Bath & North East Somerset
Community Safety and
Safeguarding Partnership
BCSSP

B&NES Safeguarding Adult Review Practitioner Briefing – 'ELLEY'

WHAT IS A SAFEGUARDING ADULT REVIEW (SAR)?

Under the Care Act 2014, the Safeguarding Adults Board has a legal duty to review any case in which:

- An adult with care and support needs has died (or sustained serious injury)
- As a result of abuse or neglect (including self-neglect)
- Where there is cause for concern about how agencies worked together to safeguard the individual

The purpose is to identify lessons learnt so that these can be applied in future safeguarding work.

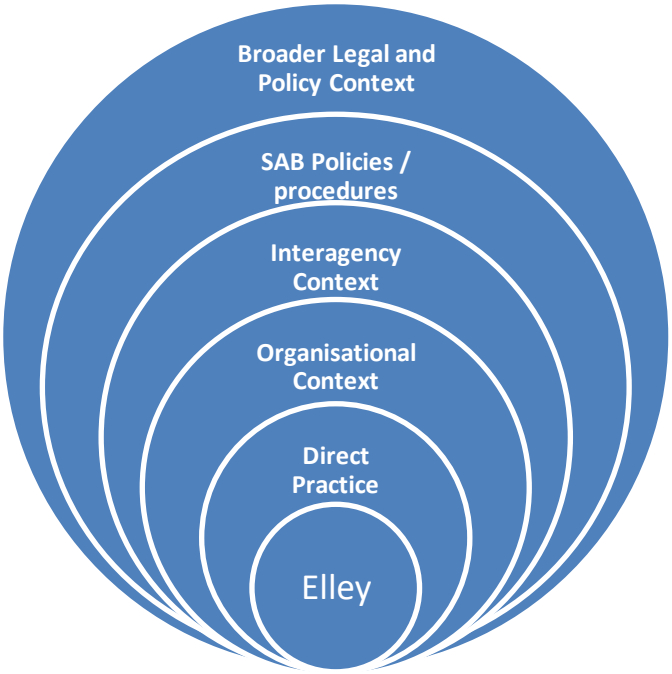
The full report can be found on the B&NES safeguarding website https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/6-safeguarding-adult-reviews alongside the Board's Response and information from the LSAB Stakeholder Event on Self-Neglect.

THE SAFEGUARDING ADULTS REVIEW

The Review Panel received written information from all agencies involved with Elley between the 1st September 2017 and the 30th September 2018**,** her death was on 26th September 2018. In addition practitioners who had known and worked with Elley attended a 'learning event' to contribute their perspectives and ensure that the review was informed by those closest to practice.

Elley's family carer contributed their account of events and thoughts as to how they and Elley were supported to the SAR Lead Reviewer, both verbally and in writing. The family carer received and commented on the draft SAR overview Report and suggested amendments and recommendations which have been accepted by the LSAB.

The Panel's analysis sought to identify not only what happened but also why: to focus on the organisational, interagency and broader contexts that influence practice.



ELLEY – A PEN PICTURE

Elley was a 93 year old woman. The cause of her death was given as a sepsis of unknown cause together with the 'frailty of old age', dementia, and heart disease. Elley had lived in her home in the B&NES area for over 60 years and following the death of her husband, she had lived there alone for almost 20 years. She described the house as holding a lot of her memories. Elley had one son who lived abroad but returned to visit his mother on regular occasions.

Elley is described as a gregarious person who enjoyed gardening, music and travelling. She drove her car until she was 90 and was often the person who organised and gave lifts to friends. Elley's family feel that her 90th year was a turning point for her as her confidence began to decline and she started to experience problems with her mobility. Elley described herself to her son as being isolated and cut off; as she no longer went out she had little contact with her friends.

Elley was in receipt of support from a domiciliary care agency (which she funded), a befriender and the District Nursing Service. Elley's health and care needs were regularly reviewed and discussed at the GP surgery's multi-disciplinary meeting. There were concerns about Elley's ability to manage at home and her apparent reluctance to accept care from the carers or consider increasing the number of calls she had from the domiciliary care agency per day.

Elley's son lived with her for a number of months prior to her death. He provided care to his mother outside of the support provided by agencies. Those working with Elley did talk to him about increasing the level of domiciliary care support his mother was receiving but the support was not increased. The professionals working with Elley had their views about why this was but they did not explore this further with Elley or her son, nor did they consider the legal avenues that may be available to them.

A safeguarding concern was raised regarding Elley; however the focus of the S42 enquiry did not focus on the practical actions to support Elley and her son now, such as a care act assessment, instead the enquiry focused on investigating the events that had taken place prior to the safeguarding referral.

What we learnt / what we need to do differently

Providing advice and support

The health professionals supporting Elley were concerned about her self-neglecting, particularly in regard to her personal care. They did talk to her and her son about increasing her level of care but were not clear what action to take when the care was not increased.

Elley's son was not familiar with the social care system and was not aware of the support that would be available to his mother. He was also not aware of the support available to him as an informal carer.

Elley and her son appeared to have been provided with incorrect information regarding the social care charging arrangements. Elley's son said that he had been informed that his mother's home would be viewed as an asset by social care even for domiciliary care and therefore neither she nor her son wanted social care involvement.

Elley was not referred for a social care assessment prior to the safeguarding referral being made, despite the concerns health professionals had regarding her personal care.

Elley's son was not referred to the Carers centre or to social care for a Carer's assessment.

Learning for Practice

It is important that all practitioners are aware of how to access the public information available regarding social care support and that they provide this information to those that they are working with.

It is important that all health and social care staff are aware of the Carer's Centre and how people can contact them.

District Nurses and Community Matron's should ensure that they have a basic understanding of the social care charging system.

Social care staff should remind themselves of the right every person has to a social care assessment - regardless of their financial status or the fact that they had an assessment in the past.

A lead professional should be identified to work with the person and their family when there are concerns regarding the person or their care and support.

Mental Capacity

Elley had been assessed a year before the safeguarding concern was raised by a health professional. This concluded that she did have capacity to make decisions regarding her care and support. However, Elley was subsequently referred to by some agencies as 'not having capacity'. This was apparently a recording error.

There was no further formal consideration of capacity prior to Elley's death, despite health and social care professionals recording a few weeks prior to her death that she did not have capacity to make decisions.

Elley's son stated that he had Power of Attorney for his mother. Professionals did not request to see a copy of the paperwork nor did they confirm with Elley's son which areas of decision making he understood he had the authority to act on.

Learning for Practice

All capacity assessments should be decision and time specific. Professionals should not rely on an assessment undertaken some time ago and in relation to a different decision.

Professionals should refer to the completed MCA paperwork when discussing the outcome of an assessment to ensure that the information they are recording is accurate.

Before a Power of Attorney is acted on by a health or social care professional, a copy of the paperwork should be viewed by the professional and the nature and extent of the power noted in the person's records.

All health and social care professionals should be aware of the role and responsibilities of the Office of the Public Guardian. This should include how to raise a concern regarding a power of attorney and how to confirm if a power of attorney has been registered.

Safeguarding

When agencies attending the MDT became concerned about the impact of inadequate personal care on Elley's declining health circumstances a referral was made to Adult Safeguarding. At the Review Learning Event participants from health agencies had a limited understanding of what Adult Safeguarding is, they did not recognise the idea of a local authority 'duty' or the criteria used in enacting that duty. Agencies described Adult Safeguarding as an 'investigative process' which they needed to submit 'evidence' to in order to elicit a response.

The information provided on the safeguarding concern detailed issues that the MDT had been concerned about over a period of 18 months – many of which had been resolved by the health and social care professionals working with Elley.

The safeguarding response did not include a request for a care act assessment for Elley or a carer's assessment for her son. Undertaking these assessments may have clarified Elley's needs and her decision making.

There was no record of a discussion with Elley or her son regarding the safeguarding concerns identified by professionals. As the concerns involved them both it would have been expected that both the referrer and the safeguarding worker would have discussed the matter with them in order to obtain their views on the issues raised.

Learning for Practice

Any professional making or receiving a safeguarding referral involving concerns that cover an extended period of time, should ask: Why is this referral being made now? What has changed in this situation? Have the risks increased and if so how? What steps have already been taken and what was the outcome?

Health organisations should ensure that their staff have undertaken both initial and regular "update" training on adult safeguarding. Staff should also be aware of who the safeguarding lead is in their organisation so that they can draw on their expertise.

Social care assessments and carer's assessments should be considered as part of the planning process for every S42 safeguarding enquiry.

All professionals should discuss their safeguarding concerns with the person and their carer, unless it is not safe to do so. This will provide the opportunity to obtain the person's views and wishes.

FEEDBACK, SUGGESTIONS AND IDEAS

- Tell the B&NES Community Safety and Safeguarding Partnership (BCSSP) how you have used this briefing in your team by Email : Kirstie_webb@bathnes.gov.uk
- Please also let us know if you identify work that could be completed by the BCSSP which would support multi-agency professionals to implement the report's findings.
- If you have any questions about the Briefing, or the BCSSP actions, please contact the Business Manager Kirstie_webb@bathnes.gov.uk
- www.safeguarding-bathnes.org.uk