Learning from a Safeguarding Adults Review

safeguarding adults at risk
a cumbria partnership

This short briefing summarises the key themes and lessons to be learned following a Safeguarding Adults Review (SAR) undertaken by Cumbria Safeguarding Adults Board (CSAB). The SAR was commissioned by CSAB in July 2018 and relates to a lady referred to as Adult B who was a white British female aged 52 at the time of her death.

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.

Adult B's Story

Adult B tragically sustained a significant brain injury during an accident as a child. This resulted in her having a learning disability and limited ability to communicate with others. She lived at home with her family as a child and moved in to supported living as a young adult residing with the same provider for over 25 years.

Practitioners and carers who cared for Adult B recalled how she liked singing and dancing and would enjoy having her hair and nails done at the Day Centre she attended.

Adult B had a long medical history including low body weight and oesophageal reflux. Medication and food supplements were prescribed to manage this however on occasions Adult B would refuse food and spit it out. Carers who knew her well became increasingly concerned about a decline in her weight, psychological and physical health. Communication became difficult even for those who had known Adult B for years.

During the last 2-3 years of Adult B's life, there was a period of decline during which time there was significant multi-agency involvement in her care. However, the review noted a number of delays during which there was deteriorating behaviour and increasing frailty, which caused carers and family concern.

Sadly, Adult B died in hospital aged 52 years old, 36 hours after a surgical procedure for the insertion of a feeding tube, which was in place to allow artificial feeding and improve her nutritional intake.

The review highlighted a number of key themes as areas for learning.

Theme: Mental Capacity & Best Interest Decision Making
Learning It is essential that all practitioners and professionals are competent and confident in the application of the Mental Capacity Act and Best Interest processes. Professionals should have an understanding of the role of the IMCA including how and when to seek the support of an IMCA with Best Interest Decision Making. There needs to be consistent approach across organisations in respect of the application and recording of the statutory checklist when making Best Interest Decisions.

Theme: Patient Pathway for underweight adults who lack capacity
Learning All professionals involved in the management of malnutrition of adults should operate within relevant NICE guidelines and best practice for adults who lack capacity ensuring the effective recording, measurement and monitoring of any deterioration.

Theme: Management of Difference of opinions
Learning Professionals need to be clear when dealing with complex cases where there is a difference of opinion how and where they can escalate concerns in a timely manner.

Theme: Continuity, Co-ordination of Care and Hospital Discharge Planning
Learning Professionals need to be clear when dealing with adults who have complex needs, who is responsible for the effective care co-ordination, which supports interventions for the individual in an appropriate and timely way.

Theme: Assessment and Funding of Care Needs
All staff should understand processes for the application of funding including; appropriate use of checklists, how to provide evidence, thresholds and how to challenge where this is dispute in decision-making.

Theme: Supporting Staff
Learning Staff need access to relevant policy, procedures, professional supervision and debrief in complex cases, which supports their own health and well-being.

If you work with Adults in Cumbria, there may be specific actions and recommendations for your agency and your role. Please ask your manager, or contact your representative on Cumbria Safeguarding Adults Board (CSAB), to find out more. You can read the full report **here.**

Learning has been shared with agencies involved in the SAR and a robust Action Plan is in place to address key themes and learning which will be monitored on a regular basis.

CSAB will deliver sessions for practitioners to raise the profile of lessons learned from this case and other SARs in the system in due course.