

A Safeguarding Adult Review (SAR) is a multi-agency process that considers whether or not serious harm experienced by an adult at risk of abuse or neglect, could have been predicted or prevented. The purpose of a SAR is to promote learning and improvement action to prevent future deaths or serious harm occurring again. Oldham Safeguarding Adults Board (OSAB) completed a [SAR in relation to Jessica](#).

- Jessica was 28 years old when she died. She had quadriplegia from the age of 9, due to injuries sustained in a road traffic accident. During the time period considered by the SAR, Jessica lived at home with her parents and a sibling and was studying at the University Campus in Oldham.
- At the age of 18, Jessica's care transferred to Adult Social Care (ASC), at which point she was supported by the Complex Needs team with a care package funded by Continuing Healthcare (CHC).

- The review found a lack of transitional arrangements between Children's Social Care and ASC. During Jessica's childhood, services seem to have focused primarily on her health needs.
- [Sections 58–66 of the Care Act 2014](#), setting out the requirement to complete a Child's Needs or Transition Assessment if there are likely to be care and support needs post age 18, have been introduced since this review. This should ensure that services are fully aware of children with substantial needs, such as Jessica who was transitioning to adult services.
- From 2011, Jessica's annual care plan reviews stopped due to the change in the funding arrangements of Jessica's care. If CHC had continued to part fund care then the annual review would have continued. As this was not the case, there is no national NHS guidance that requires her care to be reviewed.

Primary Care Learning

Jessica's GP practice deemed her ineligible for home visits for 20 months prior to her death due to a move out of their catchment area. However, the practice had erroneously applied 2015 NHS England guidance which allowed GP practices to register new patients who live outside the practice area without an obligation to provide home visits or services out of hours when the patient is unable to attend the practice. Having allowed her to remain as a patient with the practice, the GP practice could not remove her right to home visits as the NHS guidance applies primarily to new patients. Nor was it a clinically appropriate or practical decision for a patient who had quadriplegia to be denied home visits. The absence of home visits adversely affected the care received and further contributed to her isolation from services.

Multi-agency working was largely absent; when a Tissue Viability Nurse wrote to Jessica's GP sharing concerns in the months before her death, it did not prompt a review of her case. Whilst ASC had no statutory duty to review Jessica's care and support needs, as she was not in receipt of any commissioned services from the Local Authority, one of the key principles of the Care Act is the importance of preventing or delaying the development of needs for care and support. As Jessica had quadriplegia her needs were likely to change over time and she could need support to avoid social isolation, engage in work or volunteering, make use of community services or engage in recreational activities, for example. This should have led to a multi-agency risk assessment. Best practice would have involved the District Nursing team and the Tissue Viability service working with Jessica's College to consider options for reducing the amount of time Jessica spent in her wheelchair without compromising her studies. A full risk assessment was initiated in the last few weeks of Jessica's life but was not completed before her death.

Jessica's mother could have been offered training in wound care management by the District Nursing team or Tissue Viability service. The Oldham Carers Strategy 2018-2021 emphasises the importance of providing carers with the right support at the right time.

Please reflect on the findings and share with OSAB any feedback, system challenges or recurring issues you may experience as a practitioner, that may need to be considered to improve practice in cases similar to Jessica's?



Learning from OSAB SARs: Jessica

Carer's Assessment

Following the crash, Jessica's mother gave up her job as a midwife to care for Jessica. Whilst private carers also helped to care for Jessica, her mother was the primary carer. There is no record of Jessica's mother being offered a [Carer's Assessment](#). Her caring role was undoubtedly a substantial, long term and intensive responsibility. There were missed opportunities in 2011 to consider her caring role when a referral was made to ASC for Jessica and again, after the Care Act 2014 made it a duty to offer a Carer's Assessment. Whilst ASC had limited involvement with Jessica prior to her hospital admission in June 2019, the GP practice, District Nursing and Tissue Viability services had substantial contact and could have suggested a Carer's Assessment.

Person Centred Care & Support

Agencies focused observations on Jessica's physical health needs rather than on her as a person. There seems to be little consideration of her wishes, feelings, or aspirations which would have helped to gain a more holistic understanding of what was important to Jessica, day to day. This was particularly important as she was seen by many practitioners. She was a young women focused on her studies and attending college was an important part of her life. This key factor was overlooked especially within the schedule of home visits by District Nurses trying to manage her pressure ulcers. Several appointments were declined and as a result there were no District Nurse visits at all between 5 February and 14 May 2019. In light of the complexity of Jessica's needs, the cancelations and request to reduce their frequency should have prompted a review to determine what lay behind the decision. Evening and weekend visits could then have been offered much earlier. This was a major omission as National Institute for Health & Care Excellence guidance Pressure Ulcers: Prevention and Management stresses the importance of completing an assessment of pressure ulcer risk if adults have a risk factor. Of the six risk factor examples given, four applied to Jessica and sepsis arising from pressure ulcers is a leading cause death for people with a chronic spinal cord injury.

Mental Capacity Act and Advocacy

Prior to hospital admission in June 2019, practitioners did not doubt that Jessica had capacity but the series of unwise decisions made by Jessica and her mother to go against professional advice in respect of pressure ulcer care should have been challenged and escalated. The Mental Capacity Act (MCA) Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character'. The Code adds that 'these things do not necessarily mean that somebody lacks capacity...and suggests issues worthy of further investigation might including whether the person is easily influenced by undue pressure'. Alternatively, Jessica could have been considered eligible for advocacy support under the Care Act 2014 to facilitate her involvement in reviewing the care plan drawn up by the Tissue Viability service or to facilitate her involvement in safeguarding enquiries had a safeguarding referral been made earlier. Launched in 2022, the [OSAB TRAM Protocol](#) provides guidance on escalating cases involving risk where the adult is deemed to have capacity but is making what others consider to be an unwise decision.

