Suffolk Safeguarding Partnership

Safeguarding Adults

Thematic Review

Condensed Overview Report

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Contents

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1. Introduction

1.1 The purpose of a Safeguarding Adult Review (SAR) is to establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults, to review the effectiveness of procedures (both multi-agency and those of individual organisations) and to inform and improve local inter-agency practice by acting on learning.

1.2 Five referrals were made to Suffolk's Safeguarding Adult Review Panel (SARP) which did not meet the criteria for a Safeguarding Adult Review but still showed there could be significant learning that could be obtained from reviewing their cases. Taken individually, these would be operational and case-specific learning. Clustered together and reviewed against cases which have previously been reviewed, there is an opportunity to identify system learning that would have a more meaningful impact on the people of Suffolk.

2. Scope of Review

2.1. Based on the background outlined above the following objectives were set for this review to achieve:

1) To identify the common thematic issues arising from the referrals
2) To consider what professional involvement occurred immediately prior to the incident occurring
3) To identify proposed next steps on the cases being analysed
4) To ensure that all content and recommendations align with key Partnership publications
5) To consider these referrals against the recommendations arising from the National SAR Analysis
6) To review the submitted cases taking account of recommendations and actions made in previous reviews
7) To make recommendations on how a systemic approach to action planning could be created
8) To consider best practice for family involvement as part of future thematic reviews

3. Summary of Cases

3.1. As this Thematic Review of cases was undertaken by desktop analysis with the aim of pulling out wider system learning, the families or individuals concerned where still alive, were not involved. Therefore, person profiles and details of the issues will not be shared in full in this report.

3.2. Below is a summary of the five common issues across the cases reviewed:

Neglect (domestic and professional)

Suicide, suicide ideation, and self-harm

Self-neglect

Hoarding

Domestic abuse

4. Thematic learning

4.1. In 2020, the SSP undertook an analysis of learning from reviews across the partnership from 2010 to 2019 from a wider perspective, to support the thematic review of future cases, gather intelligence on commonalities in reviews and make informed recommendations about improving practice within the SSP and partner organisations. Nine Partnership Reviews

and three Safeguarding Adults Reviews were carried out over the period of this report, with very clear common themes arising. The three SARs from 2010 to 2015 all focussed on neglect. Of the nine Partnership reviews carried out from 2016-2019, six included themes of self-neglect, three included neglect and acts of omission and two included abuse.

4.2. The prevalence of SSP's reviews focussing on self-neglect and neglect is mirrored by the Analysis of Safeguarding Adult Reviews commissioned by the LGA and ADASS[1] (the National SAR Analysis). This evidenced that self-neglect was a feature of 45% of SARs nationally and 53% in the East of England. Neglect/omission was a feature in 41% of national cases and domestic abuse in 18%.

4.3. SSP's analysis of learning from reviews across the partnership from 2010 to 2019 identified the following key learning points:

1. The need for better information sharing across agencies and the development of information sharing protocols
2. To review procedures (agency or SSP) and put new systems in place where required
3. Refresh/relaunch strategies/policies and ensure professionals are following them
4. The development of training programmes around a concern or to review and improve existing training programmes on key areas of practice.
5. Ensure escalation procedures are in place and are known and understood by professionals and remind professionals and agencies of guidance/expectations.
6. Improved communication between agencies.
7. The need for professionals to be continually curious and inquisitive about the lived experiences of people and to always consider the question "what is life like for this person"

4.4. These SARs and Partnership Reviews within Suffolk have considered similar complex safeguarding issues, in particular self-neglect and mental capacity, and there are many parallels with the cases subject of this review. These mirror the common issues in thematic reviews by other SABs and the evidence base from the national SAR analysis.

4.5. Following desktop review of the cases for this review, five thematic areas for learning were identified. See below for further details.

Self-neglect

4.6. Despite good governance structures in Suffolk, self-neglect and hoarding continues to present a very serious challenge for practitioners, and was a serious risk for two of the five cases reviewed. Interventions for these cases were sporadic, relationships that were built were disrupted and without doubt affected by the pandemic and resulting lockdown. This mirrors concern raised in the 2019 SAR on Mr B,[2] which commented on the loss of momentum over the period of intervention.

[1] Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk)

[2] 2019-03-13-Mr-B-Executive-Summary.pdf (suffolksp.org.uk)

Mental Capacity

4.7. The concepts of self-neglect and mental capacity, in particular executive capacity, are inextricably linked and the majority of cases reviewed in the National Self-neglect Analysis identified this as one of their themes (p83). Linked to this were criticisms of the quality of mental capacity assessments. Repeated SARs nationally[3] have identified that practitioners must demonstrate skill and competence in applying principles of the Mental Capacity Act 2005, including identifying when an individual makes an unwise decision, as opposed to being incapable of making a specific decision, or to execute the decisions they have made. Importantly, practitioners require access to expert legal advice to explore all options to mitigate the risks.

4.8. In only one of the five cases reviewed was there evidence of a Mental Capacity Assessment being undertaken, and it did not result in a Best Interest Decision, even though the person was found to be lacking capacity in decisions that were affecting their physical health and subsequently resulted in a life changing injury.

The journey and lived experience of the person at risk

4.9. Two cases showed lack of communication and information sharing as individuals transferred between services, most specifically within health settings to keep the individual safe. This then led to a lack of coherent care plans to ensure their wellbeing when returning home, and left some family members distressed and without support.

4.10. This reflects one of the concerns identified in the 2015 SAR on Mr AA,[4] where information in respect of the reason for his physical restraints was not shared on admission to hospital, leading professionals to assume that he posed a risk to others. A recommendation from this review was for the Partnership "*to challenge, improve and promote a shared agreement and mechanisms (eg health passport) to ensure improved communication and information sharing within and across agencies so that information is accurate, timely and well informed, to ensure a person's safety and wellbeing. This to specifically include that a person's relevant history follows them through their passage of care so that each professional or clinician has the correct information to make informed decisions critical to their wellbeing.*"

Risk assessment

4.11. In one of the cases, even though the persons squalid living conditions were causing them high levels of harm, no self-neglect risk assessment was carried out.

4.12. In another of the cases, three self-neglect risk assessments were carried out, but there was little evidence that it resulted in significant change.

4.13. In the third case, there is no indication that a pressure ulcer risk assessment was completed, even though the person had a nutritional deficiency, one of the key risk factors in NICE guidelines.

4.14. In the fourth case, the person sustained a life changing injury after being discharged from services, but had health conditions that should have highlighted a number of risk factors prior to their discharge.

4.15. Three of the five cases showed suicide ideation, and two went on to take their own life, with the third persons cause of death undetermined due to the advance state of decomposition when found. An important part of effective mental health care is the assessment of risk and development of crisis and contingency plans that seek to understand signs and symptoms of

[3] Eg London Borough of Newham A Thematic Safeguarding Adults Review

[4] Safeguarding-Adult-Review-Mr-AA.pdf (suffolksp.org.uk)

relapse, and to predict and prevent relapse and personal crisis. In accordance with NICE guidelines[5], suicidal concerns need to be responded to, not with a risk assessment that distinguishes based on method and a statement of intent, but a comprehensive and immediate psychosocial assessment and engagement in a therapeutic relationship. This should then facilitate development of a care plan to prevent the escalation of self-harm and risk management plan to include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail.

Family and carer involvement

4.16. A theme running through the cases under review is the lack of focus by practitioners in the role of family and informal carers - either as a support system or a risk factor - during assessments and safety planning.

4.17. In one case, concerns were raised by a volunteers' service and care agency staff, both organisations demonstrating good safeguarding practice. However, these were not progressed as safeguarding referrals, despite the serious issues they raised.

4.18. In two cases, the immediate family were not consulted with to prepare return to home care plans or identify and eliminate further risk.

4.19. It is not recorded in the information provided whether carers' assessments were offered.

5. Recommendations and next steps

Learning theme	Recommendation(s)	Work already in place / next steps
Self-neglect Risk assessing	1. SSP to audit how risk assessments have been applied in a selection of cases as part of its Multi-Agency Audit Programme to get a wider understanding of how risk assessments are being used, and if subsequent interventions provided have resulted in positive or negative change for the person. 2. SSP to use the findings from risk assessments and subsequent services in this review, to help inform the 'Waits' Audit.	1. Build in to 2022-23 audit schedule. 2. Feed in to 'Waits' Audit through the Learning and Improvement Group.

[5] Overview | Self-harm in over 8s: long-term management | Guidance | NICE

Mental capacity	The SSP to have a focus on building professional development in understanding and application of the MCA.	ACS practitioner drop-in sessions to be opened up to multi-agency staff.
The journey and lived experience of the person at risk	1. Promoting adequate and effective information sharing between agencies to improve outcomes for people and mitigate risk. 2. Have a focus within the SSP on family/carer engagement, and proactively promoting that. 3. SSP to use the findings from this review in respect of personal journeys to help inform the 'Waits' Audit.	1. Podcast recording with stat partners on effective information sharing (links to May Miller's case). 1. Feed the findings from this Review into the Alliance work. 2. Build in to 2022-23 SSP priorities and workplan. 3. Feed in to 'Waits' Audit through the Learning and Improvement Group.
Family and carer involvement	1. The Partnership should produce a leaflet for carers who wish to take over responsibility for all care of a family member or terminate professional services, providing information about who to contact and how to obtain additional support if they are struggling to provide proper care. 2. SSP to use the findings from this review in respect of personal journeys to help inform the 'Waits' Audit.	1. SSP to produce as part of 2022 comms programme. 2. Feed in to 'Waits' Audit through the Learning and Improvement Group.

6. Glossary

ACS	Adult Community Services within Suffolk County Council
CCG	NHS Clinical Commissioning Group
GP	General Practitioner
MASH	Multi-Agency Safeguarding Hub – central point through which all safeguarding referrals are made
NICE	The National Institute for Health and Care Excellence
NSFT	Norfolk and Suffolk Foundation Trust
SCC	Suffolk County Council
SCIE	Social Care Institute for Excellence
SSP	Suffolk Safeguarding Partnership

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