East Sussex Safeguarding Adults Board
Response to the Safeguarding Adult Review regarding Ben

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 has 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 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".

Tragically, in November 2019, Ben died aged 60. The East Sussex Safeguarding Adults Board (ESSAB) extends our deepest sympathy, and we send our sincere condolences to Ben's family.

ESSAB commissioned this SAR to understand the circumstances leading up to Ben's death and to support the identification of strengths and weaknesses in how agencies worked together to safeguard Ben.

Ben was admitted to hospital, from a Care Home, in October 2019, in need of a bi-lateral amputation owing to the deterioration of his diabetic foot ulcers, however the severity of his condition, meant that amputation was not able to be considered. The hospital raised a safeguarding referral on 22nd of the same month, in relation to previous neglect and or possible acts of omission, expressing concern about Ben's health on admission. Ben had a history of risks relating to self-neglect, and non-compliance with medical care and treatment, in relation to diabetes management.

The family were invited to take part in the SAR and declined. The SAR deployed a hybrid approach, drawing on learning from a previous SAR, known as 'Adult A' (published October 2017), where similarities existed with Ben's circumstances. This SAR explored; additional areas of learning specific to Ben's case to include:

- Case co-ordination and inter-agency communication (locally, and across geographical boundaries)
- Knowledge and the practical application of Pan Sussex Self-Neglect Procedures
- How the Mental Capacity Act and Deprivation of Liberty Safeguards were understood and used in practice.
- The interface between the Mental Capacity Act and Mental Health Act in cases involving self-neglect.
- The challenges of non-engagement with adults who self-neglect.
- How well the Section 42 process is used, and implications for others at risk, if a person dies during the deployment of such an Enquiry
- The extent to which the SAR referral process is understood by frontline practitioners and managers, including awareness of the need to make timely referrals.

ESSAB has reflected on lessons learnt from this tragic case, and fully accept the overall findings. We remain committed to seeking assurance with regard to evidence- based

improvement planning across all relevant organisations involved, with progress monitoring being managed by the SAR Subgroup, who are accountable to the East Sussex Safeguarding Adult Board.

The following information represents our formal response to the findings, and learning identified in the SAR.

Case coordination and inter-agency communication

At the learning event, practitioners noted that on no occasion did agencies come together to co-ordinate plans, actions, risk assessment and or risk management and a lead agency did not exist. This was also a finding in the SAR 'Adult A'.

Board Response

ESSAB published a SAR for Adult A in October 2017. A recommendation was to review procedures, to enable agencies to be aware of when and how to convene a multi-agency review regarding a complex case. This placed particular focus on sharing all available information with agencies involved; access to advice and guidance from legal practitioners; the need to agree and follow up multi-agency action plans; and managerial oversight of complex cases, via staff supervision and audit, in order to enable staff to escalate their concerns regarding high levels of risk.

Going forward ESSAB will seek assurance regarding a) if policies, procedures, and pathways for convening multi-agency risk management meetings work well b) single agency risk management processes, identifying good practice c) draw learning from the Multi-Agency Risk Management (MARM) process which (launched 2022) to inform good practice and highlight areas for development.

ESSAB will hold a further Learning Event in 2022, to focus on how organisations have used learning from SARs to drive practice improvement and embed learning.

Understanding and deploying the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

It was also noted at the Practitioner Event that missed opportunities existed to refer Ben's case to the Court of Protection, in order to safeguard him and serve his best interests. Practitioners referred to a lack of knowledge, confidence, experience and understanding in applying the Mental Capacity Act 2005 (MCA), at the front line. It was though this could be improved by training for pre-registration nurses and trainee doctors and setting out guidance for host and 'out of area' commissioners.

Board Response

Since 2015, several SARS have identified gaps in the lack of understanding in practitioner application of the MCA, consequently SAB published the Mental Capacity Multi-Agency Policy and Procedures in 2019, with guidance for statutory and non-statutory health and social care services, across East Sussex.

A Mental Capacity Act 2005 & Deprivation of Liberty Safeguards training pathway has also been introduced, providing e-learning, foundation, intermediate, advanced, and bespoke sessions for practitioners. The current SAB training course: Mental Capacity Act 2005: A Multi-Agency Approach to Complex Cases, is designed to supplement existing MCA Training

and is available to all practitioners/clinicians, involved in mental capacity assessments and or best interest decisions. Adult Social Care (ASC) offer free, comprehensive training to all 300 care homes in East Sussex and Sussex NHS Commissioners are currently providing free 'STOP, LOOK, CARE' training online, to include MCA, aiming to increase confidence in identifying and managing deterioration in a person's health and wellbeing.

ESSAB will continue to promote MCA training pathways for partners as well as additional opportunities/resources for those with limited capacity to attend training events.

Understanding and deploying Section 42 (Care Act 2014)

The SAR highlighted that staff at the Care Home had wanted to communicate the seriousness of the deterioration in Ben's health and felt that other services did not fully appreciate or recognise this. Seemingly some GPs appear not to have recognised the importance of raising a safeguarding concern.

Board Response

As an outcome of their involvement in this SAR, the Care Home has recognised the need for improved knowledge and confidence in raising concerns and pressing for a safeguarding response, showing clear parallels with findings from the Adult A. In 2022 the three Sussex SABs developed the new Safeguarding Adults Thresholds Guidance for multi-agency practitioners. This guidance supports the understanding, reporting, and recording of safeguarding concerns, and s42 decision-making.

Understanding the SAR process

A s42 Enquiry started for Ben in October 2019, and he died the following month. The SAR referral was sent to ESSAB in February 2021. The delay occurred because the referrer had been trying to confirm if the s42 enquiry had concluded.

Board Response

SAB media channels will promote the importance of timely SAR referrals and consider reviewing the SAR protocol in terms of stating the importance of timely referrals.

The impact of COVID-19

Ben died before the onset of the pandemic, however practitioners referred to its ongoing impact on staff shortages, recruitment, training, increased use of agency staff, routine placement checks and an increasing number of cases where legal advice was being sought. In addition, whilst remote working improved attendance at multi-agency meetings, it also interrupted joint working and disrupted, established routine visits.

Board Response

In May 2021, ESSAB produced a Multi-Agency COVID-19 Safeguarding Assurance Interim Report which included the outcomes of surveying the impact that COVID-19 had on safeguarding practice, across our County. Results of this survey showed that agencies responded swiftly to adapt training resources to virtual formats, created new easily accessible resources to respond to emerging themes, extended safeguarding advice lines to be 24/7, provided expert advice to partner agencies and across sectors to enable vital safeguarding information to reach large numbers of professionals in exceptionally busy

times. Multi-agency collaboration and information sharing played an important role in ensuring agencies were prepared and were able to effectively respond to emerging themes despite rapidly changing situations.

A range of good practice was identified and shared with our Performance and Quality Assurance subgroup to provide assurance in relation to safeguarding adult's activity during the COVID-19 pandemic, capture areas of learning and identify areas for development.

The Coronavirus pandemic led to unprecedented challenges and created risks - where the importance of effective adult safeguarding became greater than ever before. Over the past year we have however, continued to seek assurance from our partners about their safeguarding responses during the pandemic, and undertaken work to ensure services have been, and continue to be supported, to respond to the emerging safeguarding themes.

Deborah Stuart-Angus

Independent Chair, East Sussex Safeguarding Adults Board