01

Rationale for Safeguarding Adults Review (SAR)

Under the Care Act 2014, Safeguarding Adult Boards are responsible for undertaking a review of cases that involve adults with care and support needs where;

- an adult has died or suffered serious harm and,
- the SAB suspects or knows that this was because of neglect or serious abuse and,
- there is concern that agencies could have worked better together to protect the adult from that harm.

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What happened?

AB had a long-standing health condition with a history of refusal to comply with advised treatment which had resulted in physical difficulties. There was increasing concern for AB as her health deteriorated. AB was informed of the risks of failure to follow advice and the likely outcome, in the case of AB amputation or death due to septicaemia.
Professionals in contact with AB questioned her capacity on numerous occasions, but struggled to balance AB's right to make an unwise decision and a duty of care to her.
The case went to the Court of Protection where an independent psychiatrist made an assessment that AB did not have capacity to make the decision about her medical care.

07

Learning Point – Mental Capacity Assessment

The report found there was at times confusion over who had the professional responsibility for assessing capacity, and over the authority to make a decision after the assessment. There was a missed opportunity for assessments to be queried by others with professional expertise, and to resolve conflicting opinions.

Recommendation

All agencies should ensure that pro-forma mental capacity assessment documents are available to staff, and professionals should be given guidance in when to complete such documentation. Agencies should ensure that all staff receive training on the practical aspects of the Mental Capacity Act 2004.

03

Learning Point – Non-Routine Referrals

Enlisting the support of other agencies proved challenging. The standard referral pathways did not allow for the complexity of the case to be understood, and the nature of the referral explained.

The case was determined to not meet the threshold for a safeguarding enquiry, and the safeguarding process did not lend itself to a multi-agency assessment of risk and response.

It is important that agencies are aware of escalation routes within their own agencies.

Recommendation

The SAB partners provide guidance in cases of significant complexity whereby professionals are able to have discussions between agencies to consider options for action, outside the routine referral process.

All professionals are given guidance on the existence of multi-agency risk panel and how to bring challenging cases to panel.

Recommendation

All Agencies should consider multi-agency training on working with individuals who present with behaviours that challenge.

The CCG provides guidance to GPs on working with patients who present particularly difficult and complex challenges, use of the Mental Capacity Act 2004 and obtaining further legal or expert clinical advice.

The primary care team consider developing a formal structure in which staff are able to debrief or to discuss particularly difficult cases.

Recommendation

Health care professionals in primary care are given briefings on the powers of the Court of Protection, and when and how to get legal advice in relation to complex cases and mental capacity.

06

Learning Point – Vicarious Trauma

AB was visited on hundreds of occasions by district nurses and other services. Her responses posed considerable difficulties to their ability to undertake their tasks. It is important to be aware of the need for reflection and support for staff in these cases.

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