Derby Safeguarding Adults Board

Learning Brief for Practitioners

Safeguarding Adults Review: Doreen

July 2023

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A Safeguarding Adults Review (SAR) is a legal duty under the Care Act (2014), which states that the Safeguarding Adults Board must arrange for a review of a case involving:

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)
b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and
c) the Safeguarding Adults Board knows or suspects the adult has experienced serious abuse or neglect and there is concern how the partner agencies have worked together to protect the individual.

The Derby Safeguarding Adults Board (DSAB) carried out a Safeguarding Adults Review (SAR) in 2021 following the death of Doreen (not her real name), who had care and support needs. It was agreed by DSAB that the timeframe would be considered by the review, would be 15 months prior to Doreen's death.

The SAR and the final report were completed by an Independent Reviewer. Information was gathered from partner agencies that had been involved with Doreen during the review timeframe. An Action Learning event took place with participation from all the key agencies involved in providing care and support for Doreen.

The key objectives of the event were established as:

- To consider what worked well.
- What could we have done better?
- What are our recommendations for improvement?

The event was focussed on what were considered the significant events and themes identified from the SAR timeline.

The SAR Panel was established consisting of senior managers from lead agencies, with no previous involvement in the case, supported the progression of the SAR. These individuals were identified to have the authority to effect change in their own agency and have the appropriate level of professional knowledge to support the SAR.

The final SAR report and recommendations were agreed by DSAB in July 2023.

Background

Doreen at the time of her death was 88 years of age. She had been married but sadly lost her husband when he died in 2018. The Coroner's inquest identified Doreen's cause of death as ischaemic heart disease, a cervical spine fracture and essential hypertension. HM Coroner ruled that it was unfeasible to identify whether Doreen had fallen and sustained a fractured neck triggering a cardiac arrest or whether she had suffered a fatal collapse as a consequence of her existing underlying natural disease and the collapse caused the fracture to her neck.

Doreen had no children and had one sister. Attempts made to engage with the sister proved unsuccessful.

It was suspected by agencies that Doreen may have been suffering from dementia at the time of her death, however this was never formally diagnosed.

Doreen received domiciliary support at home which was self-funded and commissioned by the Local Authority. Doreen was known to several agencies and during her last assessment from Adult Social Care, it was identified that Doreen required support with meals, medication, personal care, and support to manage her toilet needs. The support that Doreen received were provided by a locally based domiciliary care agency.

Areas of good practice

1. Where following reports of Doreen feeling lonely, referral to the befriending service was considered and made.
2. Action was taken by specific agencies in making several safeguarding referrals into the Multi-agency Safeguarding Hub (MASH) raising concerns about Doreen.
3. Colocation of the Derbyshire Community Health Services (DCHS) Care Coordinator in the GP Practice which promoted partnership working and multiagency information sharing.
4. Adult Social Care made the best use of technology through providing Carelink service alarms as a means for Doreen to summon support in the case of an emergency.

5. Provision of a Carelink Responder who could provide assistance if named contacts were unable to be contacted.

Recommendations

1) University Hospitals of Derby and Burton, Derbyshire Community Health Services NHS Foundation Trust and Perth House should review their discharge processes to ensure that relevant agencies are notified about a person's discharge in a timely manner and to ensure coordinated continuity of care.
2) Derby Safeguarding Adults Board should seek assurance as to the extent that the Mental Capacity Act 2005 is being applied consistently across the Derby Safeguarding Adults Partnership.
3) Derby Safeguarding Adults Board should review and amend the SAR guidance and procedures, to ensure practitioners are briefed by senior managers about the facts of the case before attending learning events and practice reviews, to protect their welfare and maximise their contribution to the learning from the case review.
4) Derby Safeguarding Adults Board should seek assurance from Adults Social Care that where appropriate Adults Social Care are establishing safety plans to manage or mitigate the risks posed to adults with care and support needs who remain living in their own home.
5) Drawing upon learning from this case Derby Safeguarding Adults Board should raise awareness to the Derby Safeguarding Adults Partnership of the Safeguarding Decision-Making Guidance Tool and promote its application to guide practitioners of the circumstances of when to raise a safeguarding referral.
6) Derby City Council should review its arrangements with Carelink to ensure the parameters of engagement undertaken by its responders are clear and explicit regarding the provision of personal care to adults they are supporting in the community.
7) Derby Safeguarding Adults Board should seek assurance from University Hospitals of Derby and Burton as to the effectiveness of its High Intensity User Service in managing the risks to adults who frequently attend its Emergency Departments.

8) Derby Safeguarding Adults Board should, through its quality assurance processes, assure itself as to the implementation and improvements to practice as identified within the Adults Social Care improvement action plan.
9) Drawing upon learning from this case Adults Social Care should ensure its workers are aware of their duty to escalate concerns through the application of Adults Social Care escalation protocols when concerns exist regarding the perceived inappropriate conduct of agencies providing support to adults with care and support needs.

Next steps

All agencies and professionals are encouraged to reflect on the findings and identified recommendations to improve future practice.

These recommendations will be monitored by the SAR Operational Group who will seek assurances from the agencies named in the above report that these recommendations are being acted upon and will inform and improve practice for the future.