West of Berkshire
Safeguarding Adults Board
Reading, West Berkshire & Wokingham

Practice Note
Aubrey's Case Review, June 2018

What is a Safeguarding Adults Review?

The purpose of a SAR as described in statutory guidance is to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.'

This Practice note is seeking to capture the main issues and learning following a Safeguarding Adult Review of a West Berkshire client. However the practice learning from the case is intended to be shared across the West of Berkshire Partnership. The Client's real name is Aubrey and his family have asked for that detail to be shared in this practice note.

Case Background

Aubrey was a 45-year-old man. He had significant and complex health needs. Aubrey still maintained a high degree of independence and was well known within his community. He had a supportive family network with which he maintained regular contact.

In late 2016 Aubrey was informed that his cancer had spread to his abdomen and lungs. Although offered chemotherapy, Aubrey declined this because he did not want to feel more unwell than he already did.

On June 23rd 2017, Aubrey was admitted to the Royal Berkshire Hospital with back pain, sepsis, and a sudden and marked deterioration in his speech and level of consciousness. A decision was made to provide Aubrey with palliative care to ensure comfort, and he was cared for at the Royal Berkshire Hospital until sadly he passed away on the 29th June 2017

Aubrey's care provider was judged as an inadequate provider by the Care Quality Commission following their inspection of March 2017. All of the Packages of Care that this provider was supporting with were reviewed as a result.

What did the SAR Find?

Issues identified by the SAR included the following points

- Refusals by Aubrey to accept treatment / care and support / equipment were not fully considered.
- No formal capacity assessments recorded to determine whether Aubrey could consent to treatment / refuse equipment / care and support / be admitted to hospital etc.
- Initial assessment, risk assessment and review did not take into account need for multidisciplinary approach to working with Aubrey (given his poor health)
- Agencies did not recognise or fully assess risks resulting in Aubrey directing his own care without the full impact of these risks being mitigated by commissioners.
- Although agencies worked in a person centred way during direct intervention with Aubrey there was a lack of professional curiosity and multi-disciplinary discussion.
- Aubrey's family were heavily involved in his care and provided significant support to him. However their involvement is not reflected in work completed and consultation with Aubrey around this is also missing.
- Review of the care package carried out in late March 2017 (triggered by the CQC inspection) records that that there weren't any concerns regarding the quality of care being delivered. This appears to be solely based on Aubrey's expressed view that he was happy with his care.
- No effort was made to seek Aubrey's agreement to discuss his care with his family in order to involve them in considering the quality of his care at this point.

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Capacity, Consent and Unwise Decisions

- A person who has the capacity to make voluntary and informed decisions for themselves about their medical treatment is legally entitled to accept or refuse any treatment that is offered to them. This decision must be respected even if the decision could result in their death.
- No person has the authority to give or withhold consent on behalf of another person over the age of 18.
- Family members do not have the legal right to be involved in a decision to accept or refuse care unless :-
  - *they have capacity and are consenting to them being informed and contributing to decision-making or*
  - *their capacity to consent has been assessed and it has been determined that they lack capacity and their family are consulted as part of a Best Interests decision-making process*

Clear Recording

A key point from the SAR is the need for clear recording of discussions with clients that enable us to clarify that we are confident that we have discussed what we judge to be unwise decisions. In Aubrey's case this was the decision to stay with an agency that was judged to be failing by CQC. Records that include direct quotes from service users, in order to help to convey their thoughts and feelings, support our work and inform our conclusions on the subject of unwise decisions. Documenting such discussions helps to explain why you as a worker are clear that you believe someone is making an unwise decision rather than an incapacitated decision.

When someone is making what you believe is an unwise decision you can suggest that they might like to discuss that decision with their family, particularly if their family members are closely involved in their care. Service user's families can feel excluded by statutory agencies, as they did in this case, and we need to be clear that we have documented our efforts to include then by recording/summarising our discussions with them. Service user's families can really help them to think more fully about potentially unwise choices they are making. This work should be done in a supportive way as capacitated individuals have every right for decisions about their care and support to remain private.

As the need for good recording was an issue in this case, this requirement will be a part of ongoing audit of case notes and examples of good practice will be anonymised and shared. We recognise that this task is central to our work and we want to support and encourage best quality recording.

Thank you for taking the time to read this practice note a copy of the full SAR can be found here:

http://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/

If you have any comments regarding this practice note please contact the Safeguarding Adults Board Business Manager Lynne.Mason@reading.gov.uk

The Board has a website with the Berkshire Safeguarding Adults Policies and Procedures https://www.berkshiresafeguardingadults.co.uk/ and a dedicated website http://www.sabberkshirewest.co.uk/