Northamptonshire Safeguarding Adults Board

Learning from Safeguarding Adult Reviews

Key findings and learning from Safeguarding Adults Review - 010 - Andrea December 2019

The Purpose of a Safeguarding Adults Review (SAR) is to promote learning and improve practice where there is concern that partner agencies could have worked together more effectively to protect the adult. A SAR will not re-investigate or apportion blame but supports professionals to adjust practice in light of the lessons learnt from the review.

Sharing Learning from both local and national Safeguarding Adult Reviews (SAR) and other reviews is a key priority for Northamptonshire Safeguarding Adults Board (NSAB).

Following the Safeguarding Adult Review 010 – Andrea, an action plan is in place with key multi-agency and single-agency recommendations and actions for organisations linked to the case. Progress will be monitored via the NSAB Quality & Performance and Safeguarding Adult Review Sub Groups.

This learning briefing summarises the key findings and recommendations from the review.

Managers should discuss this briefing with their teams to ensure that the learning is used to enhance existing good practice and to make improvements where necessary. Feedback will be sought from partner agencies via the NSAB Learning & Development Sub Group to ensure that the learning has been cascaded.

The Safeguarding Adult Review Summary - Andrea was recently published and is available on the NSAB website.

The review evaluates multi-agency responses concerning the sad death of Andrea who died in December 2017 following a period of self-neglect.

Andrea had a long-term health condition and in 2017, concerns were expressed by a range of agencies as she was not taking her prescribed medication and not attending appointments.

The period of the review was 1st January 2017 until the time of Andrea's death on 12th December2017.

Andrea's family were given the opportunity to contribute to the review.

Note: NSAB is also referred to as 'the Board' throughout the recommendations in the report.

The Safeguarding Adult Review

The Safeguarding Adults Review was led by an independent author who undertook a blended/hybrid methodology using chronologies and Individual Management Reports (IMRs). The review examined a number of key areas of concern, including:

- How did agencies engage with Andrea and was engagement proactive?
- Were the concerns made by family members about Andrea's physical and mental health acted on appropriately and how did agencies work with the family?
- How much focus was placed on Andrea's long-term health condition and how this impacted on her other medical and mental health needs.
- The effectiveness of procedures, both multi-agency and those of individual organisations.
- Did agencies consider the issue of self-neglect, and what action did they take in regards to escalation of concerns?
- Were risk assessments completed by agencies and were multi-agency risk assessments completed and shared?
- What assistance/advice was sought through adult safeguarding processes?
- How was the Mental Capacity Act applied?
- There were concerns around the issuing of the section 135 warrant. How did this impact on Andrea's level of care?
- Identify potential missed opportunities for intervention to affect a positive outcome.
- What were the circumstances under which Andrea's husband was informed of her death?

Conclusions

1. **Mental Capacity**
   a. There was a lack of evidence that Andrea's mental capacity to make decisions relating to her long-term health condition and its treatment were adequately assessed or investigated.
   b. Professionals should have considered an individual's mental capacity when they are making unwise decisions regarding their physical health needs which might result in extreme self-neglect.
   c. Hospital staff did not consider Andrea's mental capacity to make decisions relating to her physical health and its treatment and assumed that she had capacity without making the further investigations required by the Code of Practice.

2. **Information Sharing**
   a. Information regarding allegations of domestic abuse should have been shared with the children's schools.

3. **Professional Curiosity**
   a. Whilst services tried to engage with Andrea, these were ineffective and did not appear to have acknowledged her denial of her long-term health condition and the implications to her overall wellbeing.

4. **Self-Neglect**
   a. Self-neglect wasn't identified and guidance wasn't implemented in respect of escalating concerns about Andrea's mental and physical health.

5. **Executing Section 135 Warrants**
   a. The process for obtaining/issuing the s135 warrant resulted in undue delay.
   b. There was a lack of consideration of the likely impact of the s135 warrant's execution demonstrated by the number of professionals present when executed.
   c. The quality of the recording of the execution of the s135 warrant resulted in variances in basic information between different agencies.

6. **Mental Health Act 1983**
   a. Andrea's nearest relative was not advised of their rights under the Mental Health Act.

7. **Recording and retention of information**
   a. The quality of the recording for the transport of Andrea to hospital was not undertaken correctly in order to provide legal justification for the decision.
   b. The retention of assessment paperwork under the MHA could have been improved.
   c. The recording of safeguarding concerns raised about Andrea and her children within the MASH, Adult Social Care and individual agencies was confused/poor/non-existent.
   d. The quality of records relating to decision-making regarding referrals made to Children Families and Education (CFE) (now Children First Northamptonshire) and the resulting assessments could have been improved.

8. **Policies & Procedures**
   a. Despite the concerns raised by family members, no action was taken by professionals to make contact directly with Andrea.
   b. Agencies should have recognised the importance of raising safeguarding concerns and not assume another agency would do so.
   c. The Inter-Agency Procedures were not being implemented in accordance with Making Safeguarding Personal.
   d. The Inter-agency Safeguarding Children Procedures were not followed by adult services on at least one occasion.
   e. There was no evidence that CFE established any processes to monitor the children's situation or to identify them as actual/potential Young Carers.
   f. There was no evidence of CFE having a process in place to monitor and progress-chase referrals onto other services.

Recommendations

1. Partners and the services they commission should assure the Board that their policies and procedures have been reviewed and revised as appropriate to ensure that the Mental Capacity Act 2005 and its supporting code of Practice are implemented properly, with particular regard to Unwise Decisions and situations of self-neglect.
2. Children First Northamptonshire should assure the Board that they have reviewed and revised recording and assessment within its practice standards to ensure they are compliant with the latest requirements under current legal requirements.
3. Partners should assure both the Children's Safeguarding Board and the Adults Safeguarding Board that they are implementing and monitoring their policies and procedures to identify and support Young Carers.
4. Partners should assure the Board that monitoring and implementing information sharing protocols for domestic abuse is in place, particularly where the victim/survivor has additional care and support needs or there are children present.
5. Partners should assure the Board that they, and the services they commission, have monitored and revised as appropriate policies and procedures regarding DNAs to ensure they are proportionate and fit for purpose, particularly for those with a history of not engaging with services.
6. Partners should assure the Board that they are implementing and monitoring the use of the Self-neglect Guidance.
7. Partners should assure the Board that they are implementing and monitoring the appropriate use of the Adult Risk Management (ARM) Guidance.
8. Adult Social Care should assure the Board that they are ensuring their service users, their families and partner agencies are provided with adequate information as to their rights to request assessments under the Care Act 2014.
9. Partners should assure the Board that they and the services they commission are appropriately training staff to implement the Mental Capacity Act 2005 and its supporting Code of Practice, particularly in cases of possible or actual self-neglect.
10. Partners assure the Board that they and the services they commission are advising service users and their families or significant others of their rights under the MHA 1983.
11. The Board liaise with the Northamptonshire Safeguarding Children Board to jointly develop a process to ensure that partner agencies and the services they commission are appropriately cross-referring when a child is identified as being at possible risk of abuse or harm in a safeguarding adult case and vice versa.
12. Partners should assure the Board that they are implementing appropriate and proportionate policies and procedures to ensure that cases of self-neglect are identified, triaged and safeguarding concerns raised.
13. The Board consider liaising with the Health and Wellbeing Board to establish a governance process to manage cases of self-neglect that fall outside Section 42 of the Care Act.
14. The Board review and revise as appropriate the Inter-agency Procedures in place to receive, triage and respond to safeguarding concerns re adults and the recording systems to support them.
15. The Board liaise with the Northamptonshire Safeguarding Children Board to ensure that the above policies and procedures complement those for safeguarding concerns for children.
16. Adult Social Care, Northamptonshire Health Foundation Trust and the Police should assure the Board that they have reviewed and revised their joint procedures for applying for and executing s135 warrants and are monitoring their implementation.
17. Partners should assure the Board that they and the services they commission have reviewed and revised as appropriate the recording processes that apply to the obtaining and execution of s135 Warrants.
18. The AMHP Service should assure the Board seek assurance from the AMHP service that it has reviewed its recording procedures and practice re assessments under the MHA.

19. The Board review and revise as appropriate its current Inter-agency Procedures, which were due for review in April 2017, to ensure they are compliant with and implemented in accordance with the Care Act 2014, its supporting Statutory Guidance and Making Safeguarding Personal.
20. The Board review and revise as appropriate its monitoring processes of the implementation of its Inter-agency Safeguarding Procedures to ensure they are fit for purpose.

Good Practice

- Following admission from Andrea to her GP that she had not attended the specialist health service since May 2016, the GP completed a Mental Health Screening Assessment, made a referral to Mental Health Services and submitted a re-referral to the specialist health service.
- The decision to ensure the GP was present during the execution of the warrant to provide direct knowledge of Andrea to the assessment and provide assurance to Andrea was good practice.

General Observations

- Andrea's voice did not come through in the review as a result of very limited input from her family and those involved in her care.
- There was an assumption that Andrea had capacity to make certain decisions but no formal assessment was undertaken.
- There was a lack of professional curiosity from practitioners regarding Andrea's non-engagement with services until the last few weeks of her life.
- Professionals did not act appropriately in respect of the serious concerns raised by Andrea's family.
- Andrea's lack of engagement with services in relation to her long-term health condition and her mental health was not explored.
- Despite Andrea being known to a number of services, self-neglect was not identified and appropriate guidance was not implemented by any of the agencies involved.
- Responses from agencies were focused on the presenting issue at a particular point in time - no-one considered taking a holistic view including previous events.
- Panel were concerned that the response from Children Families & Education in January and September 2017 did not result in an assessment or contact with the family at the time of Andrea's death in December 2017.

Key Points for Learning

- Practitioners should understand how the Mental Capacity Act can be used to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment, and practice should be compliant with the Mental Capacity Act.
- Practitioners should understand the importance of information sharing.
- Where an individual fails to engage with services, practitioners should explore the reasons for this and consider holding multi-agency meetings to discuss the lack of engagement (and potential self-neglect).
- Practitioners should better understand how to identify and work pro-actively with self-neglect.

You can find the published summary on the Northamptonshire Safeguarding Adults Board website – **www.northamptonshiresab.org.uk**

Northamptonshire Safeguarding Adults Board - One Angel Square, Northampton NN1 1ED - Tel: 01604 365681 Email: nsab@northamptonshire.gov.uk