Safeguarding Adults Review (SAR)

MARY

EXECUTIVE SUMMARY

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INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW

Mary was a young adult in her early twenties at the time a SAR referral was made. Mary's GP had raised a safeguarding concern confirming that she was 99% sure that Mary was approximately 30 weeks pregnant and would not have been able to consent to sexual activity. A family member was convicted of offences against Mary.

A key part of undertaking a SAR is to gather the views of the family and share findings with them. Mary's family declined to be involved with the review. Mary's personal assistants were involved; their thoughts and views have been included where appropriate.

This review takes into account interagency involvement covering the nine months prior to the date Mary's pregnancy was discovered. Key background information was also included.

STRENGTH OF PRACTICE

It is important to note that many practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. This review has identified numerous elements of good practice

THEMES

The review focussed on several key emerging themes to understand the strengths of multi-agency working and to recognise gaps and areas where improvement may be required. Systems and services that worked with Mary have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this review.

The author notes that the review has not found any information, system or process that would have anticipated or prevented Mary's pregnancy. There are, however, systems and processes that may have given more light to the care Mary was receiving at home. There is also learning regarding identifying pregnancy at an earlier stage and for the safeguarding system.

There are some cross-cutting themes of application of the Mental Capacity Act and communication that will be discussed throughout this analysis section as appropriate.

FINDINGS:

Managing menstruation and identification of pregnancy

- There was a good assessment that Mary did not have capacity to be involved in decisions regarding managing menstruation.

- Management of menstruation was managed by a single agency in consultation with mother.
- When the method was changed and was more unusual and invasive procedure there was not wider discussion with other agencies.
- Prescribing contraception medication/devices for managing menstruation does not require a pregnancy test- but the exclusion of a possible pregnancy from history.
- Pregnancy was not identified until much later (30 weeks)
- Symptoms of pregnancy were not recognised as that scenario was unthinkable; professionals had known Mary for many years and had not had concerns about her care.
- Communication between various agencies regarding concerns was limited and not every professional knew the thoughts of others.
- Symptoms of pregnancy were thought to be from another cause.

Learning Point: Best interests' decisions are more robust when several of those that care for and know a person well are included, providing the decision is not an urgent one.
Learning Point: Early collaboration regarding concerning presentations of a person without capacity may lead to a prompter diagnosis.
Learning Point: Thinking the unthinkable alongside other possibilities may present earlier opportunities to protect

Continuing Healthcare System

- Mary's care and support were funder via National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (CHC). This funding was manged via a Personal Health Budget
- The system for CHC management changed.
- There was confusion amongst professionals regarding the day to day key worker role and management of social care issues for a person that is CHC funded.
- Several Issues came to light during this review that were of concern that had not been highlighted by usual contacts by professionals or the CHC team that were funding and commissioning care.
- Contact was not made with the CHC team when concerns were being raised.
- Once Mary's pregnancy was confirmed, the CHC team became heavily involved in ensuring that there was constant review of the packages of care and support plan as issues were raised and solutions considered.
- Some elements within the CHC process have already been addressed as there were recognised shortfalls in the system.

Learning Point: Where a person is in receipt of fully funded CHC and a PHB, clarity of the governance, coordination, key worker and day to day oversight provides safeguards and assurances regarding how a national framework is being delivered locally.

The safeguarding system

- Hindsight bias was not applied to this situation; learning comes from the position and the view that professionals had at the time.
- There were several missed opportunities to identify earlier that Mary was pregnant. These missed opportunities potentially prevented Mary being safeguarded from ongoing abuse and identifying a perpetrator sooner.
- Services seeing Mary on a daily basis did not consider safeguarding as the reason for her symptoms.
- When services made the first safeguarding referral, information was not shared with the police regarding an allegation that a person with no capacity to consent to sexual activity was thought to be pregnant, and not all professionals were spoken to in order to gather a fuller picture.
- There was a delay in making a safeguarding referral after pregnancy was confirmed due to a need to examine Mary.
- Following a second safeguarding referral, the safeguarding system worked well demonstrating positive multi-agency working in order to provide ongoing support and protection to Mary.
- After the decision that the referrals did not meet the criteria for a s42 enquiry, there could have been a challenge back to the safeguarding team.

Learning Point: Safeguarding decision making is more robust when information is gathered from a range of professionals involved in the care of a person with care and support needs may have been a victim of abuse.
Learning Point: Understanding and using correct terminology prevents misunderstandings regarding the safeguarding system leading to improved multi-agency working.
Learning Point: Key partners in a safeguarding investigation should be clear about roles and expectations.
Learning Point: Use of professional challenge and escalation guidance supports effective multi-agency working.
Learning Point: The role of Personal Assistants when directly employed by a family needs clarity so that vital information is not missed. PA's should be supported to identify issues to other professionals when effectively this may be seen as whistle blowing but their employment is not protected.

Parental role post 18

- It was a feature throughout this review, that Mary's mother continued to make decisions on her behalf post the time that she reached her 18th birthday.
- Post 18 the law is significantly different. Parental responsibility ends when a person reaches 18 years of age and the Care Act becomes the main legislative framework to ensure that a

person's care and support needs are met and that they are safeguarded from abuse and neglect.

- Parents can struggle with this change; it is important that parents are supported to understand the changes in decision making and the role that professionals take in health and welfare decisions.
- There was good was evidence of professionals recording assessments and best interests' decisions.
- It would be helpful if parents were provided with clear information at transition regarding how key decision making will change post 18 and options to challenge any decisions that families are not in agreement with and vice versa.

> **Learning Point:** During the transition from child to adult services, the preparation of parents regarding different frameworks for decision making post 18 may prevent misunderstandings, ensuring that the person's human rights are upheld in any decisions.

SUMMARY AND CONCLUSION

- This review has acknowledged the complexity of supporting a person who was not able to communicate and was assessed as not having capacity to make most day to day and more complex decisions. Mary therefore relied on her family, carers and professionals to make decisions that were in her best interests using the legal frameworks that provide safeguards for these situations.

- It is clear from this review that Mary received care for a long period of time from the same day centre and replacement care services who evidenced that they knew her well and understood her needs. There was also evidence that the community team remained unchanged and they also knew Mary well. This is to be celebrated as it is often not the case, with service users often having multiple changes in professional staff who care for them.

- The difficulties presented in this case manifest as a lack of key worker role and clarity regarding the CHC roles and responsibilities to those working with a person who is subject to CHC funding. Concerns were highlighted regarding.

- There was a good understanding by all those involved of the general principles of the Mental Capacity Act. There is learning, however, regarding the application of the Act where best interest decisions become the norm for a person and when that decision needs to be more widely discussed before a final decision is reached.

- Initially professionals could not consider that Mary might be pregnant as that would be unthinkable.

- As time went on and pregnancy became more likely to be the cause of the symptoms leads to the learning for the safeguarding system.

- The first safeguarding referral was closed with no challenge from professionals who believed Mary to be pregnant. The second referral did result in immediate action.

- This review has seen a plethora of good practice. What might have supported an earlier recognition of pregnancy, and therefore protecting Mary more quickly, was for professionals to apply a concept to 'think the unthinkable', followed by robust communication and professional challenge. This may have been difficult, but Mary's safety and protection could have featured alongside other possible causes, with pregnancy as the hypothesis until proven otherwise.

RECOMMENDATIONS

- Where single agencies have made their own recommendations from their own learning. WSAB will receive updates regarding progress against actions set.

- The following multi-agency recommendations are made to the WSAB as a result of the learning in this case:

1. Identifying an issue

WSAB should undertake a promotional campaign regarding 'thinking the unthinkable (TTU)' using a variety of media applicable to public and professionals E.g. video, within mandatory training, briefings, posters etc.

Topic areas to be covered within the campaign material must include:

- Examples from this review that should trigger a wider conversation regarding situations that may suggest TTU and Best Interest meetings.
- Promotion of encouragement and support of all concerned individuals being able to TTU.
- Clarity as to how escalation can be used in cases where a person 'thinks the unthinkable' where others do not share the same view.

2. The CHC System

WSAB should seek assurance that the already agreed Local Protocol is produced in a timely manner and that it includes the elements of system learning from this review:

- Ensuring there is clarity of who the Named Case Manager and PHB Nurse in commissioning services (CCG) to all provider services involved in any given case
- Agreement regarding day to day key worker role in provider services.
(The above two roles should be identified in all care plans and records)

- CHC reviews must include information gathering from all those involved in delivering care (including PAs).
- CHC Case Manager must be notified of any changes that may result in a need to amend or address issues with the package of care.
- All safeguarding concerns must be notified to CHC Case Manager either by a person who has a concern, or a formal safeguarding concern is raised.

3. The Safeguarding System

a. WSAB should identify a task and finish group to develop a 'Safeguarding Meetings Protocol' as additional guidance for effective statutory safeguarding meetings. This must include:

- Cases that may trigger a face to face meeting rather than individual emails and phone calls.
- Promotion of wide attendance using virtual meeting technology, where available, to include all relevant persons including PA's as well as service users, carers etc. as appropriate.
- Guidance for all on joint working between all agencies and clarification of how criminal investigations will be managed alongside the safeguarding process.

b. WSAB should relaunch the Multi Agency Escalation Procedure to remind and encourage escalation and challenging conversations.

4. Prescribing for contraception and menstruation control.

WSAB should formally request that agencies who may prescribe contraception and menstruation control produce Best Practice Guidance for the Prescribing of Contraception and Menstruation Control in Complex Cases where patients/service users do not have mental capacity to understand or consent. Guidance must include:

- Mental Capacity Assessment in such cases
- Assessment of need for contraception/menstruation control
- Impact on the person and their needs of method requested/chosen
- Assessing compliance and concordance
- Triggering of Best Interest meeting where implant is considered, or other unusual circumstances are featured.

5. Parental Role Post 18

WSAB should ask the Community Health Care Trust to share relevant work already undertaken regarding support for professionals and parents facing transition to Adult Services in the change of parental role in decision making post 18. This could then be used as a basis for developing tools for multi-agency use in both statutory, commissioned & the voluntary sector who work with children and young people. Resources should also be made available on the public facing Worcestershire Safeguarding websites. This recommendation should be shared with Worcestershire Safeguarding Children Partnership.