Cumbria Safeguarding Adults Board

Safeguarding Adult Review – Pauline & George Learning Briefing

This learning briefing summarises the key learning and recommendations following a Safeguarding Adults Review (SAR) undertaken by Cumbria Safeguarding Adults Board (CSAB). The SAR commissioned by CSAB relates to a couple referred to as Pauline and George.

A SAR takes place where there is reasonable concern about how the Safeguarding Adults Board or members of it worked together to safeguard the adult, the adult has died, and the SAB knows or suspects the death resulted from abuse or neglect.

The SAR combined agency reports and chronologies with a learning event for practitioners who had been directly involved with Pauline and George. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

Pauline and George

Pauline was a white woman of British heritage who was in her late eighties when she died. Pauline lived with her husband George in their own home. George was also of white British heritage and was in his late sixties. Pauline had care and support needs due to mobility difficulties following a stroke in 2015. Though Pauline could manage some tasks, she was very reliant on George as a carer for many aspects of her day-to-day living. George had his own health needs due to diabetes and cancer of the prostate. The couple attended their GP Practice and outpatient clinics for their various health needs.

Pauline had experienced multiple falls over the years, and these were increasing in frequency. On occasions, the couple called an ambulance to assist, although Pauline did not require a hospital admission, paramedics repeatedly raised concerns about the condition of the environment in which they lived and levels of clutter. Pauline and George did consent to referrals to Adult Social Care on some occasions. However, they consistently declined any subsequent assessments or support offered by services.

When George missed an outpatient appointment, a GP made a home visit where sadly, Pauline and George were both found to have died some time previously. It is believed that George died before Pauline.

Summary of the key learning points from the review

Learning Point 1: Building Relationships and Working with Resistance to Care
• The review reinforced the importance of building relationships when working with self-neglect and resistance to care. • Agencies must ensure that the views and wishes of the cared for person, and the carer, are heard independently, recognising the potential for undue influence. • Building relationships needs to go hand-in-hand with using skills of professional curiosity and working respectfully with disguised engagement. • Practitioners need additional time to establish those relationships. Practitioners need space for reflective practice and supervision to explore ways to engage with people who are at risk but who are resistant to care. The Covid pandemic impacted on the ability of practitioners to do this.

Learning Point 2: Working with Risk
• Making Safeguarding Personal means respecting an adult's rights to self determine their affairs and keeping them at the centre of decisions that affect them. Making Safeguarding Personal also involves a duty of care. Non-engagement does not negate risk. Practitioners need to take additional steps, proportionate to the risk (and relevant legal framework), to reduce the potential harm to the adult's wellbeing. • There was some good practice demonstrated by paramedics in working with risk. However, overall there was an episodic approach to concerns raised by paramedics that did not address key factors when working with risk. Where an adult declines care and treatment, their views and wishes should form part of wider consideration to understand: • The wider context of the adult's circumstances, including historic information relevant to risks • The implications of their decision including risk of harm to themselves or others • Any impairment to decision making i.e. mental capacity to make the relevant decision; undue influence, impaired executive functioning • Options for responses: mitigating actions/strengths to reduce risk, working within the relevant legal framework

Learning Point 3: Working Across Agencies and Communities
• This review, like many other SARs,[1] has highlighted the importance of multi-agency working in safeguarding adults, including when working with self-neglect. • Multi-agency working is dependent upon effective systems to share information. There were significant gaps in sharing information between all agencies involved. The GP Practice was unaware of the muliple attendances by NWAS, the paramedics concerns about self-neglect, or the recurrent pattern of George and Pauline declining services. • There are opportunities to improve this connectivity across the system, capitalising on new ways of working developed during the pandemic, and using the new collaborative structures of the Integrated Care System. • There were missed opportunities to refer into multi-agency meetings. George and Pauline's self-neglectful circumstances were not recognised either through a multi-agency complex case pathway using the Integrated Care Community meetings or through using the CSAB safeguarding adult procedures and multi-agency self-neglect guidance.[2] • Multi-agency working develops a fuller picture of the individuals' circumstances and a shared view of risk. It uses the expertise of all partners to develop solutions, working creatively to find ways to engage with the adult(s) and negotiate change. • Working in partnership needs to be a default position for all practitioners.

[1] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; Executive Summary October 2020 https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed January 2022]

[2] Cumbria Safeguarding Adult Board Safeguarding Adults Self-Neglect Guidance October 2017

Learning Point 4: Strategic Responses to Self Neglect
• The review highlighted the importance of supporting practitioners through systems and processes, training and supervision. • The learning from this review mirrored some of the findings from a CSAB SAR in 2016 relating to self-neglect. CSAB partners, need to demonstrate leadership in ensuring that practitioners have access to those key resources and that learning from SARs is disseminated and leading to improvements within their agencies. • The CSAB guidance for self-neglect would benefit from tools to aide assessment, including use of clutter rating scales. Learning from this review can also help in developing resources to support practitioners to work with disguised engagement. • There is significant interface between working with self-neglect/resistance to care, and multi-agency work with complex cases. Cumbria's Integrated Care Community multi-agency meetings, may provide an effective forum for earlier interventions in working with self-neglect. The terms of reference for that forum should reflect this preventative, safeguarding orientated practice and assure safeguarding is considered within case discussions. • Learning from this SAR should be used by the CSAB in their developmental and assurance work relating to self-neglect.

In response to the recommendations the report makes Cumbria Safeguarding Adults Board have developed a robust action plan including the following:

- CSAB will develop a suite of resources for practitioners which supports professional curiosity when working with adults where there is disguised engagement. This will link into work taking place nationally to develop a toolkit for practitioners when working with adults who are difficult to engage.
- The learning from this SAR will also be disseminated through a "lunch & learn session" to be included as a case study where relevant.
- CSAB will review current multi-agency Self-Neglect guidance to enhance the practice guidance and information for practitioners which supports assessing clutter and risks posed to adults from self-neglect. The refreshed guidance will acknowledge practitioner capacity and the resource required when working with people who self-neglect and be endorsed by all CSAB partners.
- CSAB will share the learning from this SAR with CSAB members including reminders in relation to professional curiosity ensuring there is adequate support and professional supervision for practitioners when dealing with complex cases of self-neglect.
- North Cumbria Clinical Commissioning Group will work with North West Ambulance Service to improve the flow of information across the system where possible to ensure GPs are informed of attendances by paramedics. Assurances and update will be provided through CSAB.
- CSAB will seek assurance from the partnership that learning from the SAR has been disseminated across all partner organisations. CSAB will conduct a case file audit, so we are assured that learning has been embedded across the system with evidence of the impact and outcomes.
- CSAB will seek assurance from the Integrated Care Communities of safeguarding minded practice to ensure this is embedded into Terms of Reference and multi-disciplinary case discussions.