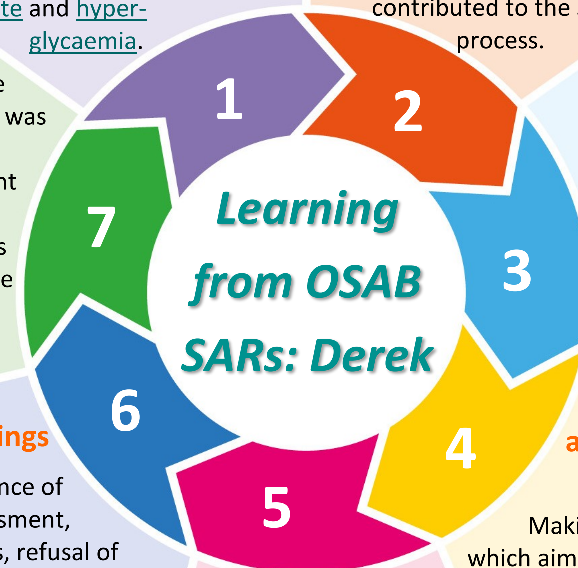
Background

A Safeguarding Adult Review (SAR) considers whether serious harm experienced by an adult at risk of abuse or neglect, could have been predicted or prevented. The purpose of the SAR is to promote learning and improvement action. It was a unanimous decision of the Oldham Safeguarding Adults Board (OSAB) SAR Subgroup that the criteria for a SAR were met in relation to Derek. The SAR Overview Report is available on the OSAB website. Since the report was published in March 2022, all agencies have undertaken a significant amount of work and changed practice, this briefing highlights some key learning themes deemed useful to ongoing practice. Derek had a diagnosed Learning Disability and number of other health conditions. He worked during his earlier life and functioned quite independently with some support. Derek was fondly described as 'old fashioned' and quite set in his ways; he always wanted to maintain control of his own life and choices. He liked to go swimming or on day trips with his best friend or watching trains. He was active and sociable in the places that he felt comfortable. Derek was 69 when he was sadly found dead in his home. He had died as a result of ketoacidotic state and hyper-glycaemia.

What Happened?

Derek's death was initially reviewed as part of the Learning Disability Mortality Review Programme (LeDeR). These reviews concern the deaths of people with learning disabilities, identify learning, and take forward the learning into service improvement initiatives. The information from family and that provided in the LeDeR report indicated that agencies involved with Derek could have worked more effectively together with regards to safeguarding, risk assessment and care planning. Concerns were raised about Derek's non concordance with diabetes treatment and agencies identified that there did not appear to be a clear care plan or risk assessment between agencies. He had increasingly started to refuse support. There were emerging concerns about hoarding in his flat and overall, his physical health and mobility deteriorated resulting in less independence and an abrupt halt to his social network of support. There were concerns about Derek's housing as his flat was in need of repair, evidence of hoarding was found and at times he expressed that he wanted to move closer to his niece, Janet. Janet was very involved in his life and she also contributed to the SAR process.



Multi-Agency Approach

With the right support, Derek had been able to have a social life, manage his physical health needs, financial needs and his home however risks escalated, his health significantly deteriorated, and multi-agency responses were required. Agencies could have come together with Derek to understand what he wanted and how he could be supported. There were episodes that could have triggered a Team Around the Adult meeting including when he refused support from a provider and expressed suicidal ideation. This would have led to identification of a Lead Professional; crucial as Derek felt 'overwhelmed' by people in his house.

Legal Literacy and Making Safeguarding Personal

Making Safeguarding Personal (MSP) is an initiative which aims to develop an outcomes focus and a range of responses to support people to improve or resolve their circumstances. Consideration of MSP should mean 'No decision about me, without me.' The absence of Derek's voice indicated a lack of person-centred Planning. Professional curiosity was not always evident and assessments, particularly in the hospital context and discharge processes, relied heavily on self-report, with home circumstances not observed and family or general practice staff not consulted. The Local Government Association MSP toolkit provides guidance about the best approach.

A Care Act assessment was completed and may have been one of the key opportunities to capture Derek's aspirations. Knowing and using legal powers and duties is a central element of practice. Utilising these as tools could have led to different outcomes. The Care Act assessment could have been reviewed in response to changing circumstances and increasing concerns.

Mental Capacity

Capacity was considered by agencies, however Derek's capacity to make decisions about his care and support was not explored regularly. There was no evidence of how practitioners communicated with him to ensure he understood the risks/consequences of unwise decisions. There was no discussion about the risks/concerns with his niece. In addition, there was little evidence of the sharing or recording of capacity assessments – *even if someone is deemed to have capacity in a specific area, how that decision has been made needs should be recorded accurately by applying the test of capacity*. More robust professional curiosity should have led to questions about his ability to make certain decisions at certain times; there was escalating risk without risk-aware responses from agencies. Examples include the risk implications of not complying with medical management plans, escalating frequency of hospital admission, serious deterioration in physical health, missed appointments and refusing support at home especially in the context of hoarding and other self-neglect indicators.

Further Findings

- The review found limited evidence of professional curiosity in relation to risk assessment, carers' needs, rapidly escalating health needs, refusal of services and poor concordance with medical management. Effective professional curiosity is a crucial part of safeguarding practice and is developed through regular and effective reflective supervision. The review identified the need for robust communication and information sharing and the need to "join the dots" and have "the right conversations and ask the right questions". Professional Curiosity Guidance is available via the OSAB website.
- Derek was understood to have a learning disability and was open to the Integrated Community Learning Disability Team. GP records included a learning 'difficulty'. He was not flagged as either at the hospital or when he was discharged. Derek not having the correct diagnosis within records may have impacted on how agencies perceived his level of understanding and how they communicated with him. While it was widely recognised that an agency should respond to and treat a person based on their presentation rather than a diagnosis, identifying the difference correctly can aid access to the right support. MentalHealth.org confirms that a learning disability constitutes a condition which affects learning and intelligence across all areas of life and a learning difficulty constitutes a condition which creates an obstacle to a specific form of learning. It was not found that an incorrect 'term' was significantly detrimental to Derek.

Carer's Assessments

Derek's main source of support was his niece Janet with whom he had a positive, close and loving relationship. Although Janet was mentioned in the Care Act assessment, she was not described as a carer, this may be part of the reason why a Carer's Assessment was not facilitated; this suggests that there was a lack of awareness. Janet provided a significant amount of informal care which was never recognised despite subsequent opportunities for all of the agencies involved. Find out more about the importance of identifying and valuing Carers and the need to ensure appropriate support is in place via a separate OSAB 7-minute Briefing.

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