Safeguarding Adult Review Learning Brief – Adult T "Mary"

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lancashire safeguarding adults board

Case Summary

In July 2020 Mary was taken to hospital by ambulance following a fall at her home where she lived with her husband. Upon arrival, staff at A&E were concerned about her presentation and care and referred her to social services. As a result, support was offered to Mary but, for reasons unknown, she was unable to engage. In October 2020 Mary was further admitted to hospital with significant dehydration, emaciation and multiple pressure sores. Sadly, she passed away a few days later, aged 74.

The focus of the Safeguarding Adult Review were the circumstances surrounding her unnoticed decline of health and frailty.

The review highlighted several key themes and areas of learning which are explained below. It is anticipated that a copy of the SAR report will be made available on the LSAB website.

Key Themes and Learning Points

Management of Patient Non-Engagement with Health Services

Mary exercised her right not to attend her GP and because the surgery held no information to suggest that she was vulnerable or may not have had the mental capacity to make this decision, she was not contacted further and no attempts were made to explore why she was not engaging with healthcare.

Consideration of Mental Capacity

Mary did not engage with healthcare services or accept professional support with her care needs.

Professionals had no cause to doubt Mary's mental capacity to make any decision for herself and her circumstances were not deemed to have reached the threshold to warrant overriding her consent to assessment, as set in the Care Act 2014. However, had professionals concluded that the threshold had been met, the local authority still lacked power to enforce an assessment and support.

In the absence of finding any authority to override Mary's wishes, it was important that professionals worked with Mary to confirm that she understood the harm she was risking by not accepting support. Workers did this by asking her questions but this communication was by telephone and professionals' ability to make safeguarding personal was affected by the loss of face-to-face contact.

Had the Self-Neglect Framework been followed, the pathway would have identified the need for a multi-agency plan which would have included consideration of who was best placed to gain Mary's confidence and how to work with her.

Understanding of controlling relationships in Older People

Concerns were raised at both hospital attendances regarding Mary's care and presentation, but health professionals did not consider domestic violence abuse and did not employ 'routine enquiry'. Consequently, the opportunity to explore this with Mary was lost.

Recognition of Self-Neglect and application of the Self-Neglect Framework

Not all professionals working around Mary were familiar with the Lancashire Safeguarding Adult Board multi-agency Self-Neglect Framework. Had professionals considered self-neglect and consulted the framework, they would have established that the criteria had been met and they would have been instructed to progress and share Mary's information multi-agency.

Without a multi-agency meeting, services worked in silos and were unable to address Mary's problems long term.

Effectiveness of Information Sharing

Referrals did not separate fact from opinion and consequently their effectiveness to identify vulnerability and risk was lessened.

Professionals would benefit from clear guidance re how to construct a referral effectively to help agencies work together to keep adults with care and support needs safe.

Professionals did not have the opportunity to escalate concerns or challenge decisions regarding referrals because they were not updated of progression or outcome. However, use of the Self-Neglect Framework would have resulted in a multi-agency model being followed which would have updated agencies/professionals of the outcome of the referrals

Effects of the Covid-19 Pandemic on the support afforded to Mary

The lack of face-to-face contact in Mary' home environment reduced professionals' ability to understand her circumstances.

Professionals' assessment of the family

Professionals did not give adequate consideration as to whether Mary's family was able to monitor, understand and/or address her care and support needs. Consequently professionals did not gain a full understanding of her isolation and vulnerabilities.