7-minute Learning Summary

Safeguarding Adult Review – Margaret

Richmond and Wandsworth Safeguarding Adults Board

Case Summary

The Richmond and Wandsworth Safeguarding Adults Board (RWSAB) undertook Safeguarding Adult Review on Margaret in order to understand how agencies might work together in future to support people who live at home and receive support from family carers.

Margaret was aged 90 at the time of her death from sepsis, as a result of infected pressure ulcers. Margaret has been described as a reluctant user of services and her physical health condition deteriorated significantly at home as her daughter struggled to manage her condition. Although support was offered, available from the Local Community Health Team and her GP, Margaret and daughter only engaged with this support sporadically. When Margaret's pressure areas became inflamed there was limited support possible. When Margaret was admitted to hospital in March 2018, she had a large number of pressure sores and developed a sepsis infection from which she could not recover.

Summary findings

1. **Across health and social care, the organisational priority placed on working closely with family members has created a tendency for practitioners to rely too heavily on information from family carers about whether and how the people they care for have their needs met. A reliance on second-hand information, without direct contact with the service user, makes it less likely that the needs, experiences, and wishes of the person themselves will be known or recorded, and that their voice may be lost in safeguarding responses.**

   - There was a notable absence of Margaret's views at every stage of all professionals' interactions with her. There was a significant reliance on the views of her daughter and grandson.
   - The statutory guidance which places a strong emphasis on involvement of families and the organisational emphasis on the importance of this means that it can be hard to hear the voice of the adult when the voice of relatives, people with Lasting Powers of Attorneys, and family carers grows louder.

2. **When raising safeguarding issues with the Local Authority there is a pattern of agencies not being specific enough about the risks, implications, and what they think needs to happen. This creates misunderstandings of issues or risk and urgency and results in appropriate action not being taken. This is exacerbated by a lack of expectation on the referrer to follow up on their contact.**

   - There was insufficient urgency given to the safeguarding referral based on the sense that Margaret was safe as she was in hospital.
   - Agencies did not communicate the risks clearly and as there was no communication and follow up between agencies there was a reliance on what each partner expected would happen. In addition, there was limited ongoing communication as new information came to light and there was not a holistic, commonly understood overview of the situation.
   - The quality of information contained in written referrals did not communicate escalating risk and was not sufficiently questioned to fully understand what the referred intended to convey.
   - The agency which raised the concern did not confirm that safeguarding actions were taking place.

3. **On receiving safeguarding concerns, there is a professional norm of turning to GPs in the first instance, and an uncritical acceptance of their professional judgment. This is underpinned by a perceived hierarchy among professional groups, service users, and their family. This use of General Practice has benefits of efficiency for safeguarding services, but risks what is a partial and misguided view carrying undue weight and going unchallenged.**

- When a family member raised concerns that the family carer was not providing sufficient care and that Margaret was experiencing abuse, the practitioners were reassured by the GP that this was not the case and as a result did not undertake a visit to evaluate the concerns and risks.
- When the community nurse and GP visited and found Margaret on the floor, this was not considered to be a safeguarding concern and the view was that the GP would raise a safeguarding concern if it was needed.

Lessons

1. In the context of Making Safeguarding Personal it is important to ensure there is equal weight given to input from the person and their family. To this end it is important that the person and their family are fully engaged in determining the safeguarding desired outcomes.
2. It is important for practitioners to ensure that family carers have the information they need to provide safe care to the person they are supporting.
3. It is important for partners to communicate clearly and effectively when making written referral and for there to be joint working and planning to ensure that everyone within the system is aware of and in agreement with the proposed course of action.
4. It is important for agencies to have a clear understanding of one another's role and function and how they contribute to the safeguarding process.
5. Practitioners need to feel empowered to be professionally assertive when working with partners on addressing safeguarding concerns.
6. It is vital that immediate and potential risks are identified at the point of a safeguarding referral, and specific actions to mitigate those risks are agreed, allocated and owned. Risk and the response must be kept under review