London Borough Richmond Upon Thames

Safeguarding Adults Review: Mr T

Summary

Mr T was a service user receiving care from health and social care agencies in Richmond who died in a fire in December 2015. The SAB requested that the care provided to Mr T was reviewed using the SCIE Learning Together methodology in order to identify if the care provided to him was appropriate, and that the local systems in place were adequate to manage future similar situations. The review was undertaken by independent reviewers working with staff and a local Review Team of senior managers. The Learning Together methodology aims to work with practitioners and managers to look at the situations surrounding decisions and practice at the time of incidents to identify if there are generalizable findings about the health and social care system that can be used to inform local practice and policy; unlike other methodologies it looks at root causes rather than isolated incidents of practice that led to the situation arising. Rather than present the SAB with recommendations the review identifies findings that shed light on what happened and why, and puts to the Board questions they might like to explore in order to reflect on local systems and practice.

Mr T was an independent minded man with full capacity who, as a result of his deteriorating condition was confined to bed. He had MS and was a smoker. Despite interventions from a range of health and social care staff, and being aware of the risks he continued to smoke in bed. He partially accepted proposed mitigations by staff to prevent future fires. Despite these, there were accidental fires in the home on 2 previous occasions prior to his death and on one of these occasions he was hospitalized with burns. Over the course of the 6 months preceding his death (the time period covered by the review) he was well supported by direct care givers and their managers.

The Review Team identified three findings

The Findings

Firstly, that outside safeguarding there are limited opportunities for staff and agencies to formally work together to plan and review cases where service users present ongoing significant risk. In this case Mr T did not fall within any safeguarding criteria until just before his death. By the time the Review too place the agencies had already put a system in place that had oversight of high risk service users who did not fit the safeguarding criteria; there were queries around membership, effectiveness, sustainability and governance within the safeguarding process.

Secondly that Richmond managers have confidence in social care staff's knowledge and expertise to agree to recommendations by them that differ from a process driven and uniform response to needs; rather staff are encouraged to maintain a person-centered approach to care provision and where there is high risk behaviour are able to

continue to monitor service users more closely than would otherwise be the case. Nationally this is thought to be unusual.

Thirdly that when an adult has capacity and chooses high risk behaviours, despite the best efforts of staff, this can leave them feeling personally and professionally responsible when they have limited legal or practical authority to keep the adult safe.

The detail of each Finding and the questions attached to them are outlined below

Finding 1

Outside safeguarding there are limited mechanisms that bring staff together from key agencies to plan and review their work in cases involving high risks, increasing the chances of interventions being less effective.

The complex nature of health and social care support to service users requires a variety of mechanisms to manage risk across agencies, to ensure that the voice of the service user remains central to the risk management planning and to support front line practitioners. Formal safeguarding processes provide this for those cases which meet the safeguarding criteria, but for high risk cases that fall outside safeguarding other options are needed.

The newly established VAMA panel has made a positive start to respond to this issue but feedback suggests it struggles at times with workloads and is also not yet known about across all key agencies.

Finding 2:

In Richmond, a willingness to make management decisions that effectively support professional judgment generates a positive climate in which person centered practice thrives.

Professor Eileen Munro in her Review of Child Protection discussed the implications when priority is given to process over practice. She identified that managerial attention in the services she reviewed had often focused on the adherence to process and performance indicator targets, which limited the ability of practitioners and managers to remain effectively focused on the needs of service users. It is essential that front line practitioners are supported by managers who value their professional judgment. While systemized risk tools offer a useful basis for decision making, the approach taken by social care managers in Richmond ensures that staff are not just reliant on the outcome generated by the system, and where appropriate decision making also draws on the experience and knowledge of practitioners, delivering a more personalised response.

Finding 3:

The tensions that exist when an adult has capacity and continues to choose high risk behaviours can leave practitioners feeling personally and professionally responsible when they have limited legal or practical authority or power to keep the person safe.

It is particularly emotionally demanding for practitioners who work with service users who have mental capacity but continue to make choices that generate risks over long periods of time. Practitioners are needing to balance a mixture of priorities including the legal requirement to support the wishes of the capacitated adults, to support positive risk taking where it is appropriate, but also to do all that they can feasibly do to reduce risks.

There is relatively little guidance currently available nationally in relation to the management of these kind of dilemmas. Over time can potentially they can result in poor practice or emotional burnout if practitioners are not given the kind of supports and systems that help them to manage these cases positively.

Safeguarding Adults Review – Recommendations

1. **FINDING 1 -** Outside safeguarding there are limited mechanisms that bring staff together from key agencies to plan and review their work in cases involving high risks, increasing the chances of interventions being less effective.

Recommendations 1

1.1 Publicise VAMA process further to ensure awareness across the partnership of its role in managing people who self-neglect.

1.2 Ensure that the VAMA panel has all relevant partners represented and in attendance at all meetings

2. **FINDING 2 -** In Richmond a willingness to make management decisions that effectively support professional judgment generates a positive climate in which person centered practice thrives.

Recommendations 2

2.1 Each safeguarding partner organisation to nurture a culture and leadership that empowers and supports front line practitioners to adopt a flexible, person centred approach to adult safeguarding.

2.2 SAB to measure the implementation of person centred practice across safeguarding organisations to check that such good practice is reflected across the partnership.

3. **Finding 3 -** The tensions that exist when an adult has capacity and continues to choose high risk behaviours can leave practitioners feeling personally and professionally responsible when they have limited legal or practical authority or power to keep the person safe.

Recommendations 3

3.1 Ensure positive learning from SAR are widely shared across the partnership

3.2 All partners to ensure that there are adequate support mechanisms in place for front line staff in relation to managing high risk and difficult safeguarding issues.

Lead Reviewers – Mary Burkett and Alison Ridley
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