South Tyneside Safeguarding Children and Adults Partnership

7 Minute Briefing

SAFEGUARDING ADULTS REVIEW

Adult AP

WHAT IS A SAFEGUARDING ADULTS REVIEW?

Care Act 2014: Statutory duty of the Safeguarding Adults Board to conduct a Safeguarding Adults Review *"Where an adult with care and support needs has died and the Board knows or suspects that the death resulted from abuse or neglect, AND There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult".*

OUTCOME
To identify lessons to be learnt from the case and apply those lessons to future cases (not to allocate blame or responsibility) AND to improve how agencies work, singly and together, to safeguard adults.

ADULT AP - BACKGROUND TO THE REVIEW

Adult AP was born in the UK, returning after a long period living in different areas of the country. An independent mother of three, she was an IT lecturer at a local college, and enjoyed an active social life, with a range of hobbies.
As a child, Adult AP had twice spent prolonged periods in hospital for scarlet fever. Infection control procedures at the time meant she was isolated from her family at this time, and this had a significant impact on her psychological and emotional health, resulting in her persistent fear of hospitals and medical staff. This continued through adulthood; she had two home births and avoided accepting routine health appointments. The chronic pain experienced through arthritis only sought to influence decision making and non-engagement with hospital and health staff.
Adult AP had a fixed flexion deformity which resulted in her head being permanently tilted towards her right shoulder. She was very conscious of this and as a result became more socially isolated.
In later life Adult AP suffered with significant pain from arthritis which severely impaired her mobility. For the last few years of her life, she had been confined to a recliner chair and was unable to access the bathroom. In the last month of her life, she developed serious pressure ulcers because of a rapid decline in her physical health. Adult AP always expressed a desire not to be taken into hospital and to die at home. Sadly, she did not respond to treatment and passed away in hospital from sepsis, aged 74 years.

THEMES OF THE CASE

Understanding the background of trauma in a person's life even if this goes back to an event in childhood.
The importance of clear communication channels, information passed to the correct service at the appropriate time.
Mental Capacity Act 2005 and the need to revisit capacity and document clearly how it has been established when someone is making 'an unwise decision' especially on repeated occasions.
Early documentation of the EHCP to allow this to be followed and the person's wishes to be upheld.

KEY LEARNING

Understanding the mental capacity of the person is crucial to managing risks associated with someone who is neglecting their health and care needs.

Mental capacity assessments should include a specific focus on self-neglect, executive functioning and the understanding of the five principles within the Mental Capacity Act 2005.

Where self- neglect is present, records should include comprehensive mental capacity assessments and document should be of an acceptable standard.

Cases involving a lack of self-care often require lengthy, flexible, and creative involvement from practitioners. This can be contrary to eligibility criteria for services and other organisational pressures.

Practitioners should use multi-agency risk management meetings to determine levels of risk and expected outcomes, considering all aspects of Making Safeguarding Personal

The process should be structured to improve co-ordination, continuity, and communication between services. It should be agreed which practitioner within each agency would have the lead role to oversee the MARM process for their organisation.

Where there is a significant/critical risk of harm because of a lack of self-care, safeguarding adults' procedures should be used to share information and to manage risks.

If concerns persist and/or risks increase, there may be a need to seek additional advice and support. This might be from legal services, senior managers and/or safeguarding/MCA specialists.

Workplaces should be that allow for adequate workforce development for example, escalation routes, safeguarding supervision provision and performance monitoring.

Practitioners should be competent and equipped to recognise where past trauma has played a significant part in the persons engagement, utilising a Trauma Informed approach to practice with Professional Curiosity and Making Safeguarding Personal at the centre of the work.

Commissioners should ensure there is appropriate provision for individuals experiencing longstanding, fluctuating and ongoing mental health issues.

Link to Full Report:
Local Safeguarding Adult Reviews - South Tyneside Council

QUESTIONS FOR CONSIDERATION

Do you include trauma and attachment informed analysis in individual risk and need assessments, and demonstrate how these link to and influence interventions, treatment and commissioning decisions?

How do you balance Ethical Dilemmas such as Respect for Autonomy & Self-Determination versus the Duty to Protect and Promote Dignity?

When a person is repeatedly making "unwise decisions", how do you use the Mental Capacity Act to revisit assessment and how is this documented?

How confident are you in the use of Escalation and Challenge where there appears to be lack of timely communication and information sharing, a resistance to change, or lack of partner buy in?