Learning Together from Safeguarding Adults Reviews

Key findings and learning outcomes from the recent Safeguarding Adult Review concerning Adult B

Adult B: The East Sussex Safeguarding Adults Board (SAB) recently published the findings of a Safeguarding Adult Review (SAR) following the death of a 94-year-old lady in September 2017, referred to as Adult B. The lady died in hospital of natural causes but, when admitted, was found to have 26 unexplained injuries including a fractured nose and jaw, as well as old and new bruising to her face, arms and legs. She was diagnosed with sepsis and pneumonia shortly after her arrival in hospital and she died eight days later.

The lady had been living firstly with her grand-daughter and then with her son and his family. They were providing most of her day-to-day care but with support from private care workers and community nurses. Following her death, the SAB launched a SAR to examine the support those professionals had provided and to establish if any lessons could be learnt.

Shared learning: Sharing learning is a key priority. This includes developing strategic learning across agencies, boards and borders, learning from national best practice and SARs.

All staff and managers are encouraged to discuss the briefing and the key learning and reflection points at the end of the briefing, to ensure that the learning outcomes are used to consolidate existing best practice and make improvements where required.

If you work with vulnerable adults in East Sussex, there may be additional specific actions and recommendations for your agency and your role.

You can read the full SAR report on the on the East Sussex SAB Website.

The Review: Focused on events from November 2012 to Adult B's death in September 2017. The SAR was led by independent reviewer, Fiona Johnson and examined the following areas:

- How effectively issues of Adult B's mental capacity and consent were addressed, including the extent to which factors such as coercion and control were considered;
- Whether the historical concerns were sufficiently considered when agencies responded to individual incidents – particularly in 2017;
- Whether practitioners involved initially at the time of the 2017 injuries were sufficiently curious in their investigations of the injuries;
- Whether assessments undertaken understood family dynamics and whether there was consideration of disguised compliance by the wider family in these assessments.

On the back of the review the SAB made a number of recommendations for how private care providers, community nurses, GPs, police and adult social care services should improve how they work together. These included ensuring service users are seen privately and personally away from their families, and better training for professionals working with complex cases, especially where there may be coercion and control. The review also questioned whether the arrangements for investigating adults' deaths at the time, where abuse or neglect is suspected were sufficient and asked for options to be scoped that reflected the procedures when a child dies.

Key findings:

Mental capacity and empowerment: While Adult B was living with her son, there was little recorded evidence of her wishes and feelings. Although there was an understanding that she had capacity, this was not formally assessed. While she was seen regularly by nursing staff, her GP and care staff she was never seen alone from her family and concerns about her care were addressed to them without obtaining information from Adult B about how injuries had occurred. There were various reasons for practitioners' actions, but a concern about asking family members in their own home for space to have private communication with Adult B was a major factor. There was a lack of continuity of nursing staff and difficulties in accessing electronic records prevented the pattern of injuries being easily identified.

Recommendation 1: All agencies to reassure the SAB that their practice, when working directly with service users, enables their practitioners the opportunity for direct personal contact, separate from family members, regardless of where they are providing the service.

Actions:

- The SAB is asking safeguarding leads in partner agencies to report on internal policies and procedures and ensure that direct personal contact is covered in staff training
- The SAB is updating its Making Safeguarding Personal (MSP) leaflet to be clear about the expectation for staff to have direct personal contact with the adults they work with.
- The SAB is developing MSP guidance with positive case studies.

Communication (Understanding of history): There was poor communication and liaison between key agencies working with vulnerable older people particularly around attendance at safeguarding case conferences and strategy discussions. This was partly because an expectation has developed that some key professionals such as GPs may struggle to engage, due to competing pressures so were not always invited. Resource pressures within the safeguarding system were exacerbated by poor IT systems that did not facilitate the use of chronologies. There were also no systems for transferring safeguarding information when the agency providing care in the home changed.

Recommendation 2: The SAB to undertake a sample audit of general agency involvement in the safeguarding process including invitation and attendance at safeguarding meetings and receipt of minutes of such meetings. This is to inform the development of robust mechanisms that ensure appropriate representation at safeguarding meetings, information sharing if attendance is not confirmed, and secure electronic communication.

Actions:

- The SAB is reviewing and strengthening multi-agency mechanisms to ensure appropriate invitation and representation at safeguarding meetings including information sharing.
- The SAB Information Sharing Protocol will be updated to promote good practice in relation to safeguarding meetings.
- The SAB will conduct a multi-agency audit of cases in relation to multi-agency involvement in the safeguarding process to assess areas for development.

Professional curiosity: Across agencies there was a lack of confidence by practitioners in challenging family members when they were providing care for a relative. In part this was about practitioners feeling inhibited because they were working in the family members' home. It is probable however that it also related to assumptions that were made about relationships within families and a difficulty for practitioners in 'thinking the unthinkable' and may also indicate different reactions by practitioners to the death of an older person as opposed to a child or young person.

Recommendation 3: The SAB to develop multi-agency workforce development opportunities for practitioners working with complex cases, for example where there is coercion and control, to enable improved confidence in engaging directly with service users and developing greater professional curiosity and more effective safeguarding of vulnerable adults.

Actions:

- The SAB will continue to promote the two-day Domestic Abuse training programme, delivered on behalf of the SAB, East Sussex Safeguarding Children Partnership and Safer Communities Partnership.
- The SAB will deliver multi-agency coercion and control training, which SAB partner agencies will be encouraged to attend.
- The learning from this review, along with learning from other reviews and multi-agency audits, will feed into a SAB Conference to be convened within a year from the publication of the report. This will support a review of progress made and how learning has been embedded into practice.
- The Sussex Safeguarding Adults Policy and Procedures will be reviewed to ensure there is sufficient guidance relating to consent and the influence of coercion and control on decision making.

Investigating the deaths of vulnerable adults:

The final investigation into the reasons for Adult B's death showed differences between the ways in which child deaths and adult deaths are investigated. The SAR identified shortcomings in the last safeguarding investigation, and it appeared a major reason for this was concern not to cause the family distress in the context of the death of Adult B.

Recommendation 4: The SAB should consider developing alternative arrangements for investigating unexpected adult deaths where abuse is suspected or known to be a factor in the death. These arrangements should be based on existing adult legal mandates and established agency roles, drawing on learning in Children's Services about the strengths and weaknesses of the current Child Death Review processes.

Actions:

- A multi-agency working group will be convened to review current arrangements for investigating unexpected adult deaths, taking into consideration relevant national and local learning and processes.

Learning and reflection: Communication

- Do you have an established process for deciding who needs to be involved in multi-agency meetings and plans?
- How do you ensure that GP practices can contribute to safeguarding enquiries?
- When circulating notes of meetings and agreed actions, do you include agencies who were not present at the meeting but who need to know what was agreed?
- How do you ensure that agreed actions are monitored and followed up?

Learning and reflection: Professional curiosity involves:

- Having the skills to explore and understand what is happening within a family or a relationship
- Not accepting things at face value
- 'Thinking the unthinkable'
- Making the time and space to have a private conversation with an adult who may be at risk and subject to controlling and coercive behaviour