Learning Together From Safeguarding Adults Reviews

Key findings and learning outcomes from the recent Safeguarding Adult Review concerning Adult C – Matthew Bates

Adult C:

During the morning of the 1st April 2015, two male residents of the same care home in West Sussex, Adult C (30 years) and Adult D (63 years) were taken to the Emergency Department of East Surrey Hospital. Both have profound learning difficulties, cerebral palsy and suffer from osteoporosis.

Each was subsequently found to have suffered fractures to a femur and were admitted to the hospital where they remained for several months before being resettled in different care homes.

Whilst the care home (Beech Lodge) was located in West Sussex, the placing authority for Adult C was Surrey County Council (Mole Valley).

The West Sussex Safeguarding Adults Board commissioned a joint Safeguarding Adult Review in July 2016 into the care of both Adult C and Adult D. The focus of this learning briefing focuses predominantly on the recommendations for Surrey in relation to Adult C, however it is also mindful of the wider findings in relation to the injuries to both vulnerable adults.

Adult C aged 30 years (at the time of the incident) has a severe learning disability, epilepsy, cerebral palsy in all 4 limbs and dystonia. He is non-weight bearing and is dependent on a wheelchair for his mobility. He has difficulties communicating and has impaired cognitive skill but is able to communicate through facial expression. His parents support him with communication.

Shared learning:

Surrey Safeguarding Adults Board is responsible for ensuring that learning from Safeguarding Adults Reviews is shared across the partnership landscape and that changes in practice occur as a result.

The main finding in relation to the SAR for Adult C is the detrimental impact that confirmation bias had throughout the enquiry and investigative process.

"At an early stage handling and moving was the emerging explanation, and this was never strongly challenged. 'Confirmation bias' appears to have reduced 'professional curiosity' leading to the lack of consideration of other possibilities."

The confirmation bias influenced and contributed to the absence of any police investigation and the poor quality of the safeguarding enquiry which lacked "**focus, consistency of evidence gathering and a failure to consider and evidence hypotheses other than manual handling. The conclusion is not clearly evidenced and based on assumptions rather than fact."**

The Review:

The Review found a number of areas of concern in relation to:

- Information Sharing
- The thoroughness of the safeguarding enquiry and the impact of confirmation bias
- The police investigation
- The monitoring of the care provided to Adult C by Surrey County Council (and Adult D by his placing authority).

Information Sharing

Both adults attended ED at ESH on the 1st April 2018. They were both seen by the same Consultant within an hour of each other, the Consultant documented his concern that although this may have been a coincidence, he did not think the fractures would have occurred spontaneously and did have concerns the injuries may have been a result of non-accidental injury. Safeguarding alerts were sent to the West Sussex social worker based in the hospital who forwarded the alerts on to the West Sussex Adult Services Community Learning Disability Team on the same day. There is nothing documented to show that Surrey County Council were informed and although the forms indicated that the police had been notified, Sussex Police were not notified that there were potential crimes committed until 09th April by which time forensic opportunities were lost.

Recommendations include:

- Potentially non-accidental injuries must be reported to Police without delay. This should be documented in policy, procedure and training.
- Safeguarding concern forms must be completed fully and accurately.
- SSAB must work with ESH to ensure policies and procedures provide clarity over the geographical split.

Safeguarding Enquiry

The review concludes that the enquiry was confused, lacked a clear lead, clear recording, and an action plan. The investigation was not thorough or independent, it was completed by the Care Home Manager and confirmed the emerging hypothesis that manual handling was the likely cause of the injuries. Although that may have been the cause, there is no conclusive evidence to substantiate that hypothesis and the conclusion appears to be based on assumption rather than fact.

Recommendations include:

- Enquiry Officers and Managers undertake specific training to be able to conduct effective and thorough investigations.
- The vulnerable adult, their family member or representative are invited to be part of the enquiry.
- The enquiry is supported with clear action plans.

Police Investigation

A Sussex Police representative attended the safeguarding enquiry meetings, the officer requested that the enquiry continued to be led by West Sussex County Council and that all investigative material was shared with him. No independent review took place to ascertain if offences had taken place and rather the officer relied on the information provided as part of the safeguarding enquiry. The review identifies that the police should have led the investigation due to the vulnerabilities of the adults and complexity of the circumstances.

Recommendations include:

- Police should take the lead in investigating unexplained injuries to vulnerable adults, in order to ensure evidence gathering is not lost or compromised.

Monitoring Arrangements

Adult C was an open case to Mole Valley locality team. In March 2013 the Out of County Monitoring Team had visited Beech Lodge to review the placement of 8 Surrey residents, it is not clear if Adult C was seen or spoken to on that day, his family were not spoken to. No concerns were identified, and it was recommended that another visit take place within 12 months, this follow-up visit did not happen and it is recognised that this compromised the ability of Surrey County Council to gain a view on the quality of care being provided.

Recommendations include:

- Surrey County Council to ensure that out of county care home placement reviews take place within required time scales.

Key Learning:

Surrey Safeguarding Adult Board are keen to ensure that the learning from this Safeguarding Adult Review is shared by all member organisations and that action is taken to prevent adults with care and support needs from experiencing abuse or neglect.

Learning 1:

All organisations must ensure that their staff understand the need to inform the police where it is suspected that an adult in their care has suffered from non-accidental injury.

Learning 2:

All organisations must ensure their staff understand the requirement to complete Safeguarding concerns fully and accurately.

Learning 3:

Safeguarding Adult Enquiries must be completed by staff who are trained, competent and confident to complete a thorough and accurate enquiry. The enquiry should include a thorough plan outlining how facts will be established and tested and how the persons representatives will be involved.

Learning 4:

From an early stage in this investigation, handling and moving became the emerging explanation and this was never strongly challenged. Other possibilities were never fully considered. All organisations must be aware of the impact of confirmation bias and the impact this can have on an investigation. When investigations are undertaken, staff must explore and investigate a range of hypotheses.

Learning 5:

Where there is a possibility of non-accidental injuries to vulnerable adults, the police must lead the investigation.

Learning 6:

The placing authority must have oversight of the care being provided to people who it has responsibility for.