From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within, or informs, safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Peter

The SAR was undertaken using the SSAB Local Learning Review and the key messages contained in this briefing reflect the learning to emerge from this.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Does my organisation have robust policies and processes in place to support people who self-neglect?
- Do I have a good understanding of how to use MCA?
- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key features of Peter's Case

Peter had an extensive history of self-neglect when living in his own home which did not resolve following his admission into full-time care. Whilst residing in a local care home Peter began to suffer with peripheral vascular disease in his feet. Unfortunately, due to persistent refusals of care and treatment his feet, then legs became gangrenous. Whilst P would initially agree to interventions such as wound care, hospital admissions, and amputation he would often renege on this. Peter's mental impairment was linked to problems with his executive functioning and alcohol use. This made assessment of his mental capacity difficult as he retained many of his core cognitive skills.

- Peter was keeping his room in an unsanitary condition, hoarding belongings, engaging in antisocial behaviour, and refusing care and support. In addition to these concerns were raised regarding 3rd party financial abuse by taxi drivers.

- At the start of Covid pandemic restrictions in March 2020 Peter began to complain of pain in his ankles and feet. He was reluctant to allow a full examination and treatment focused on pain relief.

- The following year in June 2021 a deterioration through significant peripheral disease in his lower limbs begins.

- Peter had 5 hospital admissions over the next 8 months until his death in January 2022. These prove particularly challenging with Peter refusing admission to hospital and essential care and treatment (e.g. wound care, amputation).

- Peter's mental capacity to make decisions regarding his health care and medical treatment are not formally assessed despite the Court of Protection concluding that he LACKED capacity in other key areas (DoLS, Finances).

- Communication related to discharges back into the care home is sub-optimal, and the care home's ability to meet his needs begins to falter.

Key considerations for practice arising from the review:

Mental Capacity Act, DoLS, & the Court of Protection

- Assumptions about patients should not negatively impact upon what is deemed available medical treatment for them. Clinicians must first determine what treatment is clinically available. Only then can the available option(s) be considered under the Mental Capacity Act.

- Clinicians must formally assess mental capacity where there is a reasonable cause to doubt it or where the person has been shown to LACK capacity elsewhere. The

'presumption of capacity' principle ***does not*** apply in these situations. The consideration of capacity acts as a 'gateway' to other measures that aim to protect the person's safety and human rights and is therefore of vital importance.

- Clinicians should be aware of the different approach required when assessing individuals who have an impairment of their executive functioning.

- Organisations should assure themselves that their systems and practice enable identification of essential MCA, DoLS & CoP information on the transfer of care.

- Organisations should have clear pathways for seeking legal support for complex cases.

Safeguarding Adults and duties under the Care Act

- Practitioners should be aware that s42 duties under the Care Act apply ***irrespective*** of mental capacity. Therefore, caution should be observed if the decision to open or close a case is based primarily on their capacity state.

- In a self-neglect context, practitioners should be aware that a person's inability to *'protect themselves by controlling their own behaviour'* gives greater weight to applying a s42 consideration.

- Referrers need to ensure that they follow formal processes for making Safeguarding Adults referrals to the Local Authority. Where the risk remains, or they are dissatisfied with the response then they should make use of the MARM (Multi-agency Risk Management) and /or the Resolving Professional Differences processes found on the SSAB website.

- Organisations should also assure themselves that their systems and practice enable identification of essential Safeguarding information on the transfer of care.

Further information

Somerset Safeguarding Adults Board:

- Resolving Professional Differences
- Self-Neglect Guidance
- Multi-agency Risk Management (MARM) Guidance

Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Organisation	
Date	
This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)	
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)	
Action taken as a result of the learning:	
Other feedback / discussion points	