Cumbria Safeguarding Adults Board

Safeguarding Adult Review – Sarah 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 white woman of British heritage who was in her forties when she died from self-neglect referred to as Sarah.

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.

The SAR combined agency reports and chronologies with a learning event for practitioners who had been directly involved with Sarah and her family. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

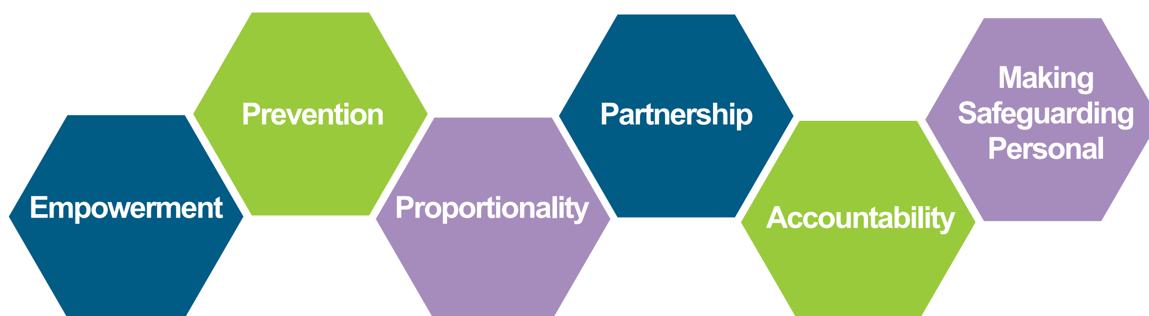
Sarah

Sarah was a white woman of British heritage who was in her forties when she died from self-neglect. Sarah had lived with her father in their Housing Association property. Sarah's father had described her as having undiagnosed mental illness. Sadly, Sarah's father died. Her aunt and uncle were very concerned that Sarah would be unable to care for herself and so approached different agencies to try and get support for her. Police, Housing, Health Services and Adult Social Care were all aware of the concerns about Sarah. Agencies endeavoured to contact her to offer support, but Sarah did not respond or declined services.

Three months after the death of her father, Sarah's body was found at her home. She had died some weeks earlier and the pathologist was unable to determine the cause of death. The coroner recorded the conclusion as self-neglect and issued a report under Regulation 28 to Adult Social Care. After an inquest, the Coroner can write a 'Prevention of Future Death' or 'Regulation 28' report. This happens especially where the Coroner has heard evidence that further avoidable deaths could happen if preventative action is not taken. Regulation 28 reports must be responded to evidence how changes have been made or will be made in response to the Coroner's recommendations.

This SAR explores responses by agencies to Sarah and her father to identify learning for individual and multi-agency safeguarding practice.

The learning from this SAR is structured around the Six Safeguarding Principles



Summary of the key learning points from the review

Learning Point 1
Principle: Prevention
Informal carers can play a crucial role in supporting adults with care and support needs. Carers may not recognise their role as carers and miss out on crucial financial, practical and emotional support. Carers may well have vulnerabilities and complex needs of their own. Agencies need to be proactive in reaching out to carers to support them, and to make advance plans for them and the cared for person, for a future point where they may be unable to continue providing care. There were missed opportunities to recognise and respond to escalating carer stress and to consider risk of domestic abuse.

Learning Point 2:
Principle: Empowerment and Making Safeguarding Personal (MSP)
Empowerment and Making Safeguarding Personal should be the bedrock for Safeguarding Adult practice. However, MSP must not be interpreted simplistically. Practitioners must be assured that adults have sufficient information to make informed decisions. Practitioners must also be vigilant to signals that may call into question an adult's mental capacity to make the relevant decision and take the necessary steps to assess this. MSP encompasses duty of care and even where an adult has capacity, reasonable steps must be taken to respond to identified need, proportionate to presenting risks. Engaging adults who may be resistant to support, needs to be approached through sensitive tenacity, and creativity in reaching out. Agencies must be attuned to hearing concerns from families and carers, demonstrating flexibility in how referrals are made and ensuring families and carers are kept involved and informed of responses to those concerns.

Learning Point 3:
Principle: Protection and Proportionality
There were some good examples of practitioners being vigilant to concerns about Sarah and being proactive in following this up. However, there was also repeated examples where there was a lack of this professional curiosity and an episodic approach to incidents. This SAR reiterates learning from other SARs, about the need for practitioners to be professionally curious: to question and delve deeper to gain understanding of a person's situation, including their needs and risks. Where concerns of 'self-neglect' are raised, this needs to be formally evaluated, including the likely trajectory. Responses must be informed by CSAB self-neglect guidance and relevant legal framework. Professional leadership and supervision is essential to support evidence based practice and defensible decision making. A recurrent message from SARs is that lack of engagement does not equate to lack of risk.

Learning Point 4:
Principle: Partnerships
Multi-agency working at the earliest stage is essential in addressing concerns of self-neglect. It brings together information, gives greater breadth to professional expertise and leads to a shared assessment of need and risks. Importantly, it should facilitate a well-coordinated plan, with an identified lead to ensure ongoing communication and review. Multi-agency forums can be highly effective in responding to self-neglect, where a Safeguarding Adult Enquiry is not yet required. However, the forums need to demonstrate safeguarding minded practice and attendees need to be adequately equipped to make effective responses to concerns of self-neglect. The absence of effective multi-agency working meant that no agency took responsibility, and no-one followed up Sarah.

Learning Point 5:
Principle: Accountability
The lessons highlighted within this review, reflect learning themes from other reviews. Systems need to support practitioners in working with self-neglect and resistance to engagement. Practitioners need time to be able to evaluate, to be professionally curious and take the additional measures needed. The restructuring of the County Council offers an opportunity to revisit the point of access to Adult Social Care to ensure it provides an open door, an appropriately skilled workforce and is supported by resilient systems

These sad circumstances were not unique to Sarah. The review reinforces (but does not repeat) the recommendations already made in a previous SAR Pauline & George, and recognises steps taken to improve services since Sarah's death. Work continues across the partnership to embed the learning from Pauline & George, this SAR makes 2 further recommendations for action:

Recommendation 1
Review of Adult Social Care Single Point of Access
Cumbria County Council should carry out a root and branch review of their Adult Social Care Single Point of Access. The review should assure the service has workforce capacity, skills, leadership and support systems to deliver an effective service. The review should benchmark against quality standards, taking account of learning from this SAR and from 'Pauline and George' SAR, along with consulting with services user's and partners, when establishing those standards.

Recommendation 2
Development and Assurance of Multi-agency Forums
Cumbria Safeguarding Adult Board should establish a task and finish group drawn from SAB member agencies, aimed at strengthening multi-agency responses below the threshold of a Safeguarding Adult Enquiry. The work should include: i) Leading a mapping exercise of multi-agency forums that may be used to support early intervention where lower level or emerging concerns of self-neglect may be discussed. ii) Generate guidance that: Provides a route map to accessing those forums and Reinforces key principles when working with self-neglect, (including professional accountability and collaborative multi-agency working at the earliest stage) iii) The task and finish group should lead targeted work with those forums to ensure they are equipped to make effective responses to self-neglect. This includes setting out expected standards e.g. maximising involvement (Making Safeguarding Personal); gathering information; dynamic assessment; appointing a lead; clear response plan, contingency planning and review, along with recognising where escalation through Safeguarding Adult procedures is merited. CSAB will continue to work with partners to ensure learning and recommendations from the SAR are embedded.

Further learning & resources for frontline practitioners

- **CSAB Self-neglect guidance & Hoarding Framework & Toolkit**
- Learning from Pauline & George; You can read the **Learning Brief** and watch the **Learning Session**
- **Professional Curiosity resources**
- **MCA learning and resources**
- **CSAB Escalation guidance**

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