Dudley Safeguarding People Partnership

Stanley

Safeguarding Adults Review
Practitioner Briefing
May 2022

WHO SHOULD READ THE SAR?

Any practitioner and manager whose work brings them into contact with children, young people, and adults. The term 'children' includes children and young people up to 18 years of age. For further information on our safeguarding review visit the Dudley safeguarding website.

BACKGROUND INFORMATION

Stanley was an elderly gentleman of White British heritage who lived alone. Stanley was the youngest of six children, brought up by his parents in the Dudley area where he continued to live. A diagnosis of paranoid schizophrenia from early adulthood, necessitated involvement with secondary mental health services at that time and support continued throughout his life.

Stanley had been admitted into hospital on 24/1/20 with a swollen abdomen and leg and he sadly died at the age 82. There had been a series of five 999 responses over the previous weeks regarding one fall and four related to issues with his catheter.

FURTHER CONCERNS IDENTIFIED

Physical health issues developed for Stanley in later life around arthritis, sciatica and some lack of muscle control and coordination of movements, all of which affected his mobility.

Due Stanley's poor mobility, low weight and smoking which he did in bed due to his mobility. He was at increased risk of skin breakdown, developing pressure ulcers for which he received regular support from carers and Community Nurses.

A prostatectomy in 2002 led Stanley to need to use intermittent self-catheterisation in order to urinate. This method became increasingly difficult for Stanley to manage, as it caused him pain and discomfort leading to a change to a long-term catheter.

The catheter often became blocked or infected and the community nursing team were involved supporting Stanley.

During the review it was noted that he was agoraphobic in later life.

Safeguarding concerns were raised from 2010 alongside calls to the police about Stanley's relationships with local people around their anti-social behaviour and financial exploitation of him.

During later years this regarded a particular neighbour 'S' who Stanley described as his friend and as his carer.

These safeguarding concerns included reference to self-neglect from January 2015 with an escalation in the year before he died regarding both categories of abuse.

In January and February 2020 there was a cluster of concerns raised with an added reference to lack of sufficient agency care.

These later concerns were triaged by the Multi-Agency Safeguarding Hub (MASH) as meeting the criteria for a safeguarding response (Section 42 enquiry) although Stanley's case was still awaiting formal allocation by adult care at the point of his death.

OVERVIEW OF LEARNING

- **Understanding the person journey** Some agencies were unaware of Stanley's strengths around family and history demonstrating a lack of sharing of important historical and familial context. Opinions needs to be professionally substantiated in relation to commenting on a person's character or ability.
- **Mental Capacity** if any professional believes or suspects a client may have additional conditions that may involve or lead to a cognitive impairment rational must be recorded Capacity assessments undertaken need to be robustly recorded and legal advice sought when considering concepts such as 'executive capacity' and legal routes such as 'Inherent Jurisdiction' need to be understood by all agencies. When there is a possibly that an adult at risk is scared or coerced and they are self-neglecting the possibility of this impacting on elements of capacity needs to be explored, referral for a specialist assessment should be considered.
- **Multi Agency Working and Communication** current key staff should be clearly identified on client records so that roles and responsibilities are transparent. Case transfer is vital when workers are absent from post where risk is ongoing. While there was much individual and agency good practice, and some multi-agency meetings, there is a question as to if the right people were present at the right meetings, It appears that collaborative working was absent. Information about sources of risk needs to be shared with key hospital staff, potential care homes and other relevant professionals as appropriate.
- **Safeguarding Process** Additional categories of abuse including 'neglect and acts of omission' that may be masked by the presenting category need to be explored in order for any safeguarding enquiries to be robust and thorough. Protective measures should be put in place regarding property, possessions and finances. Coordination of referrals between adult social care teams and Urgent Care with the aim of avoiding a repeat of Stanley's experience plus proactive safeguarding and risk assessment needs to continue after hospital admission. Duty systems need robust managerial oversight to ensure actions are undertaken and Complex cases (in particular Safeguarding cases) should not be managed on Duty Team. and whether the right policy and procedures were utilised such as formal Safeguarding and/or the Self-Neglect procedures and protocols.
- **Supervision and Managerial oversight** regarding decision-making, access to and use of policy, protocols and law that informs practice is crucial along with reflective supervision. Escalation to be considered where there are differences of opinion amongst professionals. Longevity of professional relationship is useful for consistency and establishing a relationship with the client. However fresh eyes can offer differing perspectives and may be useful where a client's behaviour is entrenched and where there is difference of opinion between agencies.
- **Record Keeping and Documentation** Keeping up to date regarding policy, protocols, and procedure alongside robust recording of use of legal systems is vital for legally defensible practice. Out comes must be sought out, recorded and shared so that any change to vulnerability, risk assessment and capacity assessment can be initiated. Accurate recording, information checking, and clear sharing of information is crucial regarding people who care for adults with care and support needs. Referral to services such as Fire Service, safeguarding needs to be followed up by the referring agency and outcomes clearly recorded.
- **Mate Crime** Recognising signs of coercion and fear in adults at risk of abuse and understanding related concepts such as 'Mate Crime' is crucial particularly when the vulnerable person concerned is making decisions that puts them at greater risk. Proactively utilising windows of opportunity to discuss options with those wavering between expressing they want help and then withdrawing statements is needed in cases of Mate Crime. Disruption of crime is more than conviction focussed. It can be preventative (a key safeguarding principle). It can include civil options. Multi-agency collaboration is key to gaining understanding of options, even if those options are not taken or able to be taken.

RECOMMENDATIONS

1. DSPP to develop an Escalation Policy as a matter of urgency to ensure partnership agencies, and staff at all levels, understand they can challenge within and outside of their systems and know how to do this.

2. A review of the DSPP Self-Neglect Policy is needed as a matter of urgency. Likewise the Multi-Agency Risk Management protocol. The revised versions need to be owned by all partners so that all partners are utilising the same policy.

3. Once updated a clear dissemination strategy needs to be implemented, including regarding transfer of knowledge to practice (i.e. to all partnership agencies and between all levels of their staff).

4. Where there is mention of a 'carer' formal checks with DWP etc. (via an established standard operation process, SOP) need to be made by the lead agency and information then recorded and shared with relevant agencies.

5. Where there are concerns about possible financial abuse, or any type of abuse, by a paid carer (whether via Carers Allowance or a formal care agency) a referral should be made to the MASH.

6. Understanding of and commitment to truly collaborative, multi-agency and preventative working needs to be endorsed and promoted by all agencies as a way of moving beyond silo working. DSPP to measure this with an annual audit.

7. All partnership agencies to ensure that learning and resources regarding financial abuse, Appointeeships, Mate Crime and civil options are accessible to all staff, they have the time and reflective space to absorb them in order to enable transfer of learning to practice and this needs to be monitored.

8. Mental Health services in particular and other single agencies would benefit from signing up to the 'Care in Health and Improvement Programme' (CHIP), a joint initiative by the Association of Directors of Adult Social Services (ADASS) and Local Government Association (LGA) which has developed a framework to help untangle the Safeguarding criteria and provide resources and recommendations as to how to do that.

9. All agencies to re-establish the MSP agenda and ensure related concepts such as Advocacy are central considerations within any safeguarding work. DSPP to measure this with an annual audit.

MORE INFORMATION

For further information and to access the full report visit our website:

http://safeguarding.dudley.gov.uk