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.

Hazel

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 with autism?
- Do I have a good understanding of how to use MCA and best interests?
- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key features of Hazel's Case

Hazel was a 60-year-old lady who lived in a house where she had her own flat, on a campus style site with several homes run by an Autism Charity. Hazel had lived on the site since she was 15 years old.

Hazel was historically diagnosed with a learning disability, autism and bell's (facial) palsy. A significant symptom of Hazel's autism was anxiety, and she was driven to complete tasks and routines which she found comforting.

In July 2019 Hazel received her supper, which included a sandwich cut in half. She was noticed by her allocated one to one support worker to be choking and first aid was commenced, and an ambulance called. The paramedics were able to restart Hazel's heart, and she was transferred to Hospital where she was placed on life support. In agreement with her family, Hazel's life support was turned off and she died three days later.

Key considerations for practice arising from the review:

The placement, commissioning and review

- Hazel's placement and funding were arranged over 40 years ago. Her family preferred her to remain with the Autism Charity, in which they had great faith.
- Hazel's care was funded by the London Borough due to her place of ordinary residence being with her parents who lived in London at that time. Place of ordinary residence originates from where a person sees themselves as ordinarily residing and where they have a linkage to; this does not change despite the length of time that someone is resident and funded in a placement. Albeit that currently the guidance relates to the Care Act (2014), the principles have remained the same.
- Hazel's needs were not being met, it underlined the isolation that Hazel was under, the home's poor records in evidencing activities and other social opportunities. Additionally, Hazel did not benefit from a personalised care plan.
- Clear escalation processes should allow for concerns regarding reviews and responses from placing authorities to protect those in receipt of care far from home.
- Autism training needs to be fit for purpose dependent upon level of activity and care given with those with neurodivergence. In this case one size does not fit all.
- The person's best interests are paramount; where there is disagreement a best interests decision following a mental capacity assessment should decide on the living arrangements and care needs of a person; the Court of Protection may need to intervene where there is dispute.

Management of STOMP medication changes and physical health

- There were several attempts to reduce Hazel's psychotropic medication under different psychiatrists. During this period the provider was increasingly concerned regarding the ability to manage the complex behaviours that challenged them. They were submitting safeguarding concerns to the local authority.

- The consultant asked for support from other teams in the NHS Mental Health Trust and that the behaviour support nurse became involved as well as the speech and language therapist.
- Significant changes in care should include family and should also include mental capacity assessment where there are concerns a person is unable to decide for themselves and/or there is disagreement in changes.

- The purpose of an annual health check is to support and identify any health needs. It is known that those people with learning disabilities are more likely to have poorer mental and physical health and that annual health checks can be effective in identifying and treating undetected health conditions. The research suggests that it can often be undetected and undiagnosed health conditions that lead to an increase of behaviours that challenge carers.

Safeguarding and Risk Management- Multi Agency Working

- Multi-agency working in complex cases is always beneficial to both the person and practitioners

- A greater understanding of legal processes can ensure the ultimate support for a person and professionals; such advice within guidance and policies is useful.

- Systems for risk management benefit from built in managerial oversight and scrutiny to ensure organisational understanding of risk and that practitioners are not left unsupported.

- It is important that advocacy is available and provided during safeguarding process is in order that a person's voice is heard and that their rights are protected.

Further information

Somerset Safeguarding Adults Board:

Deprivation of Liberty Safeguards (DoLS)

Multi-agency Risk Management (MARM) Guidance

Mental Capacity Act 2005

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	