Cumbria Safeguarding Adults Board

Safeguarding Adult Review – Jessica Learning Briefing

This learning briefing summarises the key learning and recommendations following a Safeguarding Adults Review (SAR) undertaken by Cumbria Safeguarding Adults Board (CSAB). The SAR commissioned by CSAB relates to a 36-year-old white British female with Downs Syndrome who for the purposes of this review we will refer to as Jessica.

A SAR takes place where there is reasonable concern about how the Safeguarding Adults Board or members of it worked together to safeguard the adult, the adult has died, and the SAB knows or suspects the death resulted from abuse or neglect.

This SAR was a joint review process alongside a Domestic Homicide Review (DHR) which combined agency reports and chronologies with a learning event for practitioners who had been directly involved with Jessica. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice. Note; the DHR will be published as a separate report.

It is best practice to invite families to contribute to the review process however, this SAR did not include the views and experiences of Jessica's family as both her parents sadly passed away within a year of Jessica.

Jessica

Jessica was a 36-year-old white British woman with Downs Syndrome. She had a terminal ileostomy[1] after a total colectomy[2] in her mid-teens for complications with inflammatory bowel disease. She had an under active thyroid and on occasions required transfusions due to low iron. Jessica was underweight throughout most of her life and was described as having a restricted diet only eating certain foods with specific eating habits.

Jessica lived at home with her elderly parents, her mother and father were the most important thing to her, especially her mother. Jessica would often mirror her mother's behaviour, if her mother was not well Jessica would "take to her bed". Jessica had a wicked sense of humour; she knew who and what she did and did not like. Jessica was described as often pretending not to be able to do things but whilst in respite care she would do things independently, such as, go into the kitchen to get things out of the fridge and running her own bath, but when Jessica was at home, she insisted that her mother and father did everything for her.

Sadly, Jessica died of multi-organ failure with sepsis and acquired pneumonia following an operation for an obstructed bowel.

[1] An ileostomy is where the small bowel (small intestine) is diverted through an opening in the tummy (abdomen). The opening is known as a stoma.
[2] Colectomy is a surgical procedure to remove all or part of the colon. Colectomy may be necessary to treat or prevent diseases and conditions that affect the colon.

Key learning points

The report made a total of 9 recommendations linked to the following areas identified for development;

Mental Capacity

No Mental Capacity assessments were undertaken during the review period, until Jessica required an operation. This and previous reviews have highlighted difficulties in applying the Mental Capacity Act. This review also suggested a lack of understanding around other processes such as how to check an individual's legal status and when to consider referral to the Court of Protection. Jessica was assumed to have mental capacity in respect of decisions around her health and there were no mental capacity assessments undertaken to establish whether this was or was not the case. Had mental capacity assessments been undertaken this would have confirmed, or otherwise, Jessica's ability to understand, weigh-up, retain and communicate the information relevant to decision to be taken. The undertaking of mental capacity assessments would have supported practitioners to pursue the appropriate and legal pathway to support Jessica whether that be a best interest decision, referral to the Court of Protection, consideration of Inherent Jurisdiction or supporting Jessica's right to make unwise decisions.

Deprivation of Liberty

Practitioners need to be competent in recognising when someone might be deprived of the liberty, how to make an urgent authorisation and refer for a standard authorisation. This is particularly important for both health and social care given the forthcoming Liberty Protection Safeguards.

Advocacy

Jessica had previously engaged well with advocacy but there was no consideration of advocacy services for Jessica, or her parents, during the review period. The review demonstrated that Jessica's voice was not prominent, she was rarely seen or spoken to on her own and therefore practitioners could not be confident of her views and wishes. Jessica had previously engaged well with advocacy services, and this would have been beneficial to her during the period. It may have also aided communication between agencies and individual family members

Working with older parent/carers

When working with older parent carers it is important to develop an awareness and understanding of their lived experience and consider ways to positively engage.
Jessica lived with and was cared for by her older parents, who both had their own health needs and impairments. Some of the agencies involved experienced hostility and obstruction from the parents. The review highlighted the importance of an awareness of the lived experience of parent carers which might aid effective communication and engagement.

Communication

Not all agencies had direct contact with Jessica. However, there was little evidence of any direct communication or adjustment of communication to maximise Jessica's participation.

Reasonable adjustments

This review and others have highlighted the need to make reasonable adjustments for people with learning disabilities, particularly when accessing health services. Reasonable adjustments for carers should also be considered. Overall, the review panel reflected on the lack of professional curiosity with regards to Jessica's engagement in health procedures and reasonable adjustments in response to her learning disability.

Jessica experienced a number of health issues and had struggled to maintain a healthy weight for much of her life. She was supported by a range of services in regard to both her health and social care needs. Health agencies monitored Jessica's hypothyroidism and anaemia as well as monitoring her weight. However, Jessica would often refuse interventions with regards to her health, to the extent that her weight was only successful recorded on two occasions in one year.

It should be noted that the period which has been subject to review must be viewed in the context of the covid-19 pandemic which affected both how services were delivered by practitioners and accessed by users of services. This did reduce the ability of some agencies to have face to face contact with Jessica, despite this those services which could only be delivered in-person continued to be delivered and Jessica was seen regularly given the context of the pandemic and associated lockdown.

CSAB will continue to work with partners to ensure learning and recommendations from the SAR are embedded.

Further learning & resources for frontline practitioners

- **Professional Curiosity resources**
- **MCA learning and resources**
- **CSAB Escalation guidance**
- **DoHSC Care & Support Statutory Guidance (Chapter 14 Safeguarding)**

A SAR Learning Session to share the learning from Jessica will be coordinated by the Learning & Development sub-group in due course.