Devon Safeguarding Adults Board

Safeguarding Adults Review T

Independent Report Writer:
Julie Foster

December 2016

SAFEGUARDING ADULT REVIEW SUMMARY – SAR T (DECEMBER 2016)

This summary reports the findings of a Safeguarding Adults Review commissioned by Devon Safeguarding Adult Board in November 2015 with respect to the circumstances surrounding the unexpected death of Ms X. Aged 64, Ms X had a history of serious mental and physical illness and was in contact with a number of local health and social care organisations during the last months of her life. It was considered that the criteria set out in the Care Act 2014 for a Safeguarding Adults Review (SAR) had been met and that there was learning to be gained from a SAR in order to prevent similar situations in future.

The outcome of a Safeguarding Adults Review is to ensure cross organisational learning; it is not to apportion blame. The Care Act 2014 also states (14.138) that the following principles should be applied to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; *and*
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

The SAR was carried out by an Independent person, Julie Foster (JF) who was appointed to ensure transparency and provide an independent perspective.

JF set out the purpose of this Review as needing to understand the issues surrounding the welfare and care of Ms X, and the circumstances leading to her tragic death. Given that several health and social care organisations were involved with her, over the last months of her life; and whilst there is no evidence to show that any failings in care services were causative in her demise, the complexity of her care needs and the complexity of the organisational systems designed to meet them make it appropriate to examine the circumstances to identify any learning.

A Safeguarding Adult Review Panel was set up to oversee progress and conduct the work. This was chaired by the Independent Chair of DSAB, and comprised members from the following organisations: Devon Partnership NHS Trust (DPT), Devon County Council (DCC), Horizon Care Services Ltd; Independent Mental Capacity Advocacy Service (IMCA); Southernhay House Surgery. The Review Panel was expected to operate collaboratively and reach agreed conclusions. Individual panel members were responsible for liaison with their agency during the review, briefing senior managers and individual staff as appropriate, and ensuring any independent management reports were delivered, maintaining confidentiality in line with guidance.

Ms X had a lifelong physical condition which affected her mobility and balance, resulting in a fall in the street a year before she died. The resulting fracture to her hip exacerbated her mobility problems and she became seriously depressed and physically unwell. She found it difficult to accept help and neglected her own needs.

Emergency interventions from the Police and Ambulance services were required and led to a prolonged admission to a psychiatric unit where Ms X made a good recovery. Although care services were put in place on her discharge from hospital, Ms X would often refuse or limit the help

they provided. This led to a further deterioration in her living conditions and her health and she died, alone in her flat, from a pulmonary embolism in August 2015.

The Review focused on the way in which the health and social care systems worked together to meet Ms X' complex needs to understand how the situation developed. Issues around Safeguarding Adults and mental capacity were highlighted in relation to self-neglect.

The Review took a proportionate approach based on chronologies (or timelines) of interventions supplied by organisations involved, followed by a series of meetings with practitioners and managers of services. Those organisations were:

- Devon Partnership NHS Trust (DPT)
- Devon County Council Social Services (DCC)
- Devon & Cornwall Police
- Royal Devon and Exeter NHS Foundation Trust (RDE)
- South West Ambulance Service Trust (SWAST)
- Southernhay House Surgery (GP)
- Horizon Care Services

The Review found some examples of good practice in working with a person who was reluctant to engage with services and there was no evidence of any willful neglect or bad practice in general. However, the Review did identify occasions when failures to take positive action might have impacted on the course of events. This includes the failure of care services to pass on information that Ms X was not responding to their contacts. It also includes the failure to carry out and document mental capacity assessments when Ms X was making unwise decisions about accepting help which affected her health and wellbeing adversely.

The Review also highlights the complex health and care system and the number of transfers that are made between different individuals and teams, each of which can increase risk in terms of passing on information and continuity of service. The split between the keyworker role in mental health services and the care management service from Social Services, was a particular example of this and may have meant that Ms X did not get the benefit of a fully coordinated multi-disciplinary team approach. It is also identified that Safeguarding Adults and other formal mechanisms may not always be considered in accordance with local and national policy.

This Report sets out a number of different findings together with some recommendations for actions for Devon Safeguarding Adults Board.

Key Themes

The following themes were identified in the Review:

i. Decline in Health

Ms X had both physical and mental health difficulties over many years but her decline and death do not appear to have been expected by health professionals. Whilst it is not within the remit of this review to speculate why her death occurred, several observations may be worthy of further consideration in preventing harm in future.

ii. Safeguarding Adults

A Safeguarding Adult alert was raised by the Community Nursing Team on 12th December 2014.

They were the only visiting practitioners who took this action, although several other agencies were involved.

Ms X was in hospital for 6 months and therefore not at risk during this period from the self-neglect issues which led to the Safeguarding Adult alert.

Two organisations were involved with the planning of Ms X's discharge and it may be that this resulted in a lack of clarity regarding these matters. This will be considered further under "Case Ownership'. Although it was appropriate for Ms X to be treated in the unit for older adults, the community keyworker responsible for her discharge was from an adult team. This may have led to a disjointed service.

iii. Mental Capacity

From the information provided, there is no evidence that a formal assessment under the Mental Capacity Act 2005 was carried out for Ms X, despite some references to the need to do so and to concerns over significant decisions she was making about care choices which put her health and wellbeing at risk.

There was a difference in opinion amongst practitioners as to whether Ms X knew and understood the risks attached to her lifestyle and refusal of care. However, this was never tested formally under the Mental Capacity Act. 2005.

iv. Involvement of organisations and working together

This Review concerns an individual with a set of serious and complex health and social care needs which required an appropriate level of intervention, urgent and routine. Some of these interventions were specialist around mental health or mobility. A picture emerges of an individual at the centre of a great deal of activity coming in concentrated bursts, with numerous visits, telephone calls and referrals being made. There is some evidence of good communication between organisations and individual practitioners but there are also situations where one organization seemed to be unaware of another's involvement. A co-ordinated approach to care was not evident at any stage.

v. Case ownership

This case has highlighted the network of services involved with the care and treatment of one individual with complex needs. To understand this further, the Review has considered DCC's Case Ownership Protocol ratified in June 2013 and agreed with partner organisations. This states that the 'social care assessment process will be led and co-ordinated by the team which, on the basis of preliminary information, appears to be most likely to hold expertise in the main areas of need'.

vi. Good Practice

The CPN worked with Ms X through the last year of her life and maintained regular contact with her during her hospital admission, attending reviews. On her discharge date, she collected Ms X and took her shopping before taking her home and settling her in. This was undoubtedly good practice in terms of building a rapport and managing the initial risks of the return home.

The Community Nursing team were involved with Ms X for a relatively short period for specific health reasons. They identified serious self-neglect and acted upon it by creating a Safeguarding

Adult alert in a timely way.

Conclusion of the Review

A Recommendations Plan below sets out all actions expected of each of the organisations involved. This has been presented to the December Devon Safeguarding Adults Board who will review these actions at subsequent meetings until assurance is provided that all actions are complete

Recommendations

	Recommendation	Agency Responsible	Target date
1	a) Where professionals have concerns about an individual's mental capacity and that individual is making a decision which professionals view as unwise, then a robust assessment of mental capacity in respect of that specific decision should be undertaken. It is recognised that assessments of capacity can be complex. Decision-makers undertaking an assessment of capacity should understand they can involve a second assessor to help assist them in determining whether an individual has capacity. The second assessor should have skills or expertise relevant to the individual assessment - for example they may be a speech and language therapist (SALT), neuropsychologist or mental health professional. b) Any assessment of capacity must note that the question of whether a person lacks capacity must be decided on the balance of probabilities: s.2(4); no person is to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success: s.1(3) and a person is not to be treated as unable to make a decision merely because he makes an unwise decision: s.1(4). Where it is concluded that the individual lacks capacity, a decision may be made on their behalf using the best interests' framework of the Mental Capacity Act. When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence his decision if he had capacity, and to the other factors that he would be likely to consider if he were able to do so: s.4(6).	DPT (community and inpatient services), DCC, RDE A & E, GP. DPT (community and inpatient services), DCC, RDE A & E, GP.	28/02/2017

2	Ensure that there is clarity between organisations about follow up to Safeguarding Adults Enquiries which have been closed due to a change of environment which has mitigated the risks made for adults at risk e.g. hospital placements.	Health and Social Care Partners	28/02/2017
3	Ensure that all organisations ensure that their practitioners are aware that serious self-neglect is a Safeguarding Adults category of abuse and understand when to make an alert.	All DSAB partners and public awareness	28/02/2017 plus ongoing training
4.	Ensure all agencies are aware of the necessity to protect care records, including domiciliary care records, in the event of someone dying at home. Contracts need to be clear about ownership and recovery of care records. Organisations providing paper records at home should include clear guidance in the notes to indicate that when care is no longer provided the notes should be returned to their organization.	All DSAB partners Devon County Council Adult Commissioning and Health Devon County Council Procurement Services All organisations providing care.	28/02/2017 plus ongoing training
5	Ensure all relevant organisations give clear guidance to their staff about what to do when clients do not attend routine visits or refuse care.	Health and Social Care Partners	28/02/2017
6	Put in place a very clear multi-agency case ownership protocol, with specific arrangements for people with serious mental health and physical care needs and review transition arrangements across organisations.	DCC and DPT	31/05/2017