Cheshire West and Chester Local Safeguarding Adults Board

Mary

Safeguarding Adult Review

Executive Summary

Section 1: The review process

1.1 Under the *Care Act* 2014, sections 44 (1-3), Safeguarding Adults Boards must carry out a Safeguarding Adults Review when an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse (including self-neglect) and there is concern about how agencies worked together to protect the adult. The Safeguarding Adults Board may also (section 44(4)) undertake a SAR in any other case concerning an adult with care and support needs. The purpose of all reviews is to identify learning that can drive change to prevent harm occurring in future similar circumstances.

In December 2022, Mary was referred to the Cheshire West and Chester Safeguarding Adults Board (the Board) for consideration for a Safeguarding Adults Review, due to concerns about the quality of care provided to Mary in the community and to support her discharges from hospital. It was agreed that the criteria for a statutory Safeguarding Adults Review had been met and a recommendation was made to the Board's Independent Chair that a Safeguarding Adult Review be undertaken in accordance with the multi-agency Safeguarding Adults Review Procedure.

An independent author, Mr Pete Morgan, was commissioned to undertake the review on behalf of the Board.

1.2 The agencies that contributed to this review are as follows:

ORGANISATION	ROLE
NHS Acute Hospital Trust	Head of Safeguarding
NHS Mental Health Trust	Head of Safeguarding
Local Authority	Senior Manager for Adult Safeguarding, Practice Manager and Social Worker from Adult Social Care Hospital Team, Practice Manager and Social Worker from Adult Social Care Home Assessment Team.
Cheshire West & Chester Local Safeguarding Adults Board	Board Manager
Police	Serious Case Review Officer
NHS Integrated Care Board	Designated Nurse for Adult Safeguarding
Ambulance Service	Designated Safeguarding Lead

1.3 The key issues that the review looked at were as follows:

- The impact of the Covid-19 Pandemic and the resulting lockdowns on Mary and her family, and on the staff working with them.
- Hospital Discharge Planning.
- Professionals' use and application of the *Mental Capacity Act* 2005.
- How well did agencies work together to safeguard Mary?
- Good Practice

Section 2: Agency contact and learning from this review

Mary was born in July 1940. Mary was aged eighty-one and living at a Care Home at the time of her final hospital admission.

Mary was the eldest of six siblings, none of whom lived locally. She had not been in frequent or regular contact with them for a number of years. She had lived in a rented first floor flat, which had been the family home, until 2017 when she moved to Extra Care Scheme after being admitted to hospital after a fall.

Mary was widowed in 2004, by which time her son had left home. Mary is described as having been very dependent on her husband and became more isolated and resistant to offers of help and change after his death.

While arranging her move to the care home, Mary's son, David discovered that Mary was not registered with a GP, having not seen a doctor for some years. Her placement at the care home, including support and cleaning services, was funded from Mary's savings and benefits.

In July 2021, Mary was admitted to hospital after another fall. Mary was discharged home in September but readmitted to hospital the same day before being discharged back home again in October 2021. In January 2022 Mary was admitted to hospital again after sustained concerns about self-neglect. Mary had not been eating or drinking enough, had been refusing to take medication and had not been engaging with services over the past year.

Mary was discharged home in early February but was readmitted to hospital within a week due to dehydration and self-neglect. Mary continued to refuse care, sufficient food or drink or medication and in early March was discharged to the care home. Ten days later Mary was found to be unresponsive and was admitted to hospital where she sadly died the following day.

Section 3: Key findings from the review

Mary was effectively not known to services until January 2021, although a safeguarding concern could have been raised in 2016, following a Vulnerable Person Assessment completed by the Police. From January 2021, however, Mary was known both to hospital and community services; while there are no grounds to question the commitment of staff across agencies to enabling and supporting Mary to make decisions about how her care and support needs were met, there was a lack of the implementation of any formal systems to ensure that Mary's care and support needs were assessed and responded to appropriately by statutory agencies.

Mary was described by her son as someone who was difficult to help, as she would refuse support and not engage with services, a description that was endorsed by the agencies and staff who worked with Mary. It is likely that, even had agencies functioned as this Review suggests they could and should have done, that the outcome would not have been any different without imposing interventions against Mary's wishes. The result may have prolonged Mary's life, but with a deterioration in her quality of life as Mary saw it. This does not excuse agencies for not pursuing all the options open to them to provide services to Mary but illustrates the dilemma that operational staff face in balancing a person's right to autonomy with their right to be safeguarded and their own Duty of Care.

There were 32 Findings of Good Practice highlighted by the Review. While there are concerns about some of the practice, what is also apparent is the commitment of staff to supporting Mary and David. Central to this commitment was a desire to ensure that Mary's wishes and autonomy were respected.

Section 4: Recommendations

Recommendation 1: That the Safeguarding Adults Board seek assurance from Adult Social Care and the Integrated Care Board that a multi-agency hospital Discharge Planning Procedure has been reviewed and revised.

Recommendation 2: That the Safeguarding Adults Board seek assurance from partner agencies that they have reviewed and revised their assessment procedures.

Recommendation 3: That the Safeguarding Adults Board seek assurance from partner agencies that they have revised and revised as appropriate their staff development opportunities on the *Mental Capacity Act*.

Recommendation 4: That the Safeguarding Adults Board seek assurance that partner agencies have reviewed and revised as appropriate their staff development opportunities in respect of self-neglect.

Recommendation 5: That the Safeguarding Adults Board seek assurance that partner agencies have reviewed and revised as appropriate their procedures for managing and investigating the causation of pressure ulcers.

Recommendation 6: That the Safeguarding Adults Board seek assurance that the multi-agency safeguarding procedures have been reviewed and revised as appropriate.

Recommendation 7: That the Safeguarding Adults Board seek assurance from the Integrated Care Board that GP Practices' recording procedures have been reviewed and revised as appropriate.

Recommendation 8: That the Safeguarding Adults Board seek assurance from Northwest Ambulance Service that the issue of delays in ambulances attending emergency calls has been raised regionally and nationally and is being addressed as far as is possible locally.

Recommendation 9: That the Safeguarding Adults Board seek assurance form Northwest Ambulance Service that staff are encouraged to demonstrate professional curiosity when attending possible cases of self-neglect.

Recommendation 10: That the Safeguarding Adults Board seek assurance from NHS Mental Health Trust that it has reviewed and revised as appropriate its practice and procedures to ensure consistency between services and the availability of patient information between services.

Recommendation 11: That the Safeguarding Adults Board seek assurance from NHS Acute Trust that they have reviewed and revised as appropriate their procedures and practice.

Recommendation 12: That the Safeguarding Adults Board seek assurance from the Police that they have reviewed and revised as appropriate their triage procedures.

Recommendation 13: That the Safeguarding Adults Board seek assurance from partner agencies that the examples of Good Practice have been acknowledged with the relevant members of staff and their line managers.

Recommendation 14: That the Safeguarding Adults Board seek assurance from partner agencies that they have reviewed and revised as appropriate their supervision procedures and monitoring systems to reduce the likelihood of future failures to initiate relevant internal and multi -agency procedures as identified in this Review.

Recommendation 15: That the Safeguarding Adults Board seek assurance from partner agencies that they are ensuring that staff are supported to manage the balance between their Duty of Care and their clients/patient's autonomy.

Section 5: Conclusions and next steps

A summary of the review report and key findings has been presented to the Board. The recommendations have been agreed and an action plan will be formulated by key partners. The action plan will be monitored and reviewed by the Board. A briefing for all partner agency staff will be developed and the learning from this review will be shared across the wider safeguarding partnership.