Wiltshire Council

Health and Wellbeing Board

29 March 2018

Subject: Safeguarding Adults Reviews (SAR)

Executive Summary

The Chair of the WSAB is attending the Health and Wellbeing Board on 29 March to provide members with an update on:

- Two Safeguarding Adults Reviews the Board has undertaken following the unrelated death of two adults at risk in Wiltshire
- The learning from those reviews that will help us more effectively safeguard vulnerable adults in the future
- The Board's business plan for 2018-2019

The primary statutory duty of the Board is to carry out a Safeguarding Adults Review (SAR) when:

"an adult in its area dies as a result of abuse or neglect, whether known or suspected, **and** there is concern that partner agencies could have worked more effectively to protect the adult (s.14.133)"

The purpose of a SAR is not to hold any individual or organisation to account but to allow local organisations to learn lessons from the past.

Until 2017 the WSAB had not completed such a review since 2014 when it looked at the care offered to residents of a small residential service in Wiltshire. This year the Board has completed two reviews allowing us to re-examine how effectively our multi-agency system works to safeguard adults.

At the time of writing this report these two reviews, and the Board's business plan, are in draft format. However, in order to ensure that the Health and Wellbeing Board and kept informed of the work of WSAB to assess the quality of the multi-agency safeguarding system this report:

- Summarises the circumstances that prompted these statutory reviews
- Includes the **draft** multi-agency recommendations that are likely to be made in these reviews
- Details how our WSAB Business Plan for 2018-2019 will ensure that learning from these reviews will help to improve how adults in Wiltshire are safeguarded

An action plan will be developed by the WSAB to share learning from the two SARs and to ensure that the recommendations made in these reports lead to the necessary changes being made to safeguard vulnerable adults.

Proposal(s)

It is recommended that the Board:

i) Notes the outcome of the 2018 Safeguarding Adults Reviews relating to Adult A and to Adult B
ii) Ensures that this learning has an impact on the work of its member agencies
iii) Asks the WSAB to share the finalised action plan with HWB to ensure that the recommendations of the two SARs and the learning from these reviews are shared and effect change
iv) Supports the necessary partnership resources to ensure that action plan can be delivered effectively
v) Acknowledges the aims of the WSAB's business plan for 2018-2019 and continues to support the work of the Board to safeguard vulnerable adults in Wiltshire

Reason for Proposal

The Wiltshire Safeguarding Adults Board is accountable to the Health and Wellbeing Board for its work as a partnership to protect all adults in its area who have needs for care and support and who are experiencing, or at risk of, abuse or neglect against which they are unable to protect themselves because of their needs. The WSAB's work is directly related to improving health and wellbeing outcomes for vulnerable adults across the county.

Presenter name: Richard Crompton
Title: Independent Chair,
Organisation: Wiltshire Safeguarding Adults Board

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Purpose of Report

1. To report to the Health and Wellbeing Board:
   - The outcome of two Safeguarding Adults Review (SAR) completed by the Wiltshire Safeguarding Adults Board (WSAB) in March 2018 and which are due to be published by the Board in April 2018.

2. Safeguarding Adults Board **must** arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, **and** there is concern that partner agencies could have worked more effectively to protect the adult (s.14.133).

   SABs **must** also arrange a SAR if an adult in its area has not died, but the

   SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the 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 (s.14.134).

   The adult **must** have needs for care and support, but does not have to have been in receipt of care and support services for a SAR to be considered.

3. The purpose of such a review is not to reinvestigate or to apportion blame, it is:
   - To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk;
   - To review the effectiveness of procedures (both multi-agency and those of individual organisations);
   - To inform and improve local inter-agency practice;

Safeguarding Adults Review – Adult A

Background

- Adult A was admitted to hospital in December 2016 after having been found on the floor of her flat by the attending paramedics. There were

concerns raised by the paramedics about the state of the flat and possible self-neglect. The paramedics also raised a safeguarding alert as they suspected Adult A had been financially abused by a carer.

- Adult A was admitted to hospital but in the absence of any physical problems associated with the fall was released to an ICT bed. During this time Adult A exhibited some concerning behaviours and during an assessment was found to have a degree of confusion.

- In mid-January Adult A activated her life line, the paramedics who attended reported that she was found in a situation of serious self-neglect sitting in a cold dark flat and was severely hypothermic. There was no fresh food in the flat and it appeared that Adult A had not been talking her medication.

- Adult A died in hospital in January. The coroner noted the that at time of death was suffering from hypothermia, broncho-pneumonia, left ventricular hypotrophy, hypertension, diabetes, kidney disease and dementia. The coroner's report also stated that he did not think adequate preparation had been made to ensure Adult A had provisions and support on discharge.

- The coroner concluded that Adult A would not have died at that time had Adult A not been discharged home. The review identified a number of issues, some of which may not have resulted in significant harm if they had occurred in isolation. The professionals that were interacting with each other did not challenge decisions that were made in other agencies. There was no evidence of escalation when referrals were not receiving the expected response.

- Whilst the review concluded that it could be considered that ultimately, it was the discharge planning that was the final layer of defence that failed. That, however, relied on all the other elements being effectively applied to understand what exactly needed to be part of the discharge plan and future interventions. If these had been applied robustly, Adult A may well not have been discharged at all at that time. There were many layers of protection in the system that failed at the same time culminating in a catastrophic outcome for Adult A.

Draft multi-agency recommendations

- WSAB should produce Multi Agency Self Neglect guidance to support practitioners in managing self-neglect.

- WSAB must assure itself that agencies can evidence how they will address the shortfalls in understanding and applying the Mental Capacity Act that this review has evidenced.

- WSAB should provide a learning briefing to all agencies regarding all the learning points from the review.

- WSAB should seek patient stories showing evidence of the effectiveness and safety of discharge planning processes.

Safeguarding Adults Review – Adult B

Background

- Adult B was diagnosed with a degenerative and progressive disease of the brain. Adult B lived in the community in independent living accommodation and was able to maintain a degree of independence.

- Adult B died in late 2016 in a road traffic accident after walking a significant distance from home. Prior to this fatal accident Adult B had been found on a separate occasion wandering at a considerable distance from home in a state of undress. A number of agencies were aware of Adult B and his tendency to walk long distances and become disorientated had been reported to other agencies by the police.

- Other SARs regarding people with dementia who walk, have identified people with dementia walking and subsequently dying as a result even when they have been subject to 24 hour care provision. However the WSAB review relating to Adult B concluded that with more robust communication, coordination and assessment alongside application of statutory processes and respectful challenge and escalation, Adult B might have benefitted from a safer and more secure care package.

Draft multi-agency recommendations

- WSAB should seek assurance that agencies consider the elements of NICE Guidance for supporting people with Dementia that would have made a difference in this case. In particular, that there should be an agreed approach to identifying a lead worker role when multiple agencies are working with an individual at risk and an agreed approach to shared care planning.

- WSAB Quality Assurance sub group should seek information from commissioners regarding their assessment of the risk resource and capacity issues pose to the safety and well-being of Adults with Care and support needs who are at risk of harm. There should be an expectation and an agreed process for commissioners to escalate any significant risk to the Board Chairman.

- WSAB should assure itself that all agencies and providers have robust structures in place for support and supervision of staff.

- WSAB should consider the learning from this review and undertake to ensure that there is guidance to all agencies on the importance of professional curiosity and challenge and of escalation where required to mitigate risk. This may be undertaken by the following approaches:

  - By way of a briefing note.
  - By review of the Safeguarding Procedures that include an escalation section.
  - As part of the Operating Procedures for the Adult MASH.

- An agreed multi-agency approach is required for managing risk in adults who have care and support needs. WSAB should seek assurance that this approach is developed and embedded through audit.
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- WSAB should add the learning from this review regarding understanding and application of the Mental Capacity Act, to the previously made recommendation in the Adult A SAR.

Wiltshire Safeguarding Adults Board Business Plan 2018/2019

During 2017-2018 Wiltshire Safeguarding Adults Board has focused on reviewing the wider system that aims to safeguard vulnerable adults in Wiltshire. We have done this by:

- Carrying out two independent reviews after receiving referrals regarding two adults at risk in the county who died (in unrelated circumstances), to learn how partner agencies could have worked more effectively to protect those adults
- Undertaking a self-assessment audit of our Board members and identifying areas where we can improve the way local organisations work together
- The work of our Quality Assurance group to examine local data and to seek reassurance from those organisations that practice is continually improving to protect adults at risk
- Regularly meeting with service users and carers through our reference groups to learn from their experience
- Discussions at Board Meetings and with key partners have about how changes to legislation, to demand on our member agencies and to service delivery are impacting on how effectively our members can work together

The Board is required to publish a strategic plan and in 2016 we published a three-year plan for 2016-2018. This report sets out what progress has already been made against that plan and what actions will be taken during 2018-19. In 2016 we set out three aims, which were to:

- Improve Board Effectiveness
- Develop the ethos and practice of Making Safeguarding Personal
- Develop and improve our preventative and responsive practice.

Since that time we have done much to improve the effectiveness of our Board. In Wiltshire, we have introduced an innovative model that brings together support for WSAB, our Local Safeguarding Children Board and the local Community Safety Partnership. This allows us a unique opportunity to examine how we are protecting vulnerable people from childhood into adulthood from neglect and abuse and from wider harms. We have also agreed a new business model for 2018-2019 which will see a smaller WSAB executive group meeting more often. This will allow us to increase the progress we are making to identify risk and weaknesses in the system and to act early to protect adults at risk.

Having made these changes our renewed focus in 2018-2019 will be on both Making Safeguarding Personal, on developing and promoting preventative practice and to:

- Share learning and provide assurance that learning from experience leads to improvements

As a Board our focus in Wiltshire must be on providing assurance. This work has progressed in 2017-2018 but we need to be able to more clearly identify and articulate levels of assurance relating to key safeguarding arrangements

In the last year we have also learned much from a regional study of Safeguarding Adults Review carried out by Professor Michael Preston-Shoot and from a review carried out in Somerset into the mistreatment and abuse of residents at Mendip House, a care home for adults with autism near Highbridge run by the National Autistic Society (NAS). In 2018-2019 we will be working to gain assurance in relation to how Wiltshire commissioners monitor the quality of internal and external placements, and crucially, how external commissioners monitor the quality of placements in Wiltshire.

A more detailed summary of what we have learnt through review of the system and the changes we hope to see made are set out in the Board's Business Plan for 2018-2019. This provides a framework by which our members and partners can measure success over the course of the next year. Our next three-year strategy will be published in 2019 and will report and build on the essential work we undertake this year.

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