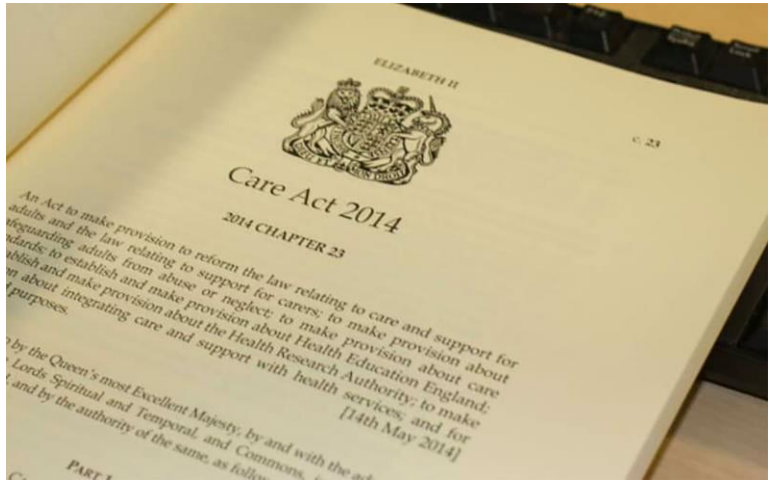
Learning from SARS

Jane Hitching, Principal Social Worker Reading Adult Social Care

for West of Berkshire Safeguarding Adult Board - Safeguarding Adults Week

24 November 2023

Safeguarding Adult Review



s44 Care Act 2014

- A SAB must arrange a review of a case where
- A person with Care and Support needs
- Has died
- Or has experienced significant abuse or neglect
- There is reasonable cause for concern regarding how SAB members or others worked together to safeguard the adult

Purpose of a SAR

(a)identifying the lessons to be learnt from the adult's case, and

(b)applying those lessons to future cases.

Never a failure Always a Lesson

What Learning do SARs identify

Learning can be about:

- Any SAB member's service
- Policies or Processes
- How policies and processes are implemented in practice
- Multi – disciplinary Working

Three West of Berkshire Safeguarding Adult Reviews

ABOUT SANDRA

- Agencies knew Sandra e.g. GP, Housing, NHS services, adult social care
- Sandra had family contact
- Services found it difficult to engage with Sandra
- Sandra's son had mental health issues and had access to her property
- Several Safeguarding Concerns were raised about physical (crime?), emotional and financial abuse by her son and the condition of Sandra's flat
- Adult Social Care had provided short term care for a few months prior to her death
- Support consisted of clearing the flat and OT for mobility.
- Sandra injured herself at home – minor injury
- Sandra dies from Sepsis in hospital

SANDRA - THE LEARNING

- Safeguarding processes must be holistic
- Case allocation must be to a team that can manage the complexity, including having capacity
- Look beyond the presenting problem: Professional Curiosity
- Risk Assessment
- S11 Care Assessments
- Mental Capacity Assessment

Safeguarding Adults Review
7 Minute Learning Summary

Safeguarding Adults Board

Sandra

Sandra was 65 years old at the time of her death in 2022, having died in hospital from a sepsis infection acquired from an injury received in her home. Prior to her death, she had been living independently in a flat provided by a local housing association and had been registered with her local GP practice since 2014. She was seen frequently at the practice; however the surgery were not aware of the concerns other agencies had about Sandra's safety.

Sandra had a number of long-term health issues including obesity, orthopaedic problems, and poor mobility. Whilst Sandra's health issues were supported by her GP and wider NHS services, who found it difficult to engage Sandra with this support. There was a pattern of her not attending or arranging appointments and then being discharged from services without the intended support being provided.

Sandra had two children with whom she was in contact, including a son who suffered from poor mental health and himself had significant needs. Due to his vulnerabilities, she felt compelled to support his needs despite this severely affecting her own wellbeing. Sandra was also in contact with her sister and brother-in-law, who continued to support her up until the point of her death. Sandra's sister would visit her regularly to help with daily tasks.

The first concerns for Sandra's safety were raised in 2013, with a report that her son had moved into her flat after being evicted from his own accommodation. There were concerns about him physically assaulting her, causing damage to the flat, and moving in a large volume of possessions that made it difficult for her to move around and access rooms. Shortly after these concerns were raised, Sandra was evicted from the property due to its condition and was supported by the local authority in being rehoused. She was provided a flat with a single occupancy tenancy and a condition that no other person should reside with her. During the subsequent years a number of further safeguarding concerns were raised about Sandra, all with similar themes relating to the risk of abuse from her son and the condition of her flat. Concerns included her son taking over her flat, whilst exposing her to physical, emotional, and financial abuse.

During early June 2022, Sandra received a minor injury in her home that became infected and led to her hospitalisation. Following her admission her condition continued to deteriorate and she died on 12th June. At the time of her death, she was actively being supported by Adult Social Care, following a safeguarding concern received in November 2021. This support had involved the provision of a social worker from the Social Work Assessment Team, which is intended to deliver a short-term service over a six-to-eight-week period.

The West of Berkshire Safeguarding Adults Board conducted a Safeguarding Adult Review to understand how different agencies worked together to safeguard Sandra, and to identify lessons to improve our systems, practice and partnership working.

Learning

- **Finding 1 –** The Assessment of Safeguarding Referrals and Social Care Prevention Pathways
Improvement is required in the way that referrals and contacts are initially assessed and allocated for further social work. New prevention pathways are required to ensure that social work teams are structured and resourced to manage cases of differing complexity.
- **Finding 2 –** The Quality of Care Act Assessments and Management of Risk
Social workers and managers need further guidance in how to prepare person centred Care Act assessments and safeguarding plans.
- **Finding 3 –** Multi-Agency Information Sharing and Planning
There is a need to promote the current multi-agency arrangements to share information and develop joint safeguarding plans. This should include improving the understanding of when a referral would still be appropriate in the absence of consent.
- **Finding 4 –** Developing Professional Curiosity
Agencies have identified how a greater level of professional curiosity by their staff would have helped to better identify vulnerability and improve the submission of safeguarding referrals.

Thankyou for taking the time to read this practice note. If you would like to provide any feedback or have any questions regarding the Board please contact: Lynne.Minion@Reading.gov.uk

ABOUT PAULINE

- Pauline was well known and liked in her community
- Pauline valued her independence
- Pauline had Alzheimer's Disease, cataracts and arthritis
- Pauline was not taking her medication
- She was known to hoard out of date food.
- Friends, neighbours and professionals had made referrals about their concerns to services
- Pauline died at home following a fall, sustaining fatal injuries
- Pauline was known to health and adult social care

PAULINE – THE LEARNING

- Practitioners and neighbours made appropriate referrals, shared information effectively, jointly assessed and monitored Pauline's welfare.
- Risks were shared and understood
- Pauline's Independence v Pauline's Safety
- Practitioners were praised for their effective practice buy the author
- Neighbours were involved – a protective factor
- Self-Neglect Policy was followed
- Mental Capacity Act was followed for decision making but not recorded.
- Confidentiality was maintained by practitioners
- Impact of Social Isolation (Covid)

ABOUT TINA

- Tina was in her 80’s and lived with her husband in a privately owned home
- Tina’s husband was struggling to care for his wife.(Carers Assessment)
- The couple paid privately for shopping and housework support
- Tina was becoming increasingly frail and at one point was not moving from the sofa
- The property was described as cluttered
- She had some periods of service from both health and social care
- Tina had declined equipment and care and was deemed to have capacity to make decisions.
- No risk assessment or mental capacity assessments were carried out.
- Tina was admitted to hospital. She was dehydrated, low in weight, had pressure damage and a chest infection. Tina had COPD.
- Tina subsequently passed away.

TINA – THE LEARNING

- When do unwise decisions amount to a need to assess mental capacity?
- A multi- agency risk assessment may have identified an action plan – sharing information
- Continuing to offer assessment, care support and equipment was good practice.
- A care assessment (s9 or s11 of the Care Act 2014) is available to all, including those who pay for their own care.
- Professional curiosity could have revealed more about Tina's decisions to decline support and equipment and her husband's capacity to provide care.
- The wider family could have been engaged sooner.
- Was the condition of the property taken into account? What are your organisations procedures regarding hoarding?
- Tina appears to have been neglecting herself. Do you know your organisation's self-neglect policy? Read the information on the Berkshire Safeguarding Policies and Procedures Website
- Raise a Safeguarding Concern

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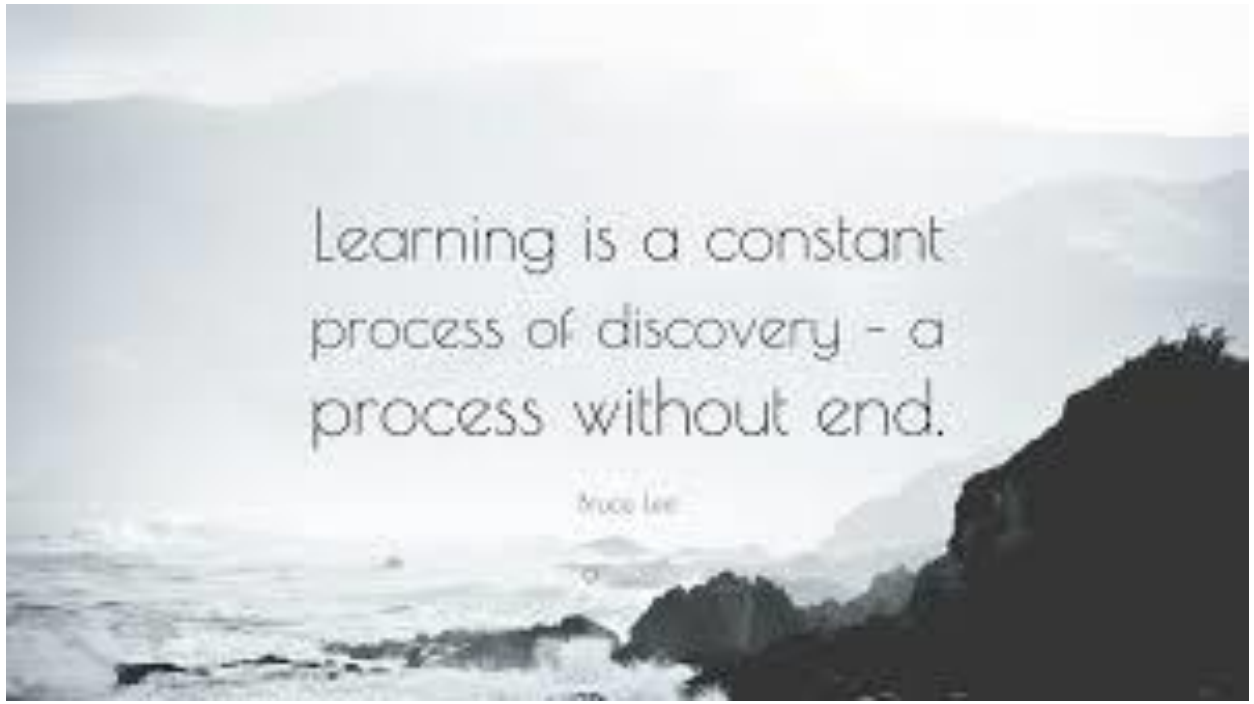
THREE SAR THEMES



THEME: MENTAL CAPACITY

- Consideration of when to apply the Mental Capacity Assessment
- Multi- agency approach to mental capacity assessments and best interest decision making
- Recording any assessment made, even a presumption of capacity when there are indicators of decision-making challenges.

THEME: PROFESSIONAL CURIOSITY

What is professional curiosity in safeguarding adults?

Professional curiosity is where a practitioner seeks to explore and understand what is happening in someone's life, rather than making assumptions or accepting what they are told at face value. It involves looking out for signs that things are not right and seeking out the evidence of what is really happening.

Source: www.leedssafeguardingadults.org.uk

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THEME: PROFESSIONAL CURIOSITY

How can I Practice Professional Curiosity?

- Find out Why?
- Seek Connections
- Explore
- Build a Relationship
- Home Visits
- Is that person really a friend?
- Seek a Second Opinion
- Indicators of Abuse
- Does it Make Sense?
- Relationships
- Thoughts
- Feelings

THEME: MULTI-AGENCY MEETING

Types of Multi-agency Meetings:

- Risk Assessments
- Multi- agency Case Meetings
- Safeguarding Strategy or Planning Meetings
- MARM

Just have the meeting

Continuing your learning from SARs journey

- Access resources – SCIE, LGA, ADASS, Research in Practice. Michael Preston Shoots research, WBSAB SAR reports and Learning Briefings, Other SAB reports and briefings
- Make SARs a part of your training in your organisations
- Have SAR's on your management and team meeting agenda's – use the briefings/webinar's/Podcasts
- Apply your learning to your procedures and practice
- Know the types of abuse
- Maintain legal literacy

Continuing your learning from SARs journey

Resources

West of Berkshire SARs Webpage https://sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews - reports, webinars and briefings

Michael Preston Shoot Analysis of SARs
https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf
Research in Practice – https://www.researchinpractice.org.uk/

West of Berkshire SAR Process https://sabberkshirewest.co.uk/wp-content/uploads/2023/04/west-of-berkshire-safeguarding-adults-board-sar-process-v10.pdf

Berkshire Safeguarding Policies and Procedures https://berkshiresafeguardingadults.co.uk/policies-procedures

SCIE SARS webpage https://www.scie.org.uk/safeguarding/adults/reviews

Please contact the Boards Business Manager if you have any queries in regards to published SARs or the SAR process on lynne.mason@reading.gov.uk or speak to your Safeguarding Lead

39 Essex Chambers - Mental Capacity Resource Centre

SCIE host the National Mental Capacity Forum --- Blogs and webinars on Mental Capacity

SAR Process

Referral to SARP via Business Manager

Consideration of case against criteria at SARP

Terms of Reference – what questions do we want answered /dtaes

Commission an author

Chronology

Learning Event

Report agreed at SARP

Report agreed at SAB

Report Published

Learning Briefing

Agencies Disseminate the learning

Throughout there is fact checking