Adult H Safeguarding Adult Review Learning Brief
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Case Summary

Adult H had an acquired brain injury (ABI) as a result of a hypoglycaemic coma. She also suffered from epilepsy, type 1 diabetes, hypothyroidism and experienced short term memory loss. Sadly, Adult H died after hanging herself whilst resident in a Continuing HealthCare (CHC) NHS funded care home for people with a mental health diagnosis. She had been placed in the care home since December 2010. Adult H expressed continued dissatisfaction and extreme frustration with her placement and she attempted to leave numerous times, when a review of the placement took place it focussed on the continuation of funding rather than a full holistic assessment. There was a Deprivation of Liberty Safeguards (DOLS) application submitted which wasn't prioritised or actioned and there were numerous safeguarding alerts submitted as a result of her escalating behaviour. The review highlighted key themes/ learning points which are summarised below, the full SAR report is available on the LSAB website.

Key Learning points

- **Acquired Brain Injury (ABI) Services** – practitioners from different agencies supporting Adult H were not aware of ABI services in their area which could have provided additional support. When working with a service user with an ABI, professionals should explore ABI support services available within their area and can contact their CCG, Acute Hospital Trust, or specialist charities such as Headway (brain injury association) for information and advice.

- **Mental Capacity Assessments** – there were many references to Adult H's capacity/ fluctuating capacity but only 1 documented assessment of capacity. Formal capacity assessments should always be completed when there are questions about a person's capacity and/ or best interest decisions are required. It is a statutory requirement that these assessments are decision specific, time specific and are accurately and promptly recorded. If you are unsure about any element of this, please contact your agency's safeguarding lead for advice in the first instance.

- **Deprivation of Liberty Safeguards (DOLS)** – A DOLS assessment had been requested from the Local Authority in 2015, this was never actioned before Adult H died in 2017. All agencies have a legal responsibility to escalate concerns to the Local Authority if DOLS are not in place and the person in the placement is raising objections and there are significant restrictions and / or restraint. Agencies should be re-assured that systems for prioritising have been changed within the Local Authority and once an application has been submitted the referrer is provided with the priority banding and how to contact the DOLS Team should they wish to discuss the banding.

- **Voice of the Adult / Think Advocacy** – Agencies should consider requirements to instruct/ refer to advocates under the Care Act (2014), Mental Capacity Act (2005), Mental Health Act (2007) or Complaints Advocacy particularly when placement reviews are undertaken and safeguarding concerns are raised. Professionals should be aware that there are several different strands to advocacy and if one type doesn't 'fit' another might, professionals should negotiate with advocacy services when they feel the criteria has been met for an advocate particularly when family members are not deemed to be appropriate.

- **Placement Reviews** – The CHC review was not undertaken for 2 years, when it did take place, there was a narrow focus on funding eligibility and it did not consider concerns about a deterioration in mental health or increasing risks. Cases funded under NHS CHC should be reviewed regularly and individuals with complex needs could be eligible for case management.

- **Multi-Agency Working** – There were missed opportunities to communicate, share information and escalate concerns. All agencies and professionals should take a collaborative approach to managing risks and give due consideration to holding a multi-agency meeting to discuss complex cases to ensure fully informed decisions are made.

- **Safeguarding Alerts** – Currently, the Local Authority system only allows a service user on service user incident to be recorded on the perceived victim's records, this is due to complexities relating to data protection. This can make it difficult for escalating behaviours, risks and concerns to be identified for 'alleged perpetrators' and result in missed opportunities to share concerns with key workers/ social workers. With every referral/ safeguarding alert submitted, where possible, professionals should highlight the frequency of previous incidents for the same service user. This will enable an informed decision to be made and information to be shared appropriately. Furthermore, a safeguarding redesign is ongoing which will consider how systems can be improved.

- **Suicide Prevention** – Adult H had a history of self-harm, suicidal ideation and struggling with her mental health; this review discussed how her chronic complex medical conditions (namely diabetes and ABI) put her at an increased the risk of taking her own life. This Review shows clear parallels to the findings of the Suicide Prevention Strategy report in identifying key risk factors and the LSAB would support the ongoing roll out and implementation of this strategy as a key support in attempting to prevent similar situations.