Executive Summary: Safeguarding Adult Review (SAR 8)

using Significant Incident Learning Process

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Introduction

1. The Cornwall and Isles of Scilly (CIoS) Safeguarding Adults Board (SAB) commissioned this Safeguarding Adult Review (SAR) following the deaths of adults with care and support needs (adults) who, at the time of their deaths, were being cared for by family members facing their own health challenges. Neglect was identified as a contributing factor in the deaths. The purpose of the SAR was to explore whether lessons could be learned from the case, specifically how the adults and their families could have been better supported, and for those lessons to be applied to future cases.

2. The review was conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. It recognises strong practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3. A key element of SILP methodology is engagement with family members at the earliest opportunity, and with support, allows them to shape/ contribute to the review and provides the "best/ nearest" understanding of the lived experiences of the subject(s) of reviews undertaken. Through this process the SAB has established trusted relationships with some family members.

Case Studies: Safeguarding Adult Review (SAR 8)

These case studies are created to provide a context to the Executive Summary produced for SAR8.

Background

A number of cases were reviewed for this SAR, and 2 case studies have been created to capture the circumstances of the reviewed cases. Some circumstances have been altered to prevent identification of the cases reviewed.

Case 1.

Andrew was 45 years old at the time of his death.

At the age of 9, Andrew was knocked off his bike and suffered a brain injury. This left him with a level of physical and cognitive impairment. He:

- gained a level of mobility with support from walking aids which was sustained into adulthood
- remained verbal, able to express his feelings and wishes
- attended a school for children with additional needs

Andrew's mother and sole parent, Belinda blamed herself for her son's "accident" at the time of the incident but appeared to come to terms with it. However, as Andrew entered adulthood, Belinda started to limit his acceptance of any outside support in caring for Andrew, suggesting that as she was to blame for the injuries, it was her responsibility to provide all the care for Andrew.

By the time Andrew reached 40, Belinda was providing all care for Andrew, and apart from occasional contact with GP, Andrew became invisible to services. However, at this time Belinda was diagnosed with breast cancer. Belinda accepted support from a friend in caring for Andrew whilst undergoing treatment but maintained her position that it was her responsibility to care for Andrew. Attempts by agencies to offer support were seen as undermining by Belinda, even when concerns emerged that Belinda and her friend were struggling to provide adequate care.

Andrew was found dead at home by Belinda's friend.

Case 2.

Michael and Norma were married and were 82 and 80 when they died within a month of each other.

Norma had multiple sclerosis, which was diagnosed in her 50s, but began to impact significantly on her daily life in her late 60s. Michael incrementally became Norma's carer, despite emerging health concerns of his own. For the last 4 years of their lives, Michael and Norma were cared for predominantly by their daughter, Olive. Michael and Norma also had a son, Peter, who expressed concerns to involved agencies about his sister's mental health and ability to meet their parent's needs. On one occasion, Peter reported significant concerns about his parent's wellbeing but then reflected that he had over-reacted to a telephone discussion he had with Olive.

Olive contacted her GP concerned about her parents who both appeared to have severe respiratory infection. Olive was also unwell with a similar illness. Michael and Norma were admitted to hospital exhibiting some signs of neglect. Michael and Norma remained in hospital until their deaths.

Learning

Application of the Mental Capacity Act

4. The provisions of the Mental Capacity Act were applied inconsistently across the partnership with limited understanding by the families involved.

5. Despite the five statutory principles set out in the Mental Capacity Act 2005 and linked Code of Practice[1], both the family carers, and professionals working with the adult's

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[1] A person must be assumed to have capacity unless it is established that they lack capacity.

made assumptions that they were unable to make decisions for themselves. This acceptance is likely to have impacted on all aspects of case assessment and intervention. Where made, demeaning comments made by the carer about capacity, did not appear to be robustly challenged by practitioners.

6. There was minimal evidence of capacity assessments which reflected on the decision to be made or attempts to facilitate decision making by the adults, utilising

   - reasonable adjustments in communication measures, or
   - timing of dialogue with the adult

   indicates professionals were not operating within the legislative framework.

7. Limitations on capacity assessments was compounded by a lack of understanding, but not consistently challenged, of legal mechanisms by which they could make decisions on behalf of another adult, i.e.

   - Court of Protection appointed Deputy, where the adults lacks mental capacity'
   - Appointed an Attorney (Lasting Power of Attorney), by an individual who has capacity, but only applicable once the donor lacks capacity to make a decision.

   and their responsibilities to make decisions in the Best Interests of the adult without capacity.

Summary of recommendation:

The SAB is asked to seek assurance from partners on how they will address the gaps in application of the MCA identified.

Assessment of care & Effective multi-agency arrangements.

8. Neglect of the needs of the adults emerged as their sole carers experienced their own significant physical and/or mental health challenges,

9. The arrangements where a single individual was providing care to at least one family member was well known to professionals working with these adults and/or the carer. However:

   - there had been times when concerns were raised about the carer's ability to meet the needs of their family member.
   - there was not robust oversight of the stability of the arrangements,
   - sometimes, professionals concentrated their attention on just one person within the care setting, without considering the overall care arrangements or the well-being of other residents.
   - emergence of health conditions for the carer did not trigger consideration of additional support required.

A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Summary of recommendations:

The SAB is asked to seek assurance that:

- an assessment of the needs of the care recipient and carers assessment are routinely offered at the earliest point
- there are effective arrangements for multi-disciplinary/ multi-agency working, which is sustained in circumstances where there are family carers, particularly where:
    - the carer has their own needs,
    - there are questions in respect of ability to meet needs of their family member.

Validity of concerns raised by non-professionals

10. Extended family members did share/ raise concerns about the welfare of the adults, and the carer with professionals working with one or more individuals within the family. Little evidence emerged from the review to indicate that these concerns were routinely recorded or shared onwards with multi-agency partners. Instead, the extended family were left feeling that their concerns were seen as interpersonal conflict. As a result, the concerned individuals felt disempowered to continue raising concerns.

Summary of recommendation:

The SAB is asked to seek assurance that all agencies and professionals respond to concerns raised by family members and members of the public in the same way as concerns raised by professional colleagues.

Provision of choice and hearing the voice of service users.

11. With very few exceptions, the adults subject to this review were not actively heard. With assumptions made about capacity to make decisions, most professionals defaulted to listening to the views of the carers. Even when the adults were known to have some capacity to make a decision, no reasonable adjustments were made to overcome their difficulties in communication.

12. The review report suggests a framework for minimum expectations for practitioners to be working in partnership and providing choice for vulnerable adults, whether they have or lack capacity, to make sure their voice is being heard.

Summary of recommendation:

The SAB is asked to seek assurance that relevant partner agencies have proactive, documented and audited standards to elicit the voice and views of adult with care and support needs throughout their care journey. Reviews of capacity to provide adequate care & continuity / how changes were responded to.