OLDHAM SAFEGUARDING ADULTS BOARD

RAPID REVIEW REPORT

Pseudonym of the Adult at Risk:	Sarah
Date of Serious Incident/Death:	September 2019
Chair:	Hayley Eccles
Date of Rapid Review Meeting:	12 January 2021

1. Contributing Agencies

Name	Agency/Role	Report (y/n)	Chronology (y/n)	Attended (y/n)
Hayley Eccles	Head of Adult Strategic Safeguarding, Oldham Council (Chair)	N	N	Y
Amanda Smith	Named Nurse Safeguarding Oldham, Community Services, Northern Care Alliance NHS Group	Y	Y	Y
Camilla Guereca	Chief Executive, Oldham Personal Advocacy Limited	N	N	Y
Charlotte Walker	Head of Service-Learning Disability and Autism, Oldham Council	Y	Y	Y
Dale Coleman	Highly Specialist Nurse, Mersey Care NHS Foundation Trust, Greater Manchester Specialist Support Team	N	N	Y
Donna Taylor	Senior Learning Disabilities Commissioning Case Manager, NHS Oldham CCG	Y	Y	Y
James Babyk-Glynn	Business Coordinator, Oldham Safeguarding Adults Board	N	N	Y
Janine Campbell	Designated Nurse Safeguarding Adults, NHS Oldham CCG	Y	Y	Y
Dr Keith Jeffery	Clinical Director for Mental Health and Learning Disabilities, NHS Oldham CCG	N	N	Y
Kevin Howarth	Social Care Lead, Learning Disability & Autism Team, Oldham Council	N	N	Y
Lydia Popplestone	Occupational Therapist, Mersey Care NHS Foundation Trust, Greater Manchester Specialist Support Team	N	N	Y
Ruth Bell	Lead Nurse for Learning Disability and Autism, Northern Care Alliance NHS Group	Y	Y	Y
Vicky Dunn	Operational Team Manager, Mersey Care NHS Foundation Trust, Greater Manchester Specialist Support Team	N	N	Y
Wendy Yuille	Safeguarding Families Specialist Nurse, Pennine Care NHS Foundation Trust	N	N	Y
Ahmed Badat	Business Support Officer, Oldham Council (Minutes)	N	N	Y

2. Agencies that have confirmed no contact

Name	Agency

3. The Report

3.1 Facts about the Case

3.1a From Case Referral

The case was referred by staff at Oldham CCG for on 04/11/2019.

The referral for a SAR was screened some time ago as there were some concerns about Sarah's presentation and agency actions. As far we are aware, Sarah had not come to any physical harm, but concerns were from an emotional perspective. Safeguarding concerns were raised because Sarah was in a neglected situation, the accommodation was in a neglected state. Sarah had been naked for some time and unable clean properly and this had limited her social interaction with others. There had been an increase in Sarah's restrictions, in relation to Deprivation of Liberty, in order to keep her safe. Her care was increased from one-to-one to two-to-one. There were other restrictions in place, including the use of safe hold techniques so that physical examinations could take place. As part of a review process, these concerns were highlighted. From that point, the multi-agency partnership worked really well together but the question now is how partners got into that situation.

There have been certain system issues highlighted, for example, dental care. There were significant concerns about this, particularly in relation to long delays for treatment for people with Learning Disabilities (LD). This was not the first time this issue has been encountered. As a system, we must review what happened in Sarah's case to learn from it and make improvements.

It was decided that the case did not meet the criteria for a statutory SAR because it was hard to 'justify' the harm criteria as there was no physical harm and we did not know the level of emotional harm that Sarah had come to. It was recognised that a Learning Review was needed as there was some learning for agencies. The Learning Review will be shared with the Oldham Safeguarding Adults Board (OSAB).
There has been another SAR for a person with LD and hopefully the learning from each case can be linked and if there is any learning exclusive to this case then OSAB can take this forward in a joint action plan.

3.1b Overview of Agency Summaries

Pennine Care NHS Foundation Trust

The PCFT staff in the Adult Learning Disability Team have provided a range of interventions over the period in question. It was shared that all Care Plans that are relevant to this period were completed, and LD Nurse involved actively promoted Sarah's physical health & wellbeing. The Nurse responded appropriately by providing information, guidance, and support to the staff team and by liaising with other professionals; these included – a Consultant Psychiatrist in Learning Disability, Sarah's GP and other GPs at the Practice and Community Dental Services.

There are examples of adjustments to usual working practices being arranged and coordinated by the LD Nurse, in order to ensure that Sarah could be seen and reviewed by specialist healthcare colleagues without causing her undue distress. These include home visits by the Consultant Psychiatrist, and home visits by the Specialist Dentist.

The Learning Disability Directorate Treatment Support Protocol was considered and used to plan for taking bloods and a potential dental examination.

The Health Lead first became involved during the home visit that prompted the safeguarding referral. A visit was arranged due to concerns about Sarah's circumstances and environment that had been escalated by the LD Nurse and Clinical Nurse Specialist in the Team. The Health Lead met with Sarah, staff team and family members. There was concerns on how the environment could deteriorate to such a significant extent.

Northern Care Alliance (NCA)

Attended Safeguarding Strategy meeting on 15/10/2019. It was agreed that in the event that Sarah required hospital attendance and/or admission the NCA Learning Disability and Autism team would work collaboratively with family and other agencies to ensure that any reasonable adjustments required were put in place to facilitate an accessible, person centred pathway of support. Sarah did not attend hospital and there has been no further involvement from the NCA Learning Disability and Autism team.

NHS Oldham CCG (on behalf of St Mary's Medical Practice)

The GP practice saw Sarah as and when required and there were periods of time, where there was an increase in involvement. The GP practice saw Sarah for a variety of problems, including possible bleeding from her vagina or her rectum, there were times when Sarah decreased her oral intake and times when Sarah's behaviour was a concern to care staff.

There were concerns for Sarah's dental care and the impact this may have had on her overall health and wellbeing.

Assessment of Sarah's mental capacity to make specific decisions appears to have been presumed that she did not have the capacity. There is evidence of practitioners following Best Interests processes although it isn't clear these decisions were formally recorded.

There is limited information in the GP records about the environment which Sarah resided in or the care providers involved. In September 2019, the concerns about her environment are detailed in respect of Sarah's behaviour (refusing to wear clothes, take a bath, passing faeces everywhere and smearing the walls,) there doesn't appear to be consideration whether the environment is able to meet her needs.

The GP practice liaised mainly with Sarah's carers, there was regular discussions with family as part of best interests decision making.

The GP stated 'Sarah's parents attended all the best interest meetings, and I would see them at her places of residence from time to time. I had known them since Sarah was a child and we had a good relationship. I knew that her carers were in regular contact with Sarah's parents and that they knew they could contact me if they felt they needed to. There had not been any specific indication for me to contact them outside of the best interest meetings as there were no single events which had stood out as highly unusual (this included the self-digitation causing bleeding which had been observed many years earlier and varied in its' frequency and intensity)'.

Adult Social Care

From an adult social care perspective, the legislative framework of the Care Act and related assessment, decision-making and support planning have been completed in this case. There are some gaps in how regularly the care was formally reviewed, though it is possible this implies stability/consistency in Sarah's presentation.

Family involvement has been consistent throughout Sarah's life, and the family continues to advocate for Sarah.

At the point of the deterioration in health and presentation in approx. May 2019, there were concerns around the responsiveness of the provider and how quickly repairs were being arranged at the house. This was especially concerning owing to the impact of not having running water or a working toilet temporarily – both for Sarah and the support staff caring for her.

The committed co-ordination of the multi-agency response to this crisis, and since, with a named lead professional, and careful application of Safeguarding framework, use of the Mental Capacity act and evidence of consideration of the Mental Health Act have given assurance of ongoing robust assessment and professional response and risk management. There has been appropriate professional challenge to colleagues where decisions were possibly being made outside of formal Best Interests processes/ by individual practitioners not in consultation with the wider MDT. Partnership working has been effective in this case, though there is always the possibility of improvement.

There has been learning from a LeDeR report relating to another client relating to formal decisions and accepted timescales for medical procedures. The lead professional in the MDT, the Health Team Lead, in particular has driven the actions on this case in conjunction with allocated workers in both health and social care, and the wider MDT. This has been vital to ensuring that actions were achieved, and where there were issues/delays, they were escalated appropriately and effectively. The leadership and co-ordination required careful consideration of need, risk and legislative framework, and was key in supporting the individual practitioners in their required actions and responsibilities. This has ensured the case hasn't had 'drift' whilst managing risks ongoing. It is also apparent that this has supported Sarah's family to understand processes and progress/barriers.

The allocated social worker has worked with Sarah since 2015, which has given consistency to the case and relationships with family and Sarah especially. In this case instance, the lead for the MDT came from the Health 'side' of the LD Service, this is an internal process to ensure co-ordination and oversight of cases where there is concern, risk of deterioration and admission to hospital. Where the primary issue relates to health needs, then a health lead would usually act as the lead professional. This does not take away from the role of the social worker, indeed it provides oversight and management of actions, ensuring all actions in line with legislative frameworks and timescales.

3.2 Case Discussion

3.2a About the adult & their lived experience (Step 2)

Sarah lives in her own home and likes her own space, enjoys watching TV and listening to music. Sarah has a good relationship with her sister and parents who are actively involved in her life. Sarah is fiercely independent, knows what she wants and is strong willed. Sarah loves baths, enjoyed holidays with her parents, especially if there was a hot tub! Sarah enjoyed trips out to the reservoirs with a packed lunch. Sarah has a learning disability and sensory sensitivities. Sarah has commination difficulties and expresses her communication through behaviour. Sarah can at times display self-injurious behaviours.

3.2b Views of family/carers

It has been discussed that Sarah had ongoing support from her family. It was discussed that Sarah's parents were quite often naive and would often go with professional recommendations, often stating the 'professionals know best' and not often challenging decisions. It was also discussed that there appeared to be an acceptance of the situation.

There was quite strong feedback from Sarah's father concerning how Sarah was presenting when she was really unwell at home. At the time, before anything happened, he said she always appeared that she was 'cold turkey-ing', as if she was on some sort of withdrawal. And just before Sarah went into hospital, he said that she was in a demented state, really anxious, depressed, and rocking on her chair.

As this is not a statutory SAR, the decision about involving family is usually taken on a case by case basis. We do have family views anyway, as they have been involved in the case, for example, they attended the best interests meeting. At that time, family were very much of the opinion that Sarah should not be taken into hospital, she had had a negative experience on a previous admission. They were against any form of restraint and restriction. It was discussed that their anxiety about her admission did not demonstrate that they saw the other risks and concerns. The bigger picture was not considered, including the fact that v was always naked in her property and was therefore not able to leave. The wider risks were explained to them and it was also explained that admission would be the last resort. Admission to hospital was certainly their largest concern and the negative impact that may have on her overall health and wellbeing.

3.2c Views of front-line professionals

Pennine Care NHS Foundation Trust

The Health Lead first became involved during the home visit that prompted the safeguarding referral. The Health Lead arranged to carry out this visit due to concerns about Sarah's circumstances and environment that had been escalated by the LD Nurse and Clinical Nurse Specialist in the Team. The Health Lead has met with Sarah, staff team and family members. The Health Lead has reflected to the author that they question how the environment was allowed to deteriorate to such a significant extent.

NHS Oldham CCG (on behalf of St Mary's Medical Practice)

The GP practice liaised mainly with Sarah's carers, there were regular discussions with family as part of best interests decision making. Sarah's parents attended all the best interest meetings, and the GP would see them at her places of residence from time to time. The GP had known them since Sarah was a child and we had a good relationship. The GP knew that her carers were in regular contact with Sarah's parents and that they knew they could contact the GP if they felt they needed to. There had not been any specific indication for the GP to contact them outside of the best interest meetings as there were no single events which had stood out as highly unusual (this included the self-digitation causing bleeding which had been observed many years earlier and varied in its' frequency and intensity).

This was a challenging case for everybody. From a GP perspective, there had been conversations with a consultant from the Medical Assessment Unit. This consultant had advised that the best course of action was to continue to treat Sarah in the community to avoid a traumatic hospital admission. There were not concerns about the diarrhoea and the anal bleeding, as that had been going on for some time

Dual management was one of the problems with this case, from a CCG perspective. As it involved someone with potential physical and psychological problems. We were balancing between physical and Mental Health services. There was no dual management. It was always "she's physical", "no, she's psychological". Until we had had the physical investigations ruled out, Mental Health services would not take on the case. We needed dual management; people are physically and mentally unwell at the same time. This issue delayed processes and treatment. The necessary practitioners were not involved in the discussions. Input from Mental Health services was coming via email. It was the same with the GP. We did not have the practitioners in a room together to have those discussions and to sign off the medical management plan going forward. Delays were caused by disagreements about who should be managing what, first.

Adult Social Care

Discussion with Social Care Lead: The Social Care Lead and I discussed this case, and reflections based on the discussions held in supervision with Sarah over the months last year especially. On reflection, it was apparent that as the situation escalated, specifically regarding Sarah's refusal to wear clothing, and the deterioration in her physical health, there were attempts to resolve the issues and appropriate actions taken to support. However, until a lead professional was agreed, and a formal MDT response structure established, limited progress was made. We have seen in similar cases historically, and to an extent this case at that point, that MDTs can often risk professional inertia or a holding of risk rather than meaningful reduction and/or escalation for support where progress is limited. The Social Care Lead reflected that there was significant focus at the time on the care provider and their response to the situation/scrutiny on the support being provided, and the evidence in care plans/behaviour charts etc. Whilst this is an appropriate consideration, it is important that all practitioners involved in a person's care be supported to reflect on their role, and what else could be considered/how issues are escalated. Positive professional challenge and evaluation of the efficacy of strategies in place to support a person's needs and assist in managing behaviour which challenges are vital in complex case management.

The escalating case situation also highlighted the need for a sensory Occupational Therapy (OT) assessment – as a service we are reliant on the Specialist Support Team (SST) via GM for this provision.

There was much discussion regarding Sarah's situation and the application of Safeguarding Adults' processes. I worked with the allocated worker, members of the wider MDT and the team managers to provide professional challenge regarding the balance of complex risk management via an MDT approach versus the use of overarching safeguarding process and structures. I was keen that we convene a multi-agency strategy meeting in the first instance to ensure that we were evidencing consideration of Section 42 thresholds, whether Sarah had come to harm, and indeed the causes of said harm, but also to ensure that we had a clear structure and associated timescales for actions, response and further escalation if required. By doing so, I was able to give clear direction in the application of relevant legislative frameworks, especially those of Mental Capacity and Best Interests processes. Whilst we progressed the actions from a risk management approach, and did not proceed to a full safeguarding investigation, the structured approach remained. It is also important that the MDT are evidenced as having considered how Sarah's needs, risks and liberty were being safeguarded.

In relation to any kind of Mental Health assessment, we went back and forth for at least a week when we were in that most acute phase, trying to get a Psychiatrist that was confident to assess Sarah because of her autism and her LD. I can remember a very specific day where most of the people in the MDT were on the phone to other people trying to get hold of a Psychiatrist who felt confident in assessing Sarah. It was the same with the duty Advanced Mental Health Practitioner (AMHP). From our perspective, this process was painful and frustrating. And from Sarah's perspective it did not get us anywhere.

3.2d Immediate thoughts/observations (Step 3)

It appeared that Sarah had good family involvement and support, but it was recognised that this support was often in agreement.

It appears that there was a lack of joined up working and a MDT response, with agencies acting/responding in silo.

Everyone appears to have a good understanding of Sarah, but there is no identified communication plan/strategy. There is no sensory assessment that has been completed despite Sarah having sensory sensitivities.

It appears that advice was given to manage the physical health challenges/difficulties were managed in the community to avoid a traumatic hospital admission. There does not appear to be any exploration of reasonable adjustments.

There appears to be challenges between referrals to organisations.

Whilst we understand what Sarah likes, and enjoys, we don't have any reflection of what she thought of this situation and what she would have wanted to happen.

No referrals made to advocacy services.

3.2e Analysis Tree: Cause and Effect – factors that may have influenced the incident and individual or/and agency practice (Step 4)

The review identified the following problem areas and continued to further analyse the cause and subsequent effect of them on practice.

<u>Communication & Pathways between agencies</u>

- Cause: Agencies acting in silo, diagnosis acting as barrier. No reasonable adjustments.

- Effect: Lack of multi-agency response. Delayed access to primary care services, including dental care.

<u>Advocacy</u>

- Cause: Professionals feeling that family were representing Sarah wishes, but having an understanding that family were unlikely to challenge, even if decisions weren't in Sarah's Best interest.

- Effect: Lack of independent advocacy.

<u>No Communication Assessment or Strategy</u>

- Cause: Professionals reliant on their experience to communicate with Sarah.

- Effect: Lack of understanding of what Sarah's behaviour was describing in terms of communication. Sarah's behaviour being viewed as challenging rather than a form of communication.

<u>No Clear Escalation Process</u>

- Cause: No identified Lead Professional.

- Effect: Concerns were not escalated in a timely way.

3.2f What are professionals worried about? (Step 5)

Professionals were worried about the delays in escalating concerns. There were concerns around Sarah's parent's ability to advocate.

If we think of people's wellbeing in general and their very basic needs. If we think about Maslow's hierarchy of needs. The basic needs are warmth, water and nutrition. We were not meeting theses for Sarah. She was not getting the correct nutrition. The CCG Case Manager saw Sarah when she was quite cold. The environment was not right. She was in significant amounts of pain. She was quite distressed. Her wellbeing and quality of life at that point was quite low.

Professionals were concerned that there appeared to be a general acceptance that 'this is Sarah' and an acceptance of the situation. Professionals were concerned that the situation had been able to progress to the point that it was having a detrimental impact of Sarah's health and wellbeing and there was no joined up, proactive approach.

Professionals are worried about including Sarah's Mental Health, physical health, home environment, wellbeing and safeguarding concerns. We were also really worried about multi-agency working as we were coming up against barriers and we were worried that we were not going in the direction that we needed to. There was no lead professional named.

3.2g What has worked well? (Step 6)

Sarah worked with professionals that had known her for a long time and they had in-depth understanding of what worked well for her, her history and her journey. Although this was not always captured in assessments such as Communication Assessments and Risk Assessments. Recognition if this is not captured, the knowledge could leave with the worker if they leave their role.

Sarah had good access to her GP, who reviewed her. Sarah was also reviewed regularly by the LD Nurses. There was a positive response when the CCG Case Manager went to see Sarah. They knew who to contact, how to escalate concerns. Sarah did have some face to face contact with people.

The safeguarding process worked well once instated. Things really started to pick up speed. There were people taking personal responsibility for actions. Sarah has ended up in a good situation compared to where she was. We started to get some of her needs met.

3.2h Learning that has/should be shared

The correlation between physical and Mental Health and the challenges there and the dental care delays.

The exploration around the bowels too, as we know the prevalence between LD and bowel and gastro issues. And, being able to put in those proactive strategies to enable Sarah to access treatment when she needed to.

Clear understanding of how individuals express pain and how this is identified in behaviours expressed.

3.3 Improvements to safeguard and promote the welfare of Adults at Risk

Systemic issues around assumptions, escalation and challenging behaviours and the labels we place on people when we become familiar with them; seeing the issues as theirs and not ours. And, not seeing her behaviour as a form of communication.

The hospital admission avoidance work that is ongoing that will promote the welfare of adults at risk and work that others are doing.

There is a huge role here for advocacy for the individual. And the need for an advocate and families to challenge professionals and the system.

3.4 SMART Actions (Step 7)			
Action	**Outcome**	**Lead Officer**	**Date**
1. Improved communication and improved pathways between services/teams. These include mental health/specialist teams.	Clear pathways and Escalation processes. (already completed and in progress) This has been supported through the multi-agency risk huddles. Work will be supported by the SOP being completed by the PSW.	TBC	
2. Improved and more timely access to dental treatment	Timely access to dental care and reasonable adjustments identified when needed.	Action for the SAB to seek assurance from NHS England in relation to timely access and support of reasonable adjustments if required.	
3. Sensory Assessments	More access to holistic sensory assessments to form part of individuals assessment of need.	CCG	
4. Clear Escalation Process when there is a deterioration in individuals' presentation particularly in relation to the condition of property and escalation to the appropriate commissioning teams if and when required.	Clear visible escalation processes (already in place or progress). Risk Management protocol. Demonstration of escalation – Multi agency Risk Huddles. Complex dependencies group.	SAB ASC CCG & ASC Commissioners	
5. Advocacy	Ensuring that individuals have and are offered access to advocacy services.	PSW SAB	
6. Bowel Referrals	To ensure individuals have access to bowel screening and consideration given when there is a presentation of altered bowel habits.	CCG	

	To ensure this is reviewed as part of Annual Health checks.		
7. Positive Behaviour Support Plans (PBS)	To ensure adult social care and community providers have access to proactive PBS strategies and reduce restrictive practice.		
8. Good Communication Plans	SAB to seek assurances from the LD partnership board in relation to communication plans for individuals. For the LD partnership board to consider the impact of terminology of 'challenging behaviour' and consider if alternative language such as 'distressed behaviour' would have a more positive impact.	SAB LD Partnership Board	
9. Reasonable Adjustments	SAB and partner agencies to provide assurance and consider access to reasonable adjustments.	SAB	

3.5 Summary of learning and Next Steps

Particularly around assessment processes, the interface between Primary Care and Mental Health services, the transparent process around reasonable adjustments to enable hospital admissions, mental capacity and how that framework can be utilised to enable people to access services and to also hold people to account.

There is learning about how we are supporting people and maximising their capacity and providing evidence for that. Also, making sure that all the relevant assessments are in place. I think the Sensory Assessment could have had an impact, moving forward. Also, assumption, not accepting the status quo and challenging ourselves. Also, significant learning about terminology. Also, learning about the lead professional.

The next steps will be related to the actions we take away. The main one is around escalation processes between Primary Care and Mental Health services and to get that agreement for joint assessment to try and break down some of the barriers.

3.6 Gaps in information/organisation representation

Name:	Hayley Eccles
Date:	08/07/2021
Signed:	