Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR - N

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 SAR N 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.

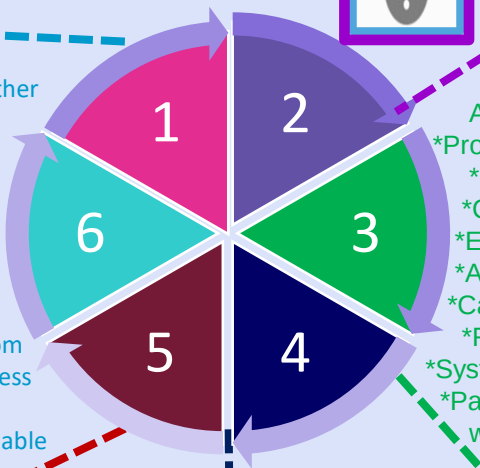
The full report can be found here – https://www.safeguardingadultsinbexley.com/wp-content/uploads/SAR-N-Redacted-Executive-Summary.pdf

2. What happened in the Case of N?

On March 28th police received information from a member of staff from Ward B who wanted to report organisational malpractice and abuse of patients on Ward B by the Consultant Psychiatrist and other individuals. The whistle-blower believed many patients were not given proper treatment or help, which lead to self-harm and attempted suicide. The individual was advised to contact the Care Quality Commission to report malpractice, following a consultation by the Officer from CID, who took the information. Police were unable to advise if this information was followed up or if a complaint was made to the Care Quality Commission. Adult Social Care commenced a section 42 Safeguarding Adult Enquiry having received a MASH referral on April 27th from Police, and Trust E's referral on the 28th. A Director from Trust D confirmed that given the seriousness of the incident, a Board Level enquiry was considered and the concern was escalated to both CQC; Commissioners and Patient Safety Lead. CQC have responded to this SAR and advised that during their Inspection (21st November 2018 to 11th January 2019), the core service rating of Trust D remained 'Good' and CQC found examples of outstanding practice in acute wards for adults of working age and in psychiatric intensive care units.

3. Themes found in this Review:

*Hard to Engage Service Users
*Clinical Assessment and Administration of Medication
*Professional Curiosity
*Discharge Decision Making
*Carer Recognition
*Equality and Cultural Issues
*Accommodation
*Care/Support Needs
*Risk Management
*Systems and Processes - Care Planning
*Patients Leaving and Entering a Ward, whilst detained under the Mental Health Act 1983
*Working Together
*Observations
*Transfers
*Handovers
*Recording
*Care Programme Approach
*Family Support Access to Health Services



4. Evidence of Good Practice:

At the Urgent Care Centre, appropriate action was taken in regard to N's hand injury and good records were kept. Police, units were appropriately dispatched to the scene of the incident and a full initial investigation was completed as far as it could be.

5. Summary:

On the 29th August 2018, the former Independent Chair of Bexley Safeguarding Adults Board (BSAB) notified partners that a SAR recommendation was received on August 6 th , regarding a 19-year-old person, in receipt of care and support services. Between August 2018 and May 2019, BSAB started to conduct a SAR and at a later date Deborah Stuart-Angus was appointed as the Independent Reviewer. BSAB met its duty under section 44 of The Care Act, by undertaking this Review, as lawful criteria were met; there was reasonable cause for concern about how BSAB members had worked together to safeguard N, and the BSAB, knew or suspected that death resulted from abuse or neglect. From this Review, lessons learned have been identified, which will be applied to the management of future cases, for improvement and prevention, and no blame will be attached to any individual or agency. All recommendations and the action plan will be monitored through the BSAB and the SAR Panel. Contributors have been: • N's Family • Trust A: Hospital 1 • Trust B: Hospital 1 • Trust C: Hospital 2 • Trust D: Hospital 3 (Ward A) and Hospital 4 (Ward B) • Trust E: Hospital 5 • Mental Health Charity • The General Practitioner • Housing Services • Adult Social Care • Children's Social Care • Local College • The Police • The Urgent Care Centre (based at Trust C, Hospital 3) • Clinical Commissioning Group • CQC N's partner (Partner A) did not take part in the Review, although contacted, no engagement followed.

6. Family Involvement:

Family members were identified and N's Mother fully participated with the SAR at various meetings and by sharing information. Differences and discrepancies were noted by N's Mother in the first draft of the Overview Report. Consequently, it was agreed that the SAR Chair, would approach the HM Coroner for clarity, and consequently the Coroner's Office availed all (23) evidence recordings from the Inquest. It should be noted that this process extended the timeline of the SAR by several months, which was unfortunate, but unavoidable within the circumstances described and the family supported the approach