From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within, or informs, safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Susan

In this case, a SAR was commissioned, but the SSAB has taken the decision that it will not be published in full due to the circumstances of the case. The SAR was undertaken using the SSAB Local Learning Review and the key messages contained in this briefing reflect the learning to emerge from this.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Does my organisation have robust policies and processes in place to support the management of medication and transfers between care homes?
- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key features of Susan's Case

- Susan was middle-aged and had a significant health condition that required daily medication. She lived with a close family member in Somerset.
- The family member strongly disagreed with medical professionals about the diagnosis and treatment of Susan's health condition, which they also expressed to the SSAB when contacted. However, as part of the SAR process the SSAB requested that her medical records be reviewed, which concluded that the diagnosis was correct.
- Following concerns that Susan's family member might be withholding her medication, or coercing her not to take it, it was arranged for a care provider to support her with this. This was self-funded. However, Susan continued to experience a number of hospital admissions related to her health condition.
- During some of these hospital admissions concerns were expressed about the behaviour of Susan's family member. Concerns were also expressed about Susan's capacity to make certain decisions, and an application was made under Deprivation of Liberty Safeguards. This was declined due to Susan's health condition not being a disorder or disability of the mind, and this decision was misinterpreted by the hospital to mean that Susan could not be assessed as lacking capacity in relation to any decisions that she was making that the hospital was concerned about.
- Several referrals were made to Somerset County Council's Adult Safeguarding Service over a number of years, but these were either closed due to there being insufficient evidence or because it was felt that the arrangements that were already in place for Susan to be supported to take her medication were sufficient.
- During approximately the last six months of her life, some professionals began to raise concerns that Susan might be a victim of domestic abuse. During this time Susan's family member cancelled her care, her social worker left their role, and she was not allocated a new one as she was considered to have a relatively low-level of care and support needs, and had been self-funding the visits from carers.
- When Susan's self-funded care package was ended a decision was made in isolation, without any reference to the wider concerns that Susan was allegedly experiencing coercion and control, that her family member could provide this care instead.
- There was good practice from a professional working at Susan's GP Practice, who was designated as a single point of contact for the practice and attempted to work with Susan. However, around this time Susan and her family member ceased contact with all services and 'disappeared' for a period of almost 3 months.
- There was no response from professionals to Susan's 'disappearance', despite it being extremely out of character. No concerns were raised, and no attempt was made to locate Susan or her family member. Her medication was stored by her pharmacy when it was not collected.
- Shortly before her death Susan and her family member resumed contact with local services, and she had a further hospital admission that was related to her health condition but, despite concerns being raised by professionals about both her capacity and the behaviour of her family member, she was discharged home without a mental capacity assessment having been completed.

- Around 2 weeks later Susan's family member called 999 after she had been found in a very unwell state. She was taken to her local hospital and then transferred to a regional centre where she died. Investigations were not undertaken to consider whether the cause of her death was related to her health condition.

Key considerations for practice arising from the review:

Alleged coercion and control experienced by Susan

- While Susan's death predates the Domestic Abuse Act (2021) the information considered by the SAR portrayed a high level of alleged controlling behaviour by a family member over time. All professionals should ensure that, if there are concerns about potential coercion and control (or any other form of abuse) taking place, attempts should be made to speak to the person on their own about the issues of coercion as well as the presenting medical issues.
- If there are differences in opinion between professionals and family members who are alleged to be using coercive and controlling behaviours (or any other domestically abusive behaviours) to influence someone, then multi-disciplinary meetings should take place so that decisions are informed by the whole multi-disciplinary team.
- A referral can still be made on the basis of professional judgement even if a DASH assessment does not indicate 'high risk'.
- Susan's 'disappearance' could and should have been recognised as a sign of potential domestic abuse accelerating.
- In Susan's case some professionals appear to have based their decisions on information received from Susan and her family member. Professionals themselves should guard against being coerced in to accepting explanations that do not fit with other information and use professional curiosity, rather than accepting information on face value.

Susan's capacity to make decisions in relation to her medication

- The potential impact of the alleged coercion and control that Susan was experiencing on her decision making does not appear to have ever been adequately considered by professionals.
- While it was correct that it was concluded that Susan was not eligible for an authorisation under DoLS based on her medical condition, it was incorrect to assume that this therefore meant that she had capacity in relation to decision making about her medication. As a result, her capacity in relation to this was never formally considered, which may have helped professionals to ascertain if the alleged coercion and control was having an impact on Susan's decision making.
- If there is a belief that a family member may be misinformed about a condition then, with the person's consent, attempts should be made to talk to the family member about this or invite them to a multi-disciplinary team meeting, so that their concerns can be considered in the context of other information that is available.
- Pharmacies should have guidance in place to alert a patient's GP if prescribed medications that could result in poor outcomes if not taken are not being collected.

The multi-agency response

- There was an example of good practice from Susan's GP surgery, which provided a single point of contact for the practice.
- However, overall, in Susan's Case the multi-agency response was fragmented, and characterised by multiple missed opportunities to jointly consider and respond to concerns that Susan may be experiencing coercion and control. Information was not shared, and professionals failed to recognise indicators that further enquiries were needed to ascertain what was happening, and for any associated risks to be assessed.
- The withholding of medication is a recognised form of physical abuse that is directly referenced in Care and Support Statutory Guidance, however this was not adequately recognised by the professionals involved in Susan's care and support. The result of this was that, when concerns were raised, they were either not followed up on at all, or where they were it was not as a safeguarding concern.
- Professionals, and organisations with safeguarding responsibilities, should ensure that concerns about abuse are considered in context with previous contacts, referrals, and other known information, rather than in isolation. This must include where contacts are received outside of normal office hours.
- All professionals should consider whether a significant change in patterns of contact, such as that which occurred when Susan and her family member 'disappeared', should trigger an escalation and the convening of a professionals meeting to discuss the situation, clearly identify the risks and agree any further actions that are required. This is because, in domestic abuse situations, a sudden change in behaviour can itself be a sign of increased risk of harm.
- All organisations should ensure that all forms of domestic abuse, not just those perpetrated by intimate partners, are able to be recognised – and acted on - by professionals.

Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Organisation	
Date	
This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)	
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)	
Action taken as a result of the learning:	
Other feedback / discussion points	