# Executive Summary-Safeguarding Adults Review (SAR) of the circumstances concerning P.

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**Introduction**

1. This SAR (Safeguarding Adult Review) was produced at the request of Berkshire West Safeguarding Adult Board (SAB) and commissioned by Reading Borough Council (RBC).
2. The SAR examined events and records for the 16 months before P's death. As a result, the final report is detailed and lengthy[1]. RBC subsequently commissioned this Executive Summary to ensure the key learning points are highlighted and available to a wide audience.

**Overview**

3. P was a white British woman, born on 4th August 1955. She was diagnosed with secondary progressive Multiple Sclerosis (MS) in 1998, aged 43.

4. She had input from health services and, following the death of her husband in 2014, 5 visits a day from homecare arranged by RBC.

5. As P's MS progressed, she developed contractures in her arms and legs that made her increasingly unable to position herself. She also experienced pain when others moved her. These worsened considerably over time.

6. P went to live in Y (sheltered housing) in 2016 following an admission to hospital where, amongst other things, she was found to be suffering from malnourishment.

7. Family members report that P neglected herself and that they felt unsupported by care services when they were attempting to improve P's diet and overall care. It was in Y that P first developed (unreported) category 4 pressure ulcers.

8. Prior to and throughout her time of living in Y, P's records show there were a significant number of complaints made by P's family about alleged failures in her care. A number of professionals from different statutory agencies also raised safeguarding alerts that were not properly followed up. This unsatisfactory situation was compounded by the failure of RBC's commissioners to achieve overall improvement in the care delivered to P from either agency. The inability of the care agencies in question to safely care for P at home contributed to P's move into a care home, a move she had previously strongly resisted

9. In June 2018 P moved into X a care home with nursing. Although at first P's pressure ulcers continued to improve this was not sustained and by Autumn of that year there was marked deterioration; P began several courses of oral antibiotics, but none of which dealt with an infection, site unknown, that was causing her high temperatures.

[1] The full report can be found here: http://www.sabberkshirewest.co.uk/practitioners/safeguarding-adults-reviews/

10. Eventually P was admitted from X to the Royal Berkshire Hospital (RBFT) on 6th March 2019. She died 6 weeks later on 20th April 2019. She was 63 years old.

11. Her death certificate states the cause of death as 1a) sepsis 1b) infected pressure ulcers and 1c) Multiple Sclerosis.

12. Taken overall, there is evidence of a significant number of failures in practice within and, communication between, agencies that, taken together, detracted from P receiving optimal care.

**Findings**

**Person-centred practice**

13. P's voice is rarely "heard" in her records, but she is remembered as saying that carers did not listen to her. Consideration of her overall psychological well-being appeared to be neglected in favour of a task-focused approach concentrating on her physical needs. The employment of an effective caseworker and or advocate should have been considered in order to make her voice heard.

14. P's health, comfort and overall quality of life were able to be alleviated by the provision of specialist equipment, adopting a postural management approach. This is particularly true of enabling her to eat, drink, sit or lie comfortably. Unfortunately, most people responsible for P's care were unaware of that. That does not excuse the misuse of equipment once it was provided or the failure to transfer it with her when she went to live in X.

**Care management**

15. Given P's health condition, it was predictable that her needs would change over time and that any care plan would need regular adjusting to remain relevant. Despite this RBC never appointed an on-going care coordinator to oversee P's care, rather a succession of individuals saw her, "fire-fighting" as issues arose.

16. P would have benefited from a named individual, able to bring together the understanding and expertise of a range of professionals to create a care plan that took account of her as a complete person, where risk was evaluated and managed. There was no one professional for P or her family to look to provide continuity or accountability. No one professional had the responsibility for holding care providers to account.

**Professional practice**

17. There were examples of excellent professional practice. However, professionals felt constrained by the pressure to "solve" immediate problems and move on. I found examples of lack of professional curiosity, long-term planning and accountability on the part of some individuals. A system of reflective as opposed to task-centred professional supervision by first line managers has the potential to change that.

**Mental Capacity**

18. P's situation raises serious questions for all agencies about professionals' and carers' understanding and implementation of the Mental Capacity Act (1995). Whilst I found numerous references by a variety of professionals about P having potential cognitive impairment / fluctuating mental capacity (going back to before the period this SAR covers) these were not followed up.

19. Despite having previously been adamant that she did not want to move into a nursing home, P did not receive independent support when the decision was made. The only formal mental capacity assessment I found was in relation to a Deprivation of Liberty authorisation in September 2018, towards the end of her life, when she was found to lack the capacity to make the decision about her care and accommodation.

20. This lack of clarity about mental capacity is significant not least because P's refusal of care and equipment was used as a justification by agency carers at Y for not always following P's care plan, as developed by district nurses and care coordinators.

21. I did not find any records of best interests' decisions taken on behalf of P.

**Safeguarding**

22. I found a number of safeguarding alerts that were not dealt with thoroughly and recording was often poor in relation to what action either was or needed to be taken.

23. I found deadlines were missed and management oversight was lacking. I saw little that reflected an understanding of the adult safeguarding duties in the Care Act or the model Making Safeguarding Personal. Risk assessment and management was poor.

24. Robust responses to allegations of poor care practice was a gap across all agencies. There were matters that should have been considered for reporting to DBS or professional regulator for further investigation.

**Implementation of inter-agency protocols**

25. There were examples across all the community agencies of gaps in this area. These include lack of notifications of concern, delayed and incomplete safeguarding enquiries, missed care calls, missed follow-ups, absence of P's voice in records, lack of communication with family, poor recordkeeping, unclear decision-making, lack of multi-disciplinary team working and absence of clear risk-management.

**Conclusion**

26. I concluded that P's quality of life could have been substantially improved if various aspects of her care had been managed differently and that this situation long pre-dated, but was not reversed by her admission to residential care.