Bracknell Forest and Windsor & Maidenhead
Safeguarding Adults Board

Learning Brief on the AB Safeguarding Adults Review (SAR) March 2018

This briefing is one of the ways in which the Board aims to share learning as widely as possible to support practice and development in our commitment to safeguarding adults at risk. Thank you for taking the time to read it.

The briefing aims to pull together key messages and lessons learnt from the review to enable you and your teams to reflect and challenge your thinking with a view to implementing positive change and promoting better outcomes for adults at risk.

We ask that you take time to read this brief (you can access the full report here) and consider the following questions:

- → Does this case identify any learning for my individual practice?
- → Does it help identify any training or development needs?
- → Does anything need to change within my team or service to implement this learning and support best practice?

Which agencies worked with AB and were involved in the review?

Regulated care agency, District Nursing Service, Adult Social Care, Fire service, Ambulance service, Hospital and GP.

Who was AB?

AB was a 74-year-old white British female living alone in her own home, having no family of her own. She was, however, a godmother to a friend's children from whom she received visits. AB was a retired district nurse and was well known and highly respected by her colleagues throughout the community nursing service and as such was known to the community nurses providing her care.

Background History

As a result of her physical health and mobility needs, AB was in receipt of a significant support package of four care calls per day with two carers. AB directly commissioned her care as a self-funder, then in receipt of direct payments and was seen over a sustained period for three visits per week by the community district nursing service. AB was known to be a heavy smoker and habitually smoked in bed. In 2010 a referral was made to the Royal Berkshire Fire and Rescue Service following referral from the housing association and action was taken to improve the level of fire safety. On the 11th May 2017 alarm was raised by a neighbour to the fire brigade in response to a house fire at AB's home address, however, sadly AB was found deceased.

What were AB's vulnerabilities and needs?

AB had a complex medical history and over the years had become morbidly obese with some consideration that she may have had undiagnosed agoraphobia. In the period prior to her death AB had become immobile having suffered a stroke with indications of minimal effect on her cognitive functioning.

Practitioners and agencies need to remain mindful that personalisation is an approach - it does not and should not override a Duty of Care. When an individual makes a choice which may have a significant detrimental impact on their health and wellbeing (or that of others) does your assessment and recording reflect full consideration of the risks and is the risk management framework applied to fully assess and manage the risk?

There is a need to ensure that all agencies and organisations are aware of the requirement to identify and respond to potential fire risk. Do you know how and where to access the (free) Fire Service's Adults at Risk programme?

Tools and training need to enable the identification of fire risks (not only for the individual but in terms of public protection) and ensure that the appropriate action plans are put in place including referral pathways to fire prevention services.

Do you consider fire risk within your risk assessment and if identified, do you assess the potential risk to others? Is this embedded in your core practice?

In cases where adults with care and support needs make unwise decisions which place them at risk, the assumption of capacity should not preclude formal capacity assessments from being undertaken and recorded to inform further interventions. Do you feel confident in the application of the Mental Capacity Act 2005 in practice? Are assessments of capacity evidenced based and fully recorded?

There should be processes in place to identify more vulnerable adults with complex or high risk needs who are in receipt of direct payments to ensure effective communication across agencies, encourage appropriate review and ensure that assessed needs are being met. When assessing suitability for direct payments is this informed by the complexity of care needs and do you ensure suitable review and reporting mechanisms in cases of increasing needs and risks?

Your organisation should have robust policies and procedures in place for safeguarding. All frontline staff (and particularly those making decisions as to whether a safeguarding framework is required when concerns are raised) need to ensure they are familiar with safeguarding procedures and thresholds, not only in terms of statutory requirements to undertake a section 42 enquiry but in terms of Care Act 2014 requirements to undertake other safeguarding enquires.
Do you routinely use the Pan Berkshire Adult Safeguarding Policy and Procedures? Do internal safeguarding policy and procedures support decision making as to when take a concern into either a section 42 or other safeguarding enquiry? If the decision not to progress the concern raised is made, is this fed back to the referring agency to enable further discussion and professional challenge?

The absence of an existing safeguarding framework should not prohibit any professional worker from convening a multi-agency meeting. All agencies should have a clear and accessible pathway to allow workers to convene a multi agency meeting in high risk or complex cases.
Are multi-agency meetings held regularly within your services? Do you know how and when a multi-agency meeting should be called in particular case?

When multiple agencies are involved in a case, there should be mechanisms to ensure appropriate information sharing and instigation of a multi-agency approach to coordinated care, regardless of the person's funding status.
Do you know how and when to convene a multi-agency meeting and do you use the at-risk pathway as part of the multi-agency Risk framework?

Issues of capacity, service refusal or lack of consent need to be fully assessed and explored. They should not act as a barrier to sharing information where the law and circumstances permit it.
Are you clear on issues of capacity, valid consent and policy as to when you can share information across agencies?

When referrals are made to an agency, a review of referral information and previous information needs to be undertaken to ensure adequate assessment and intervention. There needs to be a standard practice of feeding back to the referring agency on actions taken.
Do you undertake a full review of information to inform your interventions and assessment as standard practice? When closing a case or making significant decisions are these communicated across relevant agencies?

The use of paper records within the community can create significant risk - in this particular case, the paper records were burnt in the fire. Not only does this create opportunity for professionals to follow poor recording standards and potentially promote false assurances but in the terms of any form of review it can restrict legally defensible arguments in addition to the holistic learning in individual cases.
How confident are you that your recording standards meet your agencies requirements? Do they reflect good practice standards and clearly articulate the decision-making process?

The role of the GP can be crucial for people with complex needs who do not have any other allocated worker.
Do you recognise the role of the GP and ensure effective communication and information sharing?