BIRMINGHAM SAFEGUARDING ADULTS BOARD

SCENARIO CASE STUDY FOR DISCUSSION BASED ON THE A2 SERIOUS CASE REVIEW

Alan is a 78 year old African Caribbean gentleman with multiple health needs. His long term health conditions include diabetes, prostate cancer, and paraphrenia (late onset pyschosis). He has a right below knee amputation.

For a period of time Alan lived in a care home, but some years back his placement was reviewed and he chose to move back to independent living. Alan lives in his own accommodation in the community. Support in the community is initially financed through a Direct Payment (DP) agreement. Alan has some support from his family - his main carers are his daughter and son, and it appears that his daughter lives with him at times. However the DP are withdrawn as they are not being used to provide care and that he has no paid carer support for the last year or so he lived in the community.

Numerous agencies are involved with Alan's care. He is known to his GP, secondary care mental health services, and social services. However Alan is frequently suspicious of statutory services, is non compliant with treatment/medication, and does not attend health appointments when invited. Alan does not recognise himself as having a psychiatric disorder. He sometimes burns fruit to ward off spirits.

Alan's living conditions are poor. The bedroom has a strong smell of urine, there are mouse droppings in all rooms, and mice are often seen running around his bedroom. There is litter and clutter in the house meaning Alan has problems moving independently in his wheelchair. The kitchen is unfit for the preparation of food with mouse droppings in the cupboards. The fridge freezer often has no food in it.

Social workers and CPN are visiting the house during this period. There have been concerns expressed by professionals about possible neglect and verbal abuse of Alan by his family. Sometimes his family appear to be obstructive and restricting access to Alan. Alan himself sometimes makes allegations of theft stating that his family were stealing from him. The Police visit but no charges are pressed. Alan is not taking medication for his diabetes, nor attending any appointments with his GP. The situation persists for a couple of years.

Eventually, following a home visits by his GP, Alan's condition is considered to be very serious, and he is admitted to hospital. His admission summary reads as follows:

"Appears dehydrated; diabetic but has not been on any medication, with no routine checks for diabetes; appears to have not been eating properly; family did not appear to understand why dad needed to go to hospital; doubly incontinent; pressures sores on leg, possible grade 4"

Upon admission Alan's foot was gangrenous but it was concluded that he was not fit for surgery. A mental capacity assessment was undertaken, referral to IMCA made and a best interests decision taken to move him to a nursing home. Alan died 4 months later. Shortly before his death he was diagnosed with dementia. Cause of death was recorded as dementia, peripheral arterial disease and type 2 diabetes.

Some questions for facilitated discussion

What are the barriers to hearing Alan's voice in this situation?

If Alan mistrusts professionals, how might we better engage with him?

What do you understand the term 'self-neglect' to mean?

Should we be safeguarding people who self-neglect?

Is there a perpetrator(s) in this case? Are there indications that one individual is abusing another?

Do direct payments lead to an increased risk of abuse occurring?

If police, social services, GP and mental health services are all involved, how do we understand who does what?

Whose responsibility is it to follow through on the decisions made about Alan's care or support?

When several agencies are involved in a case, who assess the level of risk, and how?

What are the barriers to professionals sharing information and communicating better?

If a safeguarding alert had been made, what might have happened next?

How easy is it for one agency or individual to challenge the practice of another?

If you were one of the professionals involved in this case, what kind of support would you expect from within your own organisation to deal with the issues?

How could the fact that Alan is being cared for in his own home - as opposed to in a residential unit - affect professional relationships with the family? How might the situation impact on internal family dynamics?

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A2 Serious case review Recommendations

1 Empowering and including people who use services and their families/carers: member agencies to the safeguarding adults' board will ensure that person centred principles are embedded in all relevant policies, procedures and guidance.

2 Carers' assessments: relevant agencies will ensure that Carers' assessments (in line with the
relevant legislation) are offered to all identified informal carers involved in providing support to individuals who use services and that there is a process to consider/review where such offers are refused.

3 Service Users who are reluctant to engage with professionals: the Serious Case Review into the case of A1 required the BSAB to commission guidance /checklists for staff in situations of significant risk where treatment is refused. In the light of learning from the case of A2 this guidance should be strengthened to include the issues reflected in the case of A2.

4 In the handover from the PCT to Clinical Commissioning Groups (CCGs) the BSAB, the PCT and the CCGs will work together to support measures to ensure that as CCGs emerge safeguarding adults is built into commissioning and governance processes

5 Identification, assessment and management of risk: guidance outlining a joint approach to identification, assessment and management of risk will be developed and agreed across all partner agencies to the BSAB. Training in risk assessment and risk management will be reviewed in the light
of this SCR across agencies.

6 Safeguarding Adults process and practice: across agencies there was a failure to follow the process set out in the BSAB safeguarding adults policy and procedures or to apply relevant guidance and principles. Single agencies will be required to provide assurances to the BSAB that the relevant necessary actions highlighted in IMR reports are being addressed. These relate to adequacy of policy, training and management oversight.

7 Improving practice in relation to financial abuse: intervention in respect of financial abuse requires that professionals across agencies use the available research, guidance and law to inform practice so that in future they can learn from the lessons illustrated in the case of A2. The
BSAB will draw up specific practical guidance in relation to safeguarding adults from financial abuse.

8 The BSAB will establish links with the Crown Prosecution Service

9 Improving practice in relation to the Mental Capacity Act: failings in relation to practice in the context of the Mental Capacity Act were prominent across most agencies. The SCR in respect of A1 has already undertaken to consider training requirements and the effectiveness of training

in respect of the MCA. In the light of the learning from the case of A2 the BSAB will build on this,
underlining the importance of facilitating learning in respect of the MCA by making available practical case study based resources for learning and development. The BSAB will consider development of a local tool for the assessment of capacity.

10 Working understanding of the range of relevant legislation: all agencies must ensure, through training and supervision, that staff are aware of the complex legal framework and that their awareness is kept up to date. The relevant learning in this SCR will be disseminated to support this.
Organisations must be clear with staff about where and how legal advice can be accessed.

11 Challenge and organisational culture: organisations must nurture a culture which encourages and values constructive challenge and debate. Managers and staff at all levels must be encouraged to seek clarity, to challenge decisions and to escalate issues of concerns within a well defined
process. Whistle blowing procedures should be prominent in organisations.

12 Supervision: all agencies will review their policy and approach to supervision of staff involved in complex cases to ensure a focus on supporting effective assessment and management of risk and on ensuring that learning from training is transferred into practice. Supervision should include a balance facilitating management oversight and challenge, staff support and identification
of staff development needs.

13 Progress on single agency action plans will be monitored by and reported to the BSAB via the SCR subgroup to the Board

Link to A2 SCR
http://www.bsab.org/media/SCR-ExecSummary-FinalSept3rd12-_4_.pdf

The Birmingham Safeguarding Adults Board (BSAB) website for information about the Board, how to report abuse, policy/procedures/guidance and safeguarding materials (leaflets /posters /fact sheets /reports) is accessed via: www.bsab.org