Learning from Safeguarding Adult Reviews

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Heads Up


Subject matter can be upsetting
Might affect you personally or professionally
Seek support afterwards if you feel you need to
If you need a break feel free to take one

What We'll Cover

- What is a SAR?
- Personal Stories: Mairead, Ms. Stitch and Rachel
- Summary of Thematic Learning
- Lived Experience
- Legal Literacy
- Partnership Working
- Management Oversight and Supervision
- Further Learning

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.

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

Personal Stories

Mairead

Ms. Stitch

Rachel

Who Was Mairead?

- 70-year-old woman
- Severe and enduring mental illness - schizophrenia
- Living in low support accommodation with floating support attached - information lost to some services
- Diabetes
- Stroke in 2017

Who Was Mairead?

Great sense of humour

Catholic

Generous and kind

Thoughtful

Houseproud

Incredible strength to keep going in the face of such adversity - don't know how she did it.

Traumatised

Frightened

Ashamed

What Happened to Mairead?

Professionals involved: psychiatric nurse, consultant psychiatrist, social workers, floating support worker, GP

Recurrent concerns about deteriorating mental state, described on multiple occasions as appearing “unwell”

Missing appointments, refusing to let people in to her home. No one explored the reason

Opportunities to intervene were missed until she was in crisis - professionals did not work together or assess risk

Came to the attention of emergency services acutely unwell and died shortly after in hospital

Who is Ms. Stitch?

Aged 32 at time of events in SAR

Degenerative neurological condition

Depression

Needed help with:

- **financial management**
- **personal care**
- **meal preparation**
- **accessing community**

Who is Ms. Stitch?

She's a loved and loving mum, daughter, granddaughter and sister. She is friendly, outgoing and has a ready smile

Great sense of humour. And she loves films - especially Disney

She is kind and generous - always ready to make a friend. Always sees the best in people.

She courageously gave evidence in court against the perpetrators

Working hard to overcome her many injuries - physical and psychological

What Happened to Ms. Stitch?

Degenerative neurological condition caused care and support needs. Package of care, range of health professionals, social workers, GP, police involved

Care visits frequently missed, concerns about living conditions, changing addresses, and financial management difficulties. Ms. Stitch and family members requested 24 hour care - not provided

Ms. Stitch disclosed financial exploitation. Others identified domestic abuse, neglect and self-neglect. No formal adult safeguarding enquiries. No report to police.

Often accompanied to appointments by ‘friends’, ‘relatives’ or ‘carers’ who would speak for her – rarely exploration as to their identity and motivations

Told care agency she was going away – package suspended and never reinstated. Around six months later she was admitted to hospital with significant injuries - prolonged captivity, abused, and exploited

Who Was Rachel?

- 85-year-old woman, living alone
- Dementia and extremely frail
- Unable to get out of bed, go to the toilet or move around her home without help of two
- Incontinent
- Extremely fragile skin - very high risk of skin breakdown
- Chronic pain
- Lacked capacity to make decisions about her care arrangements
- Unable to follow instructions about pressure area management

Who Was Rachel?

A caring godparent and tremendously loving aunt and great aunt to many of the family's children

A strong and respected presence within her family

Her spirit for fun, generosity and devotion to her family will be much missed. But it will act as an inspiration of how to share love, support each other… and her example of how to catch a ball in a hat balanced on your head will never be forgotten!

What Happened to Rachel?

Following a hospital stay Rachel had 4 care visits a day - alone at night times and between care visits

Professionals involved: social workers, community nurses, physiotherapists, occupational therapist, health care assistants, care agency staff, GP - worked mainly in isolation

Family concerns were not given sufficient weight, assessments were insufficiently thorough. Rachel was making decisions she was not able to make. The risks to her life were not managed

Developed a pressure ulcer, which continued to deteriorate, became infected and then infected the underlying bone

Rachel passed away, at 85 years old, from sepsis secondary to an infected pressure ulcer

Rachel's family statement

We have been left traumatised by witnessing Rachel's desperation, agony and utter despair. We all know that we are going to die, it's not the act of dying, but the journey of how we get there that is the most terrifying aspect of death, especially if all the services put in place to protect and safeguard us…fail.

Even in times of desperation when Rachel was begging to die, no health professional would visit. What more does one have to say or do to obtain a service from the GP, district nurse, etc in a situation such as this?

The family all knew that Rachel's capacity to make decisions to protect her best outcomes was eroding and the best option was for Rachel to move to a residential nursing home, yet trying to obtain an assessment of Rachel's mental capacity proved fruitless. No single person is culpable, yet every single agency assigned to Rachel is.

As a family. We hear lessons have been learned so this won't happen again... We hope this is true.

Thematic Learning

- Use of Language
- Lived Experience
- Management Oversight and Supervision
- Legal Literacy: Mental Capacity Act 2005, the Care Act 2014 and GDPR
- Partnership Working
- Professional Curiosity

Lived Experience

- Remember people exist over time and space and across many domains of life. They have a history of experiences, trauma, relationships
- What does past information and events mean for the present?
- Don’t look at events in isolation – see them as part of the person’s story
- Be curious about what life is like for them – what is the role of trauma in their lives and their responses to the present
- Put yourself in their shoes… what would you want professionals to do for you or for your loved ones?
- Take a minute to reflect on what life may have been like for Mairead, Rachel and Ms. Stitch

Legal Literacy

- Mental Capacity Act 2005
- The Care Act 2014 sections 7, 9, 10, 11, 27
- Care and Support Statutory Guidance, Chapter 6

Mairead	Rachel	Ms. Stitch
Stat Guidance: Health and social care professionals did not work together or share information	Stat guidance: Health and social care professionals did not work together or share information	Stat Guidance: Health and social care professionals did not work together or share information
MCA: Mental capacity assumed when reason to doubt and explore	MCA: Mental Capacity assumed when reason to doubt and explore	MCA: Mental capacity assumed when reason to doubt and explore
Care Act: Assessment or review not conducted 2015 to 2020	MCA: Best interests decision not completed or recorded	Care Act: Safeguarding enquiries not made despite criteria met
Care Act: Carers and interested parties not involved in assessment/given weight	Care Act: Carers and interested parties not involved in assessment/given weight	GDPR: Police not informed of allegations of crimes

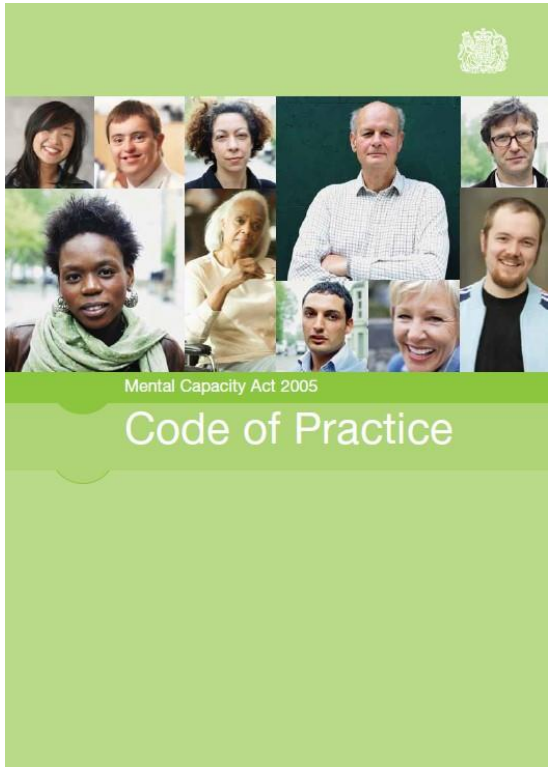
Mental Capacity Act 2005

- What is mental capacity?
- When to doubt mental capacity?
- Tips for assessing capacity
- Best interests decision making and reviews

What is Mental Capacity?

- Decision specific
- Time specific – what does this mean?
- Understand relevant information
- Retain relevant information
- Weigh and use
- Communicate
- Act on/execute decision

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.*

Assessing Mental Capacity

Consider communication needs – how can you support this?

Identify the relevant information

Explain/provide relevant information

Explore how the person reaches their decision – are they weighing and using relevant information?

Ask the views of people who know them

Assess executive capacity – can they act on the decision they make at the time they need to act?

Assessments often need to extend over multiple discussions and include multiple sources

Best Interests Decision Making

Best interests decision must be made, in a timely fashion, following lawful process in Section 4 Mental Capacity Act, clearly documented and communicated

Must consider views, wishes and feelings (past and present) of the adult and anyone caring for or interested in their welfare – loved ones and professionals

Document views gathered clearly – who consulted, when, and how you are taking them into account. If not practicable to consult, explain why

Differences of opinion between interested parties? Document clearly. If unresolved, may require arbitration in the Court of Protection. Do not override opposing views without legal advice

Review best interests decisions when circumstances change – such as new concerns, deterioration in health

Who is the decision maker?

Day-to-day decisions: what to have for lunch, what to wear, tea or coffee	Usually, the person providing direct care
Medical decisions – treatment, surgery, wound care	Relevant healthcare professional
Care and support – eg care package, placement in care home	LPA for health and welfare, local authority, Court of Protection
Signing or relinquishing a tenancy, finances, or selling property	LPA for property and affairs, Court of Protection

Care Act 2014

- Duty on all professionals to cooperate with each other – Section 7
- Duty to assess adults with the appearance of need - Sections 9
- Duty to review care and support – Section 27

Duty to Cooperate

Care Act 2014, Section 7

If local authority requests co-operation of other professional as part of an assessment, review or safeguarding enquiry

…they must cooperate, unless it is incompatible with their own duties

…and vice versa

Duty to Assess Adult's Needs

Care Act 2014, Section 9

When an adult has appearance of needs for care and support, the authority must assess their needs

…*must* involve the adult, and any carer the adult has

…any person whom the adult suggests

Where the adult lacks capacity, you must involve any person who appears to be interested in the adult's welfare

NB. If you are concerned about abuse, neglect or self neglect, you MUST assess even if the person refuses (Section 11)

Duty to Review

Care Act 2014, Section 27

A local authority must keep under review care and/or support plans – including supported accommodation and floating support

A local authority must undertake a review if a reasonable request to do so is made by or on behalf of the adult

Must involve the adult, any carers, anyone identified by the adult, and others interested in their welfare

Care and Support Statutory Guidance Chapter 6

6.14 Where an adult has a need… the local authority… must… consider whether their need(s) have… consequences on their… personal health.

6.14 The local authority must also consider whether the individual's needs impact upon their wellbeing **beyond the ways identified by the individual**

6.77 Where more than one agency is assessing a person, they **should all work closely together** to prevent that person having to undergo a number of assessments at different times.

6.78 Where a person has both health and care and support needs, **local authorities and the NHS should work together** effectively to deliver a high quality, coordinated assessment.

Partnership working

- Information gathering and sharing
- Working together across organisational and disciplinary boundaries
- Use of escalation to resolve professional differences
- Partnership with adults and their families

Mairead	Rachel	Ms. Stitch
Health and social care professionals did not seek & share information	Health and social care professionals did not seek & share information	Health and social care professionals did not seek & share information
Assessments and reviews done by one professional in isolation	Assessments and reviews done by one professional in isolation	Assessments and reviews done by one professional in isolation
Family members' views not sought or given sufficient weight	Family members' views not sought or given sufficient weight	Family members' views not sought or given sufficient weight

Best Practice in Partnership Working

- Accurate and timely information seeking & sharing is important - especially at points of transition
- Social workers, nurses, OTs, physiotherapists, and doctors, support workers/carers need to speak to each other to inform assessments when both are involved
- Share and reality check your conclusions with the adult, family, and other relevant professionals
- Don’t leave people or families to share information and concerns themselves – take responsibility yourself
- If you believe risks are not managed – whatever your role – raise your concerns. Don’t wait for harm to occur. Don’t expect someone else to act
- If there is a difference of opinion about risk, don’t wait, escalate!
- If you determine someone lacks mental capacity to decide about their care, communicate this clearly to others involved in their care

Information Sharing

Information gathering and sharing is crucial to assessing needs and risks – remember the statutory guidance about working with other professionals?

GDPR does NOT prevent you from sharing information with professional partners on an assessment or safeguarding enquiry

GDPR and the Data Protection Act 2018 support you in reporting crimes to the police or concerns about someone's safety to relevant others without consent

If you determine someone lacks capacity to make a decision about their care arrangements, share this finding with relevant other professionals and make sure carers know

Stages of Escalation

Stage One: consult a supervisor/manager to clarify your thinking to clarify the difference in opinion and what you aim to achieve.

Stage Two: contact your supervisor/manager, who should raise the concerns with their counterpart in the other agency.

Stage Three: supervisors/managers report to their respective operations managers or safeguarding leads who must attempt to resolve the differences through discussion.

Stage Four: Refer the matter to the Safeguarding Partnership Team who will seek a resolution through discussion, convene a resolution panel, or refer to the Chair of the relevant board.

Where the matter remains unresolved, or speaks to fundamental issues within the safeguarding system it may be passed to the Executive Leadership Group

Management Oversight and Supervision

- Clarity for practitioners about the purpose of management oversight
- Matching tasks with skills and experience
- Quality assurance so risks and vulnerabilities are assessed and understood
- Ensuring lawful practice, and that legal duties discharged
- Monitor actions and audit responses/outcomes
- Time for reflection and challenge
- Emotional support and resilience building
- Supporting partnership working
- Attending to lived experience, relevant history, and use of chronology
- Identifying development needs

Mairead	Rachel	Ms. Stitch
Legal literacy issues not identified/challenged by managers	Legal literacy issues not identified/challenged by managers	Legal literacy issues not identified/challenged by managers
Quality assurance mechanisms did not pick up assessment shortfalls	Quality assurance mechanisms did not pick up assessment shortfalls	Quality assurance mechanisms did not pick up assessment shortfalls
Absence of supervisory discussions and decisions in records	Absence of supervisory discussion and decisions in record	Absence of supervisory discussion and decisions in record
No evidence that lack of partnership working was challenged	No evidence that lack of partnership working was challenged	No evidence that lack of partnership working was challenged

Best Practice in Management oversight

- Make adequate time to prepare, read and update yourself about your supervisees work
- Set regular appointments to meet with teams/practitioners and keep these blocked out
- Think about the lived experience of the person – what do you know, what do you want to know, what does the information and the history tell you?
- Managers must have relevant knowledge – e.g., updated statutory guidance, relevant caselaw, knowledge of specific medical conditions. If you don't know, find out
- Agree clear plans in supervision sessions and record those plans against the adult's record. Be clear who is doing what, and when.
- Supervisors also need supervision and management oversight! Organisations should support development of supervision skills

Creating a culture of High Challenge and High Support

Management oversight and supervision comes up a lot in SARs.

We work in systems that are often triggered by crisis

We all need a time to pause and think

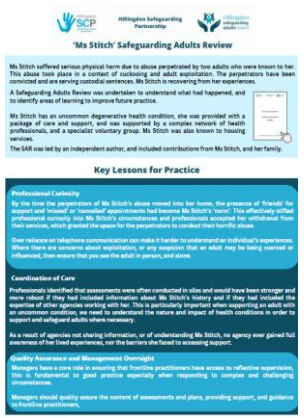
What does this look like in your teams?

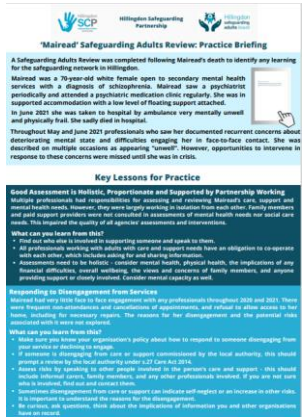
What might you be doing to create a safe place for practitioners?

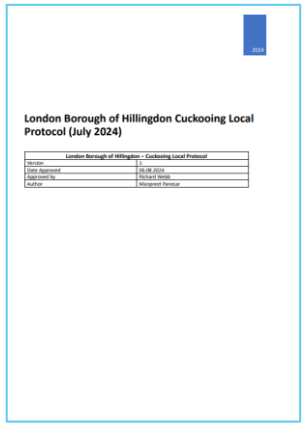
How do you manage and give feedback?

Further Learning

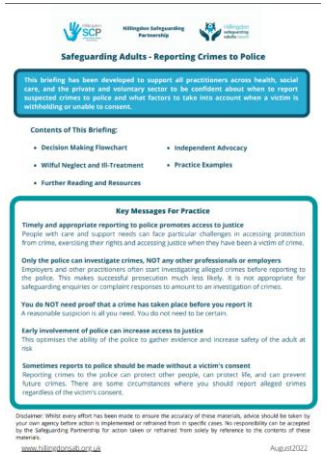
Practice briefings for Mairead, Rachel and Ms. Stitch



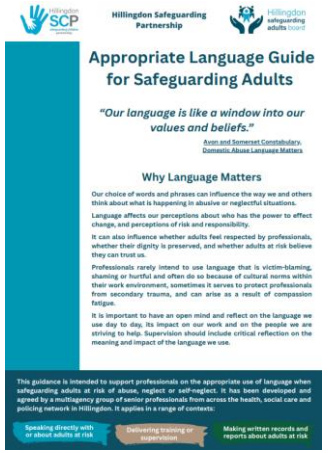




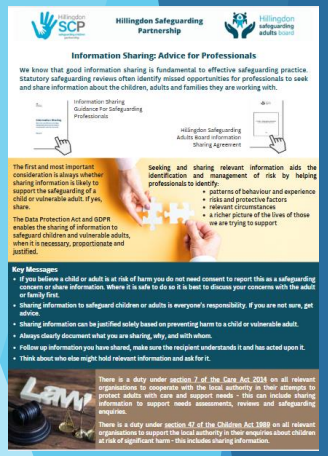
LBH Cuckooing Protocol



Reporting Crimes to Police



Appropriate Language Guide



Information Sharing

Best Practice in Safeguarding Adult Enquiry

Start Small, Start Today

Questions