Learning Brief for Safeguarding Adult Review: 'Adeena'

The Care Act 2014 requires Safeguarding Adults Boards to arrange a Safeguarding Adults Review (SAR) if an adult (for whom the safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. This SAR relates to:

- Effective practice where an adult has comorbid **chronic pain and depression**
- **Deliberate self-harm (DSH) and suicide risk and Mental Health Act assessments** – Ensuring that all agencies have a clear understanding of risk relating to DSH, and act proportionally to safeguard those at risk from DSH identifying when should a Mental Health Act assessment take place
- **Multi-Disciplinary Meetings/Concerns Meetings** which could improve interagency information sharing and impact positively on an adult at risk's wellbeing
- **Serious incident dynamic risk assessment –** ensuring all agencies have a shared understanding of risk
- **Mental Capacity Act assessments** – did professionals understand fluctuating capacity and the impact of depression on self-motivation?

Background

Adeena had been a successful financial fraud investigator, but a stroke left her with left side hemiparalysis, epilepsy and irritable bowel syndrome, fibromyalgia and Ehlers-Danlos syndrome. She experienced frequent severe pain and had very limited mobility. Consequently, she suffered the loss of her job and home, and she incurred debt. She moved to Sandwell Council accommodation where her care and support needs were assessed, and carers attended four times daily. Her ground floor flat was not equipped with a ramp therefore Adeena could not leave unaided, relying upon the assistance of carers or a friend who supported her throughout the period under review.

How did this impact upon Adeena's life?

- Adeena lived with persistent, chronic pain that impacted upon her mental health and wellbeing and used alcohol and cannabis to mitigate the impact of that chronic pain.
- Adeena would explain a history of trauma and loss in her life to any professional who took the time to understand her lived experience.
- Adeena experienced low mood and depression, accompanied by frequent suicidal ideation, expressed to professionals and carers. On many occasions, to numerous professionals she stated she wanted to die '*because her life was not worth living*'. She could not apparently envisage a better time where she might regain some independence and autonomy.
- Over a 10-month period, professionals attended six DSH episodes involving alcohol and prescribed and unprescribed medication (usually painkillers).
- Responses to these incidents included: two occasions where she was deemed by paramedics to lack capacity and was taken to ED and assessed by Psychiatric Liaison Team or CRISIS teams and discharged to her GP. Once, she was assessed at home by Street triage and referred for community assessment and on another occasion, Adeena agreed to go to ED for assessment.
- Six safeguarding referrals were received by Adult Social Care, which had one or other referral as an 'open' case for almost the entire period under review, but there was little evidence of co-ordinated multi-agency working.
- Due to the continued absence of a ramp, Adeena was unable to leave her home unaided nor could she evacuate her flat in an emergency.

- In the final weeks of her life, Adeena began to use arson as her intended method of deliberate self-harm and indicated to professionals an intention to kill herself. Professionals and their managers struggled to co-ordinate an appropriate risk management plan and emergency services attending incidents did not develop a shared understanding of Adeena's risk.
- Adeena allowed natural gas to fill her flat and stood with a lighter threatening to 'blow herself up and take the street with her'; the immediate risk was prevented by the attendance of the West Midlands Fire Service.
- Over the following week, she lit a fire adjacent to her bedside that could have got out of her control but was extinguished by West Midlands Fire Service (WMFS) who attended.
- Three days later, Adeena lit another fire, which took hold in the flat. She died as a result of her injuries.

What were key issues identified for professionals?	How could professionals make a difference?
Chronic pain and the impact it had upon Adeena's wellbeing	• Health professionals across all disciplines should ensure they have greater awareness of the links between chronic pain and depression and ensure care plans always address these comorbidities holistically. Care plans could demonstrate that care is person-centred, by identifying 'What does a good day look like for you?', 'What does a more difficult day look like for you?' and 'What would make a difference then?' • Consider, and be aware of, the range of therapies available to a patient. • Take into consideration health conditions and chronic pain when assessing both mental health or wellbeing.
Deliberate self-harm and suicide risk and Mental Health Act Assessments	• Be aware there are 'red flags' that require immediate referral to mental health services and a robust safety plan, support, and a removal of access to means. These include hopelessness, pain and chronic medical illnesses, drugs and alcohol misuse, financial loss, and a perception of lack of social support. • Identify and consider with partners each previous suicide attempts, or any deliberate self-harm behaviour as evidence of escalating risk.
Multi-disciplinary meetings	• Be confident in calling MDTs using the Sandwell Vulnerable Adult Risk Management Guidance to bring together professionals to identify how

	best to respond to a vulnerable adult's complex needs.
Serious incident dynamic risk assessment	• Where you believe a developing incident poses an immediate and serious risk to life, the emergency services must be informed**,** and your risk assessment made clear to call handlers. Managers should ensure that where the emergency service response appears inappropriate, they take immediate responsibility to escalate that concern. • At any incident where there is a risk to life and limb, all emergency responders should debrief to ensure there is a shared understanding of the level of risk, thereby ensuring logs are accurate and correctly identify risk, in the event of future attendance.
Mental Capacity assessment	• Take into account that depression can impact upon capacity and self-motivation when assessing capacity. MCA assessments should be recorded to include the decision and choices made and indicate why a patient lacked capacity.

Some general learning from the SAR on supporting all vulnerable adults

- Ensure your visits to adults with needs for care and support that are already being met include all key professionals, including those providing commissioned care/personal assistance, so you maximise opportunities for effective working together and information sharing. Try to ensure the visits are well coordinated and timely, to minimise the impact of multiple unnecessary visits that may cause distress.
- We often list in detail available options refused by a citizen but seldom record asking 'is there anything else I can do to help you?' Take every opportunity to include work on making safeguarding personal and adopt better informed, person-centred, and strength-based approaches.
- Make sure you have at your disposal all the relevant information you could reasonably be expected to gather before a visit, so that citizens do not have to repeat their accounts and experience frustration with processes rather than be involved in useful conversations.
- Identify the impact of loss and trauma will help make safeguarding personal.

Messages for Management and Strategic development	
How can we support implementation of the relevant recommendations?	**The Recommendations**
Chronic pain and depression	**The SAR recommends that the Sandwell and West Birmingham CCG and Sandwell**

• Hospital Trusts could ensure that discharge letters provide clear guidance to GPs on the management of chronic pain.	**and West Birmingham Hospital Trust undertake a review of the assessment and management of chronic pain to ensure that commissioned services are delivered as far as possible in line with best practice as described in the NICE guidance for the Assessment and Management of Chronic Pain published in April 2021. This should also involve raising awareness of the guidance amongst primary and secondary care.**
Deliberate self-harm and suicide risk and Mental Health Act Assessments • Hospital Trusts should ensure that ED staff are aware of the five risk factors in any DSH: chronic alcohol and drug problems, multiple repeaters, mood disorder, medical illness, isolation and consider referral to specialist mental health services and Adult Social Care. • Hospital Trusts should consider a 72-hour follow-up protocol after DSH to reduce risk of suicide and repeat DSH.	**The Sandwell Safeguarding Adults Board and Black Country Healthcare NHS Foundation Trust should develop an effective multi-agency case study-based training package, to be used in either single agency or multi-agency training, that raises professionals' awareness of when referrals for Mental Health Act assessments are required and all relevant pathways to mental health support. The training should also explore the interface between the Mental Capacity Act 2005 and Mental Health Act 1983.**
Multi-disciplinary meetings All agencies should: • Encourage staff to consider MDTs for complex cases especially where there is no safeguarding plan. • Audit MDT use and share best practice.	**The SAR recommends that Sandwell Council and partners develop 'Vulnerable Adult Risk Management' Guidance that promotes an increased use of MDTs or strategy meetings in complex cases and that this is incorporated in the current review of local Safeguarding procedures. The Guidance and Safeguarding procedures should encourage such MDTs in all cases of vulnerable adults with complex needs (including those without care and support needs).**
Serious incident dynamic risk assessment WMP, WMAS, WMFS • Emergency services should ensure that emergency responders take responsibility to submit an appropriate referral whenever a safeguarding concern is identified and should not assume it will be done by another agency.	**The SAR recommends WMP review policy and procedures relating to attendance of officers or staff at incidents involving vulnerable adults where there are safeguarding concerns. They should concentrate upon ensuring safeguarding/vulnerability referrals (or repeat referrals) are made where there is a history of concerns and that wherever possible, police supervisors are consulted where officers have any immediate safeguarding concerns.**

• How can our agency ensure that incident logs have properly identified known and continuing risk? • Do our professionals know how to raise care and welfare concerns as well as safeguarding referrals?	
Mental Capacity assessment **All agencies should:** • Consider reviewing the training of Mental Capacity; do your professionals know how and when to assess capacity and how to record those assessments?	**Recommendation Five: The SAR recommends that, Sandwell and West Birmingham Hospital Trust, Black Country Healthcare NHS Foundation Trust, Dudley Group NHS Foundation Trust and West Midlands Ambulance Service audit the appropriateness and accuracy of Mental Capacity assessments undertaken by their professionals, to ensure they comply with current MCA Guidance. The audits should also focus upon correct recording and documentation when any capacity assessment is undertaken, including where the assessment concludes the citizen has capacity.**