East Sussex Safeguarding Adults Board
Response to the Safeguarding Adults Review regarding Anna

Section 44 of the Care Act 2014 sets out that a Safeguarding Adults Review (SAR) must be carried out for every case in which abuse or neglect is known or suspected and an adult had died (including death by suicide) or come to serious harm, and there are concerns about how organisations or professionals worked together to safeguard the adult.

The SAB commissioned this SAR to understand the circumstances leading up to the death of Anna and to support the identification of strengths and weaknesses in how agencies worked singly and together. The purpose of a SAR as set out in the Care and Support Statutory Guidance is to "promote effective learning and improvement action to prevent future deaths or serious harm occurring again".

Anna died in hospital in 2020 at the age of 85. Her cause of death was due to natural causes but there were concerns about her presentation on admission to hospital on early in 2020 when she was noted to have multiple bruising and skin tears over several parts of her body. There were historical concerns regarding abuse of Anna by her daughter and she had been placed in residential care where she lived for over a year. Anna then moved back to live with her daughter five months prior to her death.

We extend our deepest condolences to the family. The family were invited to take part in the review but declined.

This review took a hybrid approach and was undertaken as two parallel pieces of work:

1. An audit on how the relevant actions of Adult B have been embedded and what impact they are having on practice and adults with care and support needs.
2. A learning event involving frontline practitioners and their managers, with specific focus on the 2 safeguarding enquiries held from 2017 to 2020 and how learning from Adult B can be further embedded and include the following additional points relevant in this case:

- How cultural needs were identified and responded to.
- Consideration of delays in instigating enquiries, particularly in relation to the safeguarding enquiry commenced in October 2019
- What inhibited practitioners from responding to the hostility and aggression by family members.
- Information sharing about risks related to ownership of firearms by the family.
- How legal routes to gain access to Anna were explored.

- How issues in this case were escalated and supervised across the agencies involved.

Specifically, this review has considered the following research questions:

- How well has the learning from Adult B been embedded in general safeguarding practice?
- How effective are practitioners at intervening when faced with hostility and aggression from carers?
- How well do practitioners share information about risk and co-ordinate safeguarding work between different agencies

The East Sussex Safeguarding Adults Board (ESSAB) has reflected on the lessons arising from this tragic case. We accept the overall findings of this SAR and are committed to taking the learning forward as far as is possible within existing statutory frameworks. The role of the ESSAB is to seek assurance from organisations in East Sussex about changes they have made since the death of Anna.

This report sets out the formal response of the ESSAB to the findings and learning identified in the review. The actions arising from this review will be monitored by the SAR Subgroup with progress reported to the Board.

Deborah Stuart-Angus

Independent Chair, East Sussex Safeguarding Adults Board

Finding 1:

Of greatest significance was the absence of formal planning meeting involving front line staff which led to assumptions about what was being done and the protection this afforded Anna. There is suggestion that such practice is not unusual and that therefore there is a need for the role of multi-disciplinary planning meetings to be promoted.

Board Response

The ESSAB published a Safeguarding Adults Review for Adult B in February 2020. One of the recommendations from this review was to undertake an audit of multi-agency involvement in safeguarding. The audit was conducted jointly across East Sussex and Brighton & Hove Safeguarding Adults and aimed to assess the effectiveness of multi-agency involvement and communication at key stages of the safeguarding enquiry process, including how agencies follow up invitations and achieve clear outcomes. A learning briefing was published with the findings from the audit and we will further promote the identified areas of how effective multi-agency working could be improved.
The reasons why meetings were not held in this case were not clear. The role and benefits of multi-disciplinary planning meetings will be promoted through the action plan working group for this SAR including consideration of different models of how this can be improved especially with frontline practitioners who have reduced capacity to attend learning and training events and promoting best practice.

Finding 2:

The review showed that there needs to be greater awareness of the needs for formal assessment of capacity and improved practice in this area however there is also a need for better understanding of the impact of coercion and control on capacity assessments and for this to be considered when developing safeguarding plans. Furthermore, work with the wider family needs to be strengthened to enable staff to be able to better understand family dynamics and empowering them to challenge family members when necessary.

Board Response

The SAB will review the current Coercion and Control: A Multi Agency Workshop for Staff Working with Domestic Abuse to identify gaps in agencies attending and review attendance levels and ensure the training reflects the impact of coercion and control can have on capacity assessments. We will consider developing a series of podcasts/digital media materials on legal interventions and types of situations they should be considered when supporting older people which will include encouraging the use of professional curiosity when putting safeguarding plans together to help understand what is happening within a family rather than making assumptions or accepting things at face value.

Finding 3

The review identified that there is good working between Finance and ASCH staff when assessing whether there has been financial abuse however there are no formal systems in place to guarantee a similar co-operative working when making and recording decisions regarding recoupment of debts from relatives. This means there is the potential for such decisions to be made without sufficient consideration of safeguarding risks to vulnerable adults.

Board Response

In relation to this finding we will be asking ESCC to review their current finance systems for pursuing debts from relatives with a likely review of the current Debt Recovery Policy and Debt Recovery Operational instructions. We will request the use of risk assessments, to be considered, to protect vulnerable adults where debts are being pursued through family members and encourage staff in identified financial teams to participate in financial abuse awareness training.

Finding 4

The review has highlighted some limitations in the processes whereby clinicians assess the causes of bruising in vulnerable adults which could undermine the effectiveness of the ADP

Board Response

We will request our that our East Sussex Healthcare Trust (ESHT) partners review their current processes in place to evaluate bruising in vulnerable adults and develop systems to enable better reconciliation of clinical differences including whether there is a need to have internal escalation processes in place and whether a named Doctor for safeguarding Adults should be appointed. If processes are changed these will be added into the Sussex Adult Death Protocol - the Protocol applies to cases where:

- an adult dies in unexpected or unnatural circumstances, and
- there is a suspicion, or it is known, that abuse or neglect was a contributory factor in their death, and
- the abuse or neglect was caused by a third party.

Finding 5

The implementation of the recommendations from the Adult B SAR showed how difficult it is to know when practice has changed in response to new guidance, supervision and training. It is clear that all agencies have acted in response to the Adult B SAR however it is less assured that there has been sufficient cultural change to ensure practitioners are acting differently.

Board Response

The SAB will be developing a partnership Learning Event for 2022 which will focus on embedding learning from East Sussex SARs, how effectiveness of learning is

evaluated which will include researching national best practice to learn from, we will revisit the previous recommendations from Adult A & B to evaluate implementation and consider the use of evaluating learning through an online staff survey with SAB partner agencies.