Learning from OSAB SARs: Lisa

Background

A Safeguarding Adult Review (SAR) is a multi-agency process that considers whether serious harm experienced by an adult at risk of abuse or neglect, could have been prevented. The purpose is to promote learning and improvement action to prevent future deaths or serious harm occurring again. It was a unanimous decision of the Oldham Safeguarding Adults Board (OSAB) SAR Subgroup that the criteria for a SAR were met in relation to 'Lisa'. Lisa was in her fifties when she died. She had multiple children, some of secondary school age who had carers roles for Lisa. The family had always lived in rural communities, were largely self-sufficient, and did not engage in social activities outside the home. Lisa struggled with mobility following a broken pelvis. She had reduced eyesight and her partner worked away, this resulted in the home being in a poor state of repair. Lisa self-reported as disabled but appears not to have been formally registered as disabled by any agency. Lisa experienced childhood trauma; the impact of this appears to have had a lasting effect on the rest of her life. Lisa had a deep mistrust of services. She suffered with depression and had made previous attempts to end her own life.

What happened?

Lisa's nutritional state was poor, and both her physical and mental health were of concern. Lisa reported feeling down and using alcohol to self-medicate due to her poor vision. Lisa initiated a conversation about having suicidal ideation and exploring euthanasia. This was explored further to see whether she would act upon suicidal ideation herself. Lisa's adult children stated that she drank excessively as she had become physically unwell, particularly with her eyesight. Lisa had bilateral cataracts and was awaiting surgery but this was cancelled due to conjunctivitis. Lisa's GP expressed concerns for her health because her partner had to physically support her to a planned appointment. The GP felt Lisa was potentially septic and urged her to attend A&E. She declined. She did not want to be admitted. The risk of death was explained to her. A DNACPR document was discussed and completed with her consent. Later, Lisa had fallen down stairs and two days later, following a 999 call, she was found in a room that was malodorous and in a very poor condition. She was unclothed, covered in urine and faeces, and there were flies all over her body. She had rib, back and pelvis fractures and a collapsed lung.

Resources and Information

Practitioners can find further guidance related to the findings of the SAR via the links provided throughout this briefing. In addition, the following resources are also available: OSAB Professional Curiosity Guidance, OSAB Guidance Where the Individual or Family are not Engaging with Services, OSAB Mental Capacity Act Policy and Procedures, OSAB Practical Guide to Assessing Capacity, and OSAB Partner Agency Safeguarding Roles and Responsibilities Profiles. OSAB also offers multi-agency training related to the findings of the SAR including Risk Management in Oldham, Professional Curiosity, Mental Capacity Act, and Self-Neglect.

Assisted Suicide

Following learning related to Lisa's expressed suicidal ideation, thoughts on euthanasia and her wish to have a DNACPR form, the SAR recommended that an Assisted Suicide: OSAB Practitioner Briefing and the Oldham Suicide Prevention Strategy be widely shared and included in training to support staff in providing care to individuals who disclose thoughts of 'assisted suicide' or 'euthanasia'. The SAR also recommended that the briefing is used to prompt discussions about Advance Decision to Refuse Treatment (ADRT) with people it would be applicable to have the conversation with.

Multi-Agency Working & Information Sharing

Some agencies were unaware that other agencies were working with Lisa. There was no contact with the GP by ASC or CSC when the referral (mentioned earlier) was received. Had the GP been made aware of the referral and the subsequent decisions to take no further action because of Lisa refusing services, this could have added to better informed decision making relating to later safeguarding referrals. OSAB partners use the Tiered Risk Assessment and Management (TRAM) Protocol which provides guidance to help practitioners working with adults with multiple and complex needs who are at serious risk of harm or abuse. The Protocol includes advice about when and how to escalate risk into a multi-agency setting, and balance positive risk taking with an individual's human rights. It does not appear that this resource was referred to or utilised in the attempts to support Lisa and there were missed opportunities to arrange Team Around the Adult (TAA) meetings. Holding a TAA meeting is not dependent on gaining consent to share Information; the OSAB Data Sharing Agreement sets out the legal framework for partners to share information. Further information is available in the OSAB 7-Minute Briefing - Record Keeping and Information Sharing. Anyone from any agency can call a TAA meeting and escalate any concerns about the lack of engagement with, or cancellation of TAA meetings to their manager or agency safeguarding lead.

Self-Neglect

Lisa's self-neglect was of concern to agencies that had direct contact with her. Four safeguarding adult referrals were made by agencies supporting her, all of which referenced signs of self-neglect. One safeguarding adult referral was shared with Children's Social Care (CSC) but Lisa declined input from Adult Social Care (ASC) and CSC. Her lack of consent led to no further action being taken by ASC. ASC only had telephone contact with Lisa, it was not felt that her mental capacity should be more formally assessed. This was a missed opportunity to apply professional curiosity and override Lisa's decision to not engage. Lisa's ability to maintain a healthy living environment for her and her children was compromised by her poor eyesight. Practitioners considered Lisa's mental capacity but did not find any evidence to support that she lacked the mental capacity to make decisions about care and treatment, therefore no formal capacity assessment was recorded. Additional questions could have been asked to confirm whether Lisa could retain, assess, and weigh up the information relevant to the decisions she was being asked to make.

Think Family

There was no professional curiosity applied in relation to conflicting information given to CSC following the referral into ASC. Lisa had told the referrer she had no support yet when asked she stated that her older children were regularly supporting her. The young carer role of the children was identified, but due to the refusal of support no further referrals were made. A 'Think Family' approach does not appear to have been considered in any depth by either ASC or CSC with a lack of professional curiosity about the role of the children as carers for Lisa. A joint safeguarding strategy meeting should have taken place and a young carers assessment was required. Lisa also disclosed that she was purchasing drugs over the internet however this did not result in a Think Family approach and consideration of Lisa's reliance on this medication and how this might be impacting on the quality of life for her children. The OSAB Self-Neglect and Hoarding Strategy and Toolkit have since been reviewed to include the importance of a 'Think Family' approach and guidance for staff working with children.

Website: www.oldhamsafeguarding.org
Email: OldhamSafeguardingAdultsBoard@Oldham.gov.uk