Cumbria Safeguarding Adults Board

Learning from a Safeguarding Adults Review

This learning report briefly 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 gentleman referred to as Mr X.

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 Safeguarding Adult Board knows or suspects the death resulted from abuse or neglect.

The methodology adopted for this SAR produced learning identified through a SAR in Rapid Time which is primarily concerned with 'systems findings'. This methodology recognises the complex circumstances in which practitioners work together to safeguard adults; seeks to evaluate practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight; providing systems findings that help to understand the social and organisational factors that impact on work beyond a single case. The methodology uses standardised processes and templates to support analysis and to identify systems findings in a timely manner.

Background

Mr X was a white British male aged 93 years at the time of his death. He was admitted to hospital in August 2018 for further medical tests after he became unwell.

Within the first week of Mr X's hospital stay his family raised concerns with staff that he had blood around his mouth and a problem with his front teeth. Mr X was unable to tell his family what had happened and they assumed that he had fallen. The discussion was recorded in medical notes and a ward manager agreed to investigate further as there were no reported falls. However, this matter was not investigated. Family visited Mr X two days later, when he appeared to be upset and declined to share what happened only to say, "it doesn't matter, there were no witnesses". Family members raised their concerns with medical staff on the hospital ward and also shared this information with the Community Psychiatric Nurse.

Mr X's stay in hospital continued for a number of weeks during which time he disclosed to a number of medical professionals that a carer on the ward had been cruel to him. The alleged abuse was reported verbally to ward staff and noted in medical notes, however, no safeguarding concerns was formally reported.

During a Best Interests meeting three weeks later, Mr X disclosed to professionals and relatives in attendance that there was "a man on the ward who is cruel" and also disclosed that he had been subject to sexually inappropriate personal care. Professionals agreed to take these concerns forward however, there was a lack of ownership of the actions, and this resulted in the safeguarding concern not being reported appropriately or in a timely way.

There was also confusion as to the purpose of the Best Interest meeting with some professionals understanding this was a Discharge Planning meeting.

Mr X's allegation was later escalated to the Police and Adult Social Care and a formal police investigation commenced, however safeguarding procedures were delayed to allow the police investigations and HR procedures to progress.

Mr X was discharged just over two weeks later to a local care home where he died the following year.

Systems Learning

The review highlighted the following "systems findings" for action;

1. There was a lack of clarity in procedure and practice when managing parallel safeguarding adults' enquiries, police investigations and human resource procedures.

Decisions were taken not to progress safeguarding enquiries due to "parallel" processes taking place in the form of HR procedures and a Police investigation.

Actions

- Cumbria Safeguarding Adults Board (CSAB) will use the learning from this SAR to review our People in Position of Trust guidance and ensure it provides the necessary clarity when managing parallel review processes.
- The guidance will define the roles and responsibilities to manage processes in a timely way ensuring the adult at risk is safeguarded.
- Cumbria Safeguarding Adults Board have published **Safeguarding Procedures** which clarify that s42 enquiries should continue in parallel to police investigations. The Procedures acknowledge that any police investigation may take some time and other organisations also have a duty to act. In these circumstances, agreement must be reached at the Strategy stage about what actions can be taken and when.

2. Frontline staff are not familiar with the multi-agency guidance, Responding to Positions of Trust Concerns.

Front line professionals were not aware of the process or multi-agency guidance for reporting concerns relating to a Person in Position of Trust.

Actions

- CSAB with the support of our partners will ensure that refreshed guidance is implemented across partner organisations and ensure front line staff have an awareness of how and when to access. This will be further disseminated through virtual learning sessions to share the learning from the SAR.
- Staff and managers have an awareness of the new multi-agency guidance and understanding of when they should refer to it including, the role they play when responding to concerns relating to people in a position of trust. Through the learning sessions staff and managers will also understand the learning from this SAR.

3. Staff did not use the systems and procedures in place for responding, recording, and escalating safeguarding adults' concerns.

The review found that professionals receiving concerns did not fulfil their professional responsibilities in respect of safeguarding concerns, reporting, and investigating these.

Actions

- CSAB will seek assurance from partner agencies that safeguarding training at all levels provides staff with an understanding of the procedures in place for reporting safeguarding concerns.
- Partner agencies will ensure that organisational safeguarding policies and procedures align with CSAB multi-agency guidance.
- Adult Social Care now have a dedicated safeguarding team who are skilled and experienced when dealing with safeguarding concerns. Staff can access advice relating to safeguarding through a dedicated email address.
- Partner agencies have strengthened internal safeguarding teams so staff can access professional advice in relation to concerns of abuse or neglect.

Practice Learning

The review highlighted the following “practice findings” for action;

1. Making Safeguarding Personal for Adults and their representatives
Family members were unaware of the outcome of relevant investigations undertaken in this case. The Making Safeguarding Personal toolkit would have supported keeping Mr X at the centre of the enquiry and provided family with an outcome. **Actions** • In line with CSAB Business Plan 2021/22, the Board will review and relaunch MSP practice guidance and the MSP toolkit to ensure this is applied and that adult and families are kept up to date in relation to investigations/ enquiries. • CSAB will build MSP into annual partner assurance areas presented to the Performance & Quality Assurance sub-group to establish how partners apply principles of MSP before, during and after a safeguarding enquiry. • CSAB will continue to monitor the MSP data (qualitative) captured following a safeguarding enquiry at the point of closure. Through our partner assurance process, we will receive case studies as experiential feedback (qualitative).

2. Agency Record Keeping
The quality and accuracy of record keeping completed by professionals involved in the review did not met expected standards. **Actions** • Through a quality sample check of Best Interest meetings CSAB will ensure that meetings are accurately recorded and fully documented. We will also seek assurance from partner agencies regarding internal “quality” audits of records in relation to the quality and standards of record keeping.