Cumbria Safeguarding Adults Board

Safeguarding Adult Review – Miss B
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 43-year-old British white woman who for the purposes of this review we will refer to as Miss B. Miss B's sad death was unexpected and there were concerns about how agencies worked together to protect Miss B from self-neglect.

Specifically, Miss B was known not to adhere to her medication plan, including the administration of insulin. The information presented in the SAR referral indicated that agencies could have worked together more effectively to prevent harm resulting from the self-neglect occurring.
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 combined agency reports and chronologies with a learning event for practitioners who had been directly involved with Miss B. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

Miss B

Miss B lived with her partner and their young son. Miss B was diagnosed with a mild learning disability and also suffered from Diabetes. Miss B was supported by a number of professionals and services with additional support from her partner and her mother.

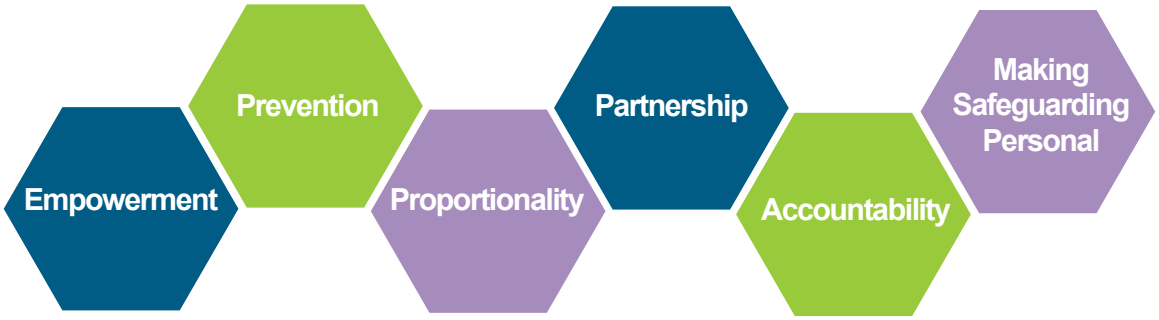
Practitioners who worked with Miss B described her as an endearing, warm and friendly person and a brilliant mother. Family was extremely important to Miss B who enjoyed being at home with her family. Miss B loved to chat with professionals she trusted and was interested in hearing about their lives. However, Miss B did have some verbal communication difficulties which she could be self-conscious of. In addition, it was known that Miss B was also self-conscious of the specialist footwear she was prescribed.

Miss B was described as 'knowing what she wanted' and could be quite determined which was described as a positive feature by the professionals who worked with her.

Miss B had a history of disengaging from services and treatment plans that were provided to maintain her physical health. On many occasions throughout the period of the review, consideration was given to Miss B's capacity to understand the reasons for her treatment and the consequences of not adhering to it and this was discussed between professionals. The context in which Miss B's capacity was considered was in respect of her non-adherence to her oral medication regime, lack of self-administration of Insulin and interference with her foot dressings.

Practitioners working who knew Miss B well had regularly expressed concern about the risks during periods when it was believed she was not taking her medication effectively and her lack of adherence to her treatment plan as self-neglect.

The review identifies opportunities for learning across the system linked to the Six Principles which underpin all Safeguarding Adults work:



Empowerment
Many of the professionals involved with supporting Miss B knew her well including what was important to her. Despite this, there appears to have been a missed opportunity to utilise this knowledge and a determination to deliver support in the way that the professionals believed it should be delivered.

Prevention
Unlike many scenarios involving self-neglect, Miss B was in regular and frequent contact with services. Although described as someone who would 'disengage', information submitted to the review highlighted many opportunities when Miss B actively sought the support or advice of professionals. Practitioners were concerned about Miss B's non-adherence to treatment plans, however there is little evidence to suggest that a flexible collaborative approach was developed to engage with Miss B.

Proportionality
The professionals involved believed they were working in a proportionate way and were in their view respecting Miss B's legal right to make 'unwise' decisions. However, given the significance of the recognised risk to Miss B, the reviewer suggested that this approach was misguided and a more proactive response to safeguard Miss B could have been considered.

Protection
Opportunities were identified for some services working with Miss B to improve their legal literacy in relation to Safeguarding Adults to ensure that the support of other partners is sought in a timely way which could have protected Miss B from the anticipated harm resulting from the self-neglect. Learning was identified in relation to mental capacity. There was clear evidence that professionals believed that Miss B had capacity in respect of the management of her health needs and therefore felt that they could not challenge or intervene. However, irrespective of whether Miss B had the mental capacity to make decisions in respect of adhering to her treatment plan or whether the s.42 safeguarding duties applied, Safeguarding is not a substitute for providers' responsibilities to provide safe, high- quality care and support. It appears that there was professional over-reliance on the capacity assessment, and this had an impact on what care they felt could or should be delivered. The reviewer also noted limited flexibility in the approach to care delivery.

Partnership
There was clear evidence of regular liaison between individual professionals who knew Miss B well. The professionals involved understood each other's' roles and predominantly shared the same views and perceptions with regard to the extent of and limitations to, the way Miss B should be supported. However, the approach adopted did not prove successful in achieving the desired outcomes and there was a missed opportunity to explore views, perceptions or an alternative approach with a wider multi-agency group. The formal raising of a Safeguarding Concern with the Local Authority may have provided this opportunity. In addition, engaging a wider group of professionals via a referral to the Integrated Care Community (ICC) complex case and multi-disciplinary meetings, may also have resulted in a more comprehensive risk management or health and care support plan for Miss B.

Accountability
The findings in this review identify areas for learning and improvement with respect to working in a person-centred way which could have explored how Miss B would have wanted to be supported. This in turn would have required professionals to be accountable to Miss B in exploring whether this could be achieved. The formulation of a multi-agency risk or case management plan could have resulted in clearly identified roles, responsibilities and action owners. Wider inter-agency involvement via the ICC would create the opportunity for professional challenge and scrutiny where normalisation of behaviours or unconscious bias or misconceptions may be present.

The review made a number of recommendations:

Recommendation 1
The Integrated Care Communities (ICC's) should consider including a structured risk management approach in their complex case meetings when significant risk of harm is identified. To include the identification of each specific risk, its likelihood, potential impact and what mitigating actions can be deployed and by whom. The risk management document should be shared across all organisations involved and timescales for review agreed.

Recommendation 2
Cumbria Safeguarding Adults Board should seek assurance across the system in respect of professional's legal literacy in respect of Safeguarding Adults. Professionals need to be fully conversant with the Care Act 2015 statutory guidance relating to Safeguarding Adults.

Recommendation 3
Cumbria Safeguarding Adults Board should support the organisations represented in this review to undertake a Reflective Practice event to focus on the learning from this review with a specific focus on considering the use of language and the impact of professional bias. Critically evaluate their responses to meeting individual needs which may require a flexible approach.

Recommendation 4
Cumbria Safeguarding Adults Board should develop a briefing in respect of the role and expectations of informal carers. This should include an outline of statutory duties towards carers and support an approach whereby informal carers views are sought and valued.

Recommendation 5
Cumbria Safeguarding Adults Board should support the partnership to improve their knowledge and understanding of trauma informed care and how it can strengthen a person-centred response to Adult Safeguarding.

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**
- **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 Miss B will be coordinated by the Learning & Development sub-group in due course.