ***widely misunderstood*** *by those involved in care. It is sometimes [wrongly] used to* ***support non-intervention*** *or* ***poor care****, leaving* ***vulnerable adults exposed to risk of harm"***

The House of Lords Select Committee

Key message:

Setting the threshold for doubt too high puts people at risk of harm

When should we doubt capacity?



The Mental Capacity Act Code of Practice is the guidance that we all must follow.

It tells us how to understand and apply the Mental Capacity Act 2005.

- If the person's **behaviour or circumstances cause doubt**
- If somebody else says they are **concerned about the person's capacity**
- If the person has **been diagnosed with an impairment or disturbance** affecting their mind or brain; **and** it has already been **shown they lack capacity to make other decisions** in their life.

What are behaviours or circumstances that cause doubt about someone's mental capacity?

If somebody:

- repeatedly makes decisions that appear unwise and put them at significant risk of harm or exploitation, or
- making an unwise decision that is obviously irrational or out of character.

For example…

- Refusing help with personal care when you clearly aren't managing it yourself
- Refusing help with managing a biting dog when you cannot protect yourself from it

What to do when you doubt mental capacity

Support the person to make the decision themselves (tailor your communication!)

Explore their reasoning and understanding of the risks involved – curiosity, scepticism and respectful challenge are vital

Explore the influence of other people on their decision making

If you still doubt capacity after taking these steps, it needs to be assessed.

Partnership Working: Assessing Needs

Gather information from other professionals with involvement and information – duty to cooperate and share information

If you make a referral to another service, follow up to find out what happened

Share information about the outcome of an assessment and/or withdrawal of support

Explore and discuss differences of opinion and seek to understand others' perspectives

Partnership Working During Safeguarding Enquiries

The Local Authority has the responsibility to coordinate partnership working during a safeguarding enquiry

Use multiagency planning meetings and in safeguarding enquiries

Use the Safeguarding Partnership Escalation Policy to address barriers to partnership working

Engage family members in safeguarding enquiries, even where someone has died

If you hold information relevant to a police investigation, do not wait to be asked for the information – share it

Any Questions?

Thank you for your time and contributions

Don't forget to complete the evaluation form!