Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR - JENNY

1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to JENNY could learn lessons and improve practice.

Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight.

The overall aim of a SAR is to improve services because of that learning. **What do you do?** Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR.

The full report can be found here –

https://www.safeguardingadultsinbexley.com/wp-content/uploads/SAR-JENNY-3.pdf

2. What happened in the case of Jenny?

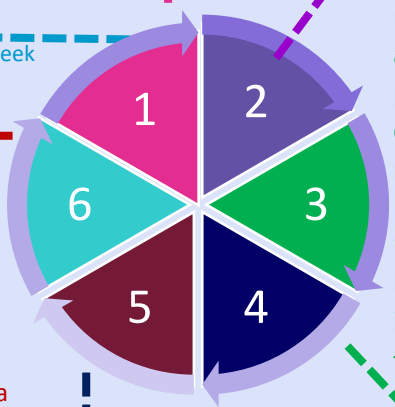
The subject of this review is a white British woman in her early sixties who was assessed as having a mild learning disability and a number of health conditions including epilepsy and dementia.

She died a few days after being admitted to a care home after a 17 week stay in hospital.

Prior to her death she was known to learning disability and health services

3. Involvement of Family & Significant others:

Records show that Jenny had four brothers and two sisters but she was only c communicating regularly with one of her brothers as at year 2015.However, when she was in hospital a discharge planning meeting was held and one brother and his wife did attend. Jenny's partner visited her in hospital almost every day. At the meeting the members of Jenny's family nominated her partner as her 'next of kin'. Whilst there is no legal basis to this, it does indicate the importance placed on his role by the family. Her partner did not wish to contribute to the LeDeR review & neither he nor any other family member have been contacted in relation to this SAR in view of the lack of recent involvement.



4. Review of Agencies Involvement:

There was continuity, but the different agencies did not work together to determine what was really the position. No individual professional went beyond passing on their concerns to another individual or agency. There were several t times during the period 2016 to 2018 when her key worker from the community learning disability team could have called a multi-agency review to share information and co-ordinate support.

This would have been in response to the feedback from the day centre that she was not attending and the view of the centre and other professionals that Jenny's level of confusion was increasing. In the absence of this, not enough was known about the extent of Jenny's needs and what support she might have been prepared to accept. At no point was there any consideration given to offering her partner a Carer's Assessment or considering whether Jenny had the capacity to make decisions about her care & support. By the time her partner took her to register with a GP in Bexley her health had deteriorated to the extent that London Ambulance Service and QEH raised safeguarding concerns.

These were not progressed while she remained in hospital, nor was a subsequent safeguarding referral that was received while she was in hospital, as it had been decided that those concerns should be looked at as part of the discharge process. In my view they should have been followed up at the time to inform the discharge process.

5. Partnership Recommendations:

In a situation where one or more professionals raises concerns about deteriorating health and increasing care needs, these should be proactively followed up as soon as possible. In this situation a multi-disciplinary review should be called. Any professional can and should ask the CLDT for such a review if they are concerned. If as in this case, there is an allocated key worker from the CLDT they should ensure a review is held if they are aware of concerns raised by other health or care professionals.

As part of a review of support needs, every effort should be made to see an individual at home to ascertain how well they are coping. In situations such as these a partner should be offered a Carer's Assessment by adult social care or the CLDT.

If safeguarding concerns are raised during hospital admission, enquiries should be progressed and not deferred until the discharge planning process.

Whilst the process relating to discharge of patients with complex needs and meeting the criteria for Continuing Health Care has changed since 2018, it is important to ensure that Mental Capacity Act assessments and Best Interest Decisions are completed within the hospital prior to discharge when there is doubt regarding an individual's decision making capacity.

All agencies should ensure greater awareness amongst front line staff and managers on when to undertake a MCA assessment, to determine an individual's capacity to agree to their care and support plan, and the follow on Best Interest meeting if required.

LeDeR reviews should be progressed in a timely way and wherever possible be completed within 6 months to ensure any learning is acted on. If at any point the LeDeR reviewer considers there were safeguarding issues, then a referral should be made to the SAR subgroup. Where there are difficulties in accessing information requests should be escalated to the SAB.

The Bexley Safeguarding Adult Board has established a pressure ulcer task and finish group to consider lessons from a previous SAR. The task group should review the issues raised by this SAR and any additional learning.

6. Recommendations for the BSAB:

BSAB to seek updates from partners regarding the embedding of this learning through the BSAB SAR Sub Group.