Richmond and Wandsworth Safeguarding Adults Board Safeguarding Adults Review – Margaret recording script

The Richmond and Wandsworth Safeguarding Adults Board 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 members.

Margaret was aged 90 years old 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 look after her.

Although support was offered, available from the Local Community Health Team and her GP, Margaret and her 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 many pressure sores and developed a sepsis infection from which she could not recover.

What did the review find?

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 Margaret, made it less likely that her needs, experiences, and wishes were known or recorded, and more likely that her voice may be lost in safeguarding responses.

    - There was a notable absence of Margaret's views at every stage of all the professionals' interactions with her. There was a significant reliance on the views of her daughter and her grandson.
    - The statutory guidance which places a strong emphasis on the 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 concerns with the Local Authority there was a pattern of agencies not being specific enough about the risks Margaret faced, implications of those risks, and what they thought should be done about them. This created misunderstandings about the concerns and the level of risks and the urgency required to respond to them. As a result, appropriate action was not always taken. This was exacerbated by a lack of expectation by agencies to follow up on their contact to find out what was happening.

    - Agencies did not communicate the risks that Margaret faced clearly, and since there was no contact and follow up after concerns had been raised, partners formed their own beliefs about what actions were being taken. Agencies did not confirm what safeguarding actions were being taken.
    - There was insufficient urgency given to the safeguarding concerns based on the sense that Margaret was safe since she was in hospital and no assessment was made of her family carer's needs and ability to care for Margaret.

- In addition, there was limited ongoing communication as new information came to light and there was no holistic, commonly understood overview of the situation was formed.
- The quality of information contained in written concerns and referrals did not indicate that risks were escalating and there was insufficient questioning of concerns and referrals to fully understand what they intended to convey.

3. On receiving safeguarding concerns, there was a professional norm of turning to General Practitioners in the first instance, for their views about safety and an uncritical acceptance of their professional judgement. This was underpinned by a perceived hierarchy among professional groups, service users, and their families. This use of General Practice has benefits of efficiency for safeguarding services, but the risk is that a partial and sometimes misguided view carrying undue weight and goes 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 themselves.
   - When the community nurse and GP visited and found Margaret on the floor, this was not considered to be a safeguarding concern since the view was that the GP would raise a safeguarding concern if one was necessary.

What lessons can we learn?

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 desired safeguarding 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 referrals 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 each other’s role and function and how they each 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 when a safeguarding concern is raised, and specific actions to mitigate those risks are agreed, allocated and owned. Risks and the response to risks must be kept under regular review.