Learning from a Safeguarding Adults Review

safeguarding adults at risk
a cumbria partnership

This short briefing summarises the key themes and lessons to be learned following a Safeguarding Adults Review (SAR) undertaken by Cumbria Safeguarding Adults Board (CSAB). The SAR commissioned by CSAB relates to a lady referred to as Robyn, a white British female aged 85 years old at the time of her death.

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.

Robyn's story

Robyn was an 85-year-old lady who had repeated involvement with a number of agencies between 2015 and the date of her death in December 2018. This included numerous safeguarding concerns relating to her care. In 2015, Robyn suffered a fall when she sustained a traumatic head injury from which she was not expected to survive. During her hospital stay which followed an artificial feeding tube was inserted and she was later discharged home to the care of her son with whom she lived. At the time of discharge Robyn was in a minimally conscious state. However, Robyn survived at home for a further 3 years.

The review found that the insertion of the artificial feeding tube was not fully supported by all family members. This included conflict of opinion regarding whether a decision should be reached to cease life sustaining treatment in line with what was believed to be Robyn's previously held wishes.

In 2017, North Cumbria CCG pursued a decision relating to this matter at the High Court in London. The High Court ruled in December 2018 that life-sustaining treatment in the form of assisted nutrition and hydration should be stopped. Robyn died peacefully shortly afterwards in a local hospice.

The review highlighted a number of key themes as areas of learning

Theme: Adult Safeguarding

Learning

- When individuals present at Accident & Emergency Units, there should be a system in place to alert clinicians that the individual is or has been, the subject of Safeguarding concerns.
- When individuals present at hospital in Accident & Emergency and there is suspected abuse or neglect, the necessary safeguarding enquiries must take place.
- There should be an effective process to manage repeat safeguarding concerns, which is applied consistently.
- Where there is an accumulation of concerns on an individual that have not led to an enquiry, there should be a process for review of the previous concerns raised.
- Staff understand and are clear about what constitutes abuse or neglect and the process for raising any concerns. This should include suspected injuries post hospital admission.
- Multi-agency guidance is available for staff so they understand their role in safeguarding and the formal route to raise concerns which also promotes formal safeguarding strategy or planning meetings.

Theme: Discharge Planning

Learning

- An effective discharge planning and management process is in place which includes all professionals involved, records of discussions are retained and there is consideration of any risks or safeguarding concerns.

Theme: Advance Decisions

- There is improved awareness and understanding of the process for making Advance Decisions ensuring wishes are clear and comprehensive.
- Advance Decisions are shared (with consent) to ensure that all professionals have access.
- Professionals should obtain a copy of Advance Decisions and where necessary seek support to interpret ensuring that the person's wishes are respected.

Theme: Mental Capacity Act (Best Interests)

Learning

- Professionals understand their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and are clear in what circumstances a Best Interest decision is required.
- Professionals should apply the guidance contained in the MCA Code of Practice, including consideration of who should be consulted and when a meeting is required. Clear and accurate records of the meeting and decision, must be documented and kept on the persons' record.

Theme: Working with Family Carers

Learning

- Practitioners are aware of when it would be appropriate to offer a carers assessment and triggers that should prompt a review.
- Practitioners understand the complexities involved supporting a carer who is resistant to help.

Theme: Resolving Professional Disagreement

Learning

- Practitioners have access to a process for escalating issues when dealing with complex cases with multi-agency involvement and understand how to resolve professional disagreement.

Theme: Coercive Control

Learning

- Practitioners have an understanding of coercive control and domestic abuse including how to recognise this in familial or caring relationships.

Theme: NHS Continuing Health Care (CHC)

Learning

- Assessments under the CHC framework meet quality standards and criteria.
- Professionals should be aware of the need to revisit cases where support needs change and in cases previously assessed as being ineligible.

Learning has been shared with all agencies involved and a robust Action Plan developed to address key themes and learning which will be monitored on a regular basis.

CSAB will develop further mechanisms to disseminate learning for practitioners to raise the profile of lessons learned from this case and other SARs in the system in due course.

For more information visit our **website** where you will find a full copy of the report.