Cumbria Safeguarding Adults Board

Safeguarding Adults Review

'Mr X'

@cumbriasab cumbriasab.org.uk

Cumbria Safeguarding Adults Board

Safeguarding Adults Review

‘Mr X’

Contents

1. Introduction

1.1 This Safeguarding Adult Review (SAR) concerns the care and treatment of a 93-year-old Caucasian man who will be referred to in this report as 'Mr X'. Mr X was admitted to hospital in August 2018 for further medical tests after he became unwell.

1.2 Whilst a hospital in-patient, Mr X made a number of disclosures of physical and sexual abuse to health and social care staff, however, these where not followed up or investigated appropriately despite Cumbria Safeguarding Adult Board(CSAB) and all its members having relevant Safeguarding and Person in a Position of Trust (PiPoT) procedures in place. This distressing episode of care resulted in the perpetrator being investigated, employment terminated and subject to a Sexual Risk Order under Sec 122A of the Sexual Offences Act 2003 prohibiting him from contact with any vulnerable adult.

1.3 Following the referral to Cumbria Safeguarding Adults Board by North Cumbria Integrated Care NHS Foundation Trust in July 2020 a sub-group of CSAB assessed the circumstances of the case and decided that they met the criteria for a SAR[1] to be undertaken determining that Mr X had suffered significant abuse and that staff had been unaware of how to escalate a safeguarding concern or take appropriate action. There was also reasonable cause to believe partner agencies could have worked together more effectively to protect Mr X.

1.4 An internal NHS investigation took place in the intervening period (in addition to police and HR investigations) and the outcome was shared with Mr X's family.

2. Purpose of a Safeguarding Adult Review (SAR)

2.1 A SAR[2] should always be considered if: an adult had died and abuse or neglect is known or suspected to be a factor in their death; or an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity or quality of life or the individual would have been likely to have died but for an intervention; and there is concern the partner agencies could have worked more effectively to protect the adult.

A Safeguarding Adults Board may also arrange for a SAR of any other case involving an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs).

2.2 The purpose of a SAR, as described very clearly in the Statutory Guidance[3], is to ensure "lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account".

2.3 The purpose and underpinning principles of this SAR are set out in section 3.4 of the North West Safeguarding Adults Policy (v2.5),[4] which incorporates Cumbria Safeguarding Adult Board.

2.4 There is no single prescribed method to conduct a SAR; methodology should be proportionate to the specific circumstances of the case, taking account of the time between the incident and referral and any other investigations that have taken place. This particular SAR was conducted using a 'SAR in Rapid Time'[5] methodology designed by the Social Care Institute for Excellence (SCIE) to:

- Recognise the complex circumstances in which practitioners work together to safeguard adults;
- Seek to evaluate practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Provide systems findings that help to understand the social and organisational factors that impact on work beyond a single case.

2.5 The SAR Systems Finding Report (at page 6 of this report) provides details of the systems and practice findings that have been identified through utilising the 'SAR in Rapid Time' methodology.

[1] Sec 44 (3) of the Care Act 2014
[2] Sec 44(1-4) Care Act 2014 Care Act 2014 (legislation.gov.uk)
[3] Care and support statutory guidance - GOV.UK (www.gov.uk)
[4] CSAB Safeguarding Adults Policy
[5] Introduction to Safeguarding Adult Reviews (SARs) In Rapid Time | SCIE

2.6 The SAR author is a member of staff at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust who had no previous involvement with the case or with Mr X or his family and has acted independently and impartially.

2.7 A Panel of senior staff from across the partnership were drawn together to guide the SAR and take responsibility on behalf of CSAB; to ensure proper process was followed and to support the preparation of the report and the agreed recommendations.

The Panel consisted of the following individuals:

Lead Reviewer	Cumbria Northumberland Tyne & Wear NHS Foundation Trust
Second Reviewer	North West Probation Service Cumbria
Detective Inspector	Cumbria Constabulary
Senior Manager	Adult Social Care, Cumbria County Council
Named Nurse Safeguarding	North Cumbria Integrated NHS Trust
Board Manager	Cumbria Safeguarding Adults Board
Named Nurse for Safeguarding (assumed Mental Health Services from Cumbria Partnership NHS Foundation Trust)	Cumbria Northumberland Tyne & Wear NHS Foundation Trust

3. Key Questions

3.1 On the basis of the initial information collected, which included a multi-agency chronology and agency reports, the Panel agreed a set of questions specifically related to the incident in order to obtain an understanding of the facts and themes of the case from the practitioners involved. (as per the SAR in rapid time methodology).

The key questions covered are highlighted :

What are the wider systems issues or areas that we want to learn about?

- How organisations perceive their responsibility when an allegation is made against member of staff or another agency (Person in Position of Trust)
- How far does a person's age or previous mental health influence a response (Unconscious bias)
- Making Safeguarding Personal; hearing the voice of the adult. How can we use this to inform safeguarding training/messages disseminated.
- Assurance that if the incident happened again would agencies respond in a timely and appropriate way to protect from further/other abuse
- Accountability; following up actions
- Record keeping; decision and actions recorded accurately
- How to recognise Safeguarding (not a complaint)

4. Background – Mr X

4.1 Mr X's family contributed to the review and advised that he'd suffered from severe depression after his wife's death and as a result, he'd received on-going psychiatric care, including regular check-ups from a Community Psychiatric Nurse.

4.2 Although he could be withdrawn at times, Mr X could also be a very sociable individual and regularly socialised with other residents in his sheltered housing complex and in the wider community.

4.3 Mr X was admitted to hospital for further medical tests after he became unwell in August 2018.

4.4 The circumstances culminating in a SAR are set out in the timeline below and focus on Mr X's treatment and the subsequent response from medical and partnership staff.

4.5 Mr X died in a Care Home in October 2019. Although his death was not attributed to the incidents that occurred in hospital, Mr X's family believe he never fully recovered from this ordeal.

5. Timeline and details of the incident

Date	Details
1/8/18	• Mr X was admitted to Hospital after a deterioration in his physical health.
6/8/18	• Visiting family concerned about blood around his mouth, had a problem with his front teeth that he couldn't speak easily and couldn't seem to tell his family what had happened. They believed he may have fallen • Family raised concerns and the information was recorded on Mr X's hospital record • No action was taken
8/8/18	• Visiting family again raised concerns about his mouth and that he had difficultly speaking with Mr X reporting it doesn't matter" "there's no witnesses". • Family raised concerns again with a Doctor, who informed a Ward Manager who ruled out that any fall had occurred • The Ward Manager agreed to investigate the matter however, no further action was taken.
9/8/18	• Family reported the same concerns to the Occupational Health Team during a telephone conversation. • No further action was taken.
24/8/18	• Mr X disclosed to a junior medical practitioner that he'd been sexually abused by a member of staff in the ward. ('a man in a white coat') • The allegation was recorded in the notes and discussed with nursing staff • These staff were all unclear about what next steps they should take • The details of the allegation were reported to a senior member of nursing staff 4 days later but due to the time delay this member of staff assumed the matter had already been addressed by another colleague. • No investigation or safeguarding concern was progressed.
30/8/18	• Mr X made the same disclosure to a multi-agency meeting (Best Interest Meeting regarding his ongoing health care needs). Mr X and his family were in attendance. • Mr X also raised concerns about his care and how he had been treated and handled • Despite the range of professionals in attendance the matter was not investigated or appropriately progressed as a safeguarding concern.
12/9/18	• Mr X's allegation was escalated to Police and Adult Social Care and a formal police investigation commenced. • Safeguarding procedures were also delayed to allow the police investigation and HR procedures to progress due to a result of lack of understanding of safeguarding procedures with regard to parallel investigations processes.
17/9/18	• Mr X was discharged from hospital to a Care Home.

6. SAR Systems Findings Report

6.1 This section of the report forms the final output of the SAR In Rapid Time. It provides the systems and practice findings that have been identified through the process of the SAR and focuses on the social and organisational factors that influenced the effective and timely response by staff to concerns, including People in a Position of Trust. Although the focus of the review was to identify systems findings, analysis of the case specific issues was also undertaken and have been incorporated within the overall report findings.

6.2 The time period of the case reviewed is 1st August 2018 (date of admission to hospital) to 17th September 2018 (date of discharge).

6.3 Information was obtained from the following agencies:

- North Cumbria Integrated NHS Trust
- Cumbria Partnership NHS Foundation Trust[6]
- Police
- Adult Social Care

6.4 Practitioner events were held on 3rd December 2020 and 19th May 2021. This provided an opportunity for the professionals who were involved in the case to collectively reflect on what happened at the time including the enablers, barriers and missed opportunities to safeguard Mr X. This also provided the opportunity to learn from what happened in order to develop practice improvement for the future.

The available data collected and the information obtained from the practitioner events was assessed and 'systems findings' issues were identified as a result. This information has been presented to the Safeguarding Adult Board in the form of questions for them to consider and address.

6.5 Summary

Mr X was admitted to Trust 1 in August 2018. During his time in hospital relatives raised concerns twice regarding an unexplained injury to Mr X. Mr X also raised concerns with a medical professional about a member of staff and the care being provided.

These issues were not recorded, escalated or reported in line with single or multi-agency safeguarding procedures.

These concerns were also discussed by professionals and relatives of Mr X at a multi-agency meeting held on the ward. This also included concerns personally raised by Mr X in relation to how he'd been treated by a member of staff. (Person in a Position of Trust)

Once concerns were escalated there were delays in completing safeguarding and HR investigations as it was agreed that a police investigation into the case would take primacy.

CSAB have developed guidance which outlines the process for making a referral for a SAR, the decision making and methodologies to ensure that we promote effective learning and improvement to prevent future deaths or serious harm.

[6] On 1st October 2019 mental health and learning disability services delivered by Cumbria Partnership NHS Foundation Trust (CPFT) transferred to other providers. In north Cumbria services transferred to Northumberland, Tyne and Wear NHS Foundation Trust (NTW), thereafter renamed to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) to reflect the transfer. In south Cumbria services transferred to Lancashire Care NHS Foundation Trust (LCFT), thereafter renamed to Lancashire and South Cumbria NHS Foundation Trust (LSCFT) to reflect the transfer. On the same date as this transfer, CPFT merged with North Cumbria University Hospitals NHS Trust (NCUH) to become North Cumbria Integrated Care NHS Foundation Trust (NCIC)."

7.1 System Findings

1. There is lack of clarity in procedure and practice when managing parallel safeguarding adult enquiries, police investigations and human resource procedures.

The review has identified that decisions were made to halt safeguarding enquiries and human resource procedures while police investigations were completed. This led to a significant delay in issues, out with the police investigation, being reviewed and addressed by the agencies involved.

Questions for the SAB and Partners:

- How is the Responding to Positions of Trust Concerns policy and guidance aligned to the CSAB Safeguarding Adult Procedures which includes: 7 steps of Safeguarding Adults, Safeguarding enquiries and Making Safeguarding Personal?

2. Frontline staff are not familiar with the Multi Agency Policy and Guidance: Responding to Positions of Trust Concerns.

It is the responsibility of an employer (Person in a Position of Trust lead) to assess any potential risk to adults with support and care needs where an allegation has been made against an employee.(Person in a Position of Trust).

As the allegation made by Mr X related to an employee (Person in a Position of Trust) this information should have been passed to the Person in a Position of Trust Lead within the hospital to assess the risk posed by the employee. However, this information was not appropriately communicated to the Person in a Position of Trust Lead.

Feedback from the practitioner's event identified that front line staff are unfamiliar with the guidance and the need to escalate concerns to their own organisation's Position of Trust Lead.

Questions for SAB and partners:

- The Responding to Positions of Trust policy and guidance is currently under review. How do the SAB and partners wish to ensure the learning from this case is included in the guidance to strengthen the procedures?
- What needs to happen to ensure that front line staff and their managers are aware of the policy and their role within it?

3. Staff did not use the systems and procedures in place for responding, recording, and escalating safeguarding adults' concerns

In this review it is apparent that professionals receiving concerns did not fulfil their professional responsibilities with regard to safeguarding adults in their care despite committing to actions to investigate concerns when they were reported.

A disclosure made by Mr X to junior medical staff was then discussed with a member of the nursing team. At the time both individuals were unsure how to respond to the concern. This information was later reported to a more senior member of staff but the senior member of staff assumed the matter had previously been reported via handover and would have been responded to by another colleague because the incident had occurred 4 days previously.

Staff at the practitioner event also advised that a discussion had taken place at the time where some staff members had suggested that it was unlikely that another member of staff would act in the way described by Mr X.

It was also reported that staffing levels at the time were not in line with appropriate staffing levels leading to time pressures for ward staff. North Cumbria Integrated Care NHS Trust practitioners at the event confirmed this is no longer the case.

Some staff at the practitioner events reported that additional training may have helped them to understand roles and responsibilities. However, it was reported that the quality and standard of training has improved since the incident.

North Cumbria Integrated Care NHS Trust staff were also able to confirm that safeguarding knowledge, understanding and incident reporting has increased since this incident took place and systems are now in place which identify low and high levels of safeguarding reporting from all wards which leads to assertive input from Trust 1 safeguarding team.

Whilst considerable detail about the case was obtained from staff from North Cumbria Integrated Care NHS Trust at the practitioner events it is however noted that not all staff were able to attend the events.

Questions for the SAB and partners:

- Is the training provided to staff (multiagency and single agency) explicit as to what actions are required when allegations are made against staff, either within or out with their own organisation?
- What assurance is required from partners that staff understand their individual responsibilities and are responding to concerns in line with internal and external safeguarding adults' policies and procedures?
- Is there a need for additional guidance for Adult Social Care care staff receiving safeguarding adult concerns, given Adult Social Care are the decision maker for safeguarding enquiries?

7.2 Practice findings

1. Making Safeguarding Personal for Adults and their representatives

Following discussion with Mr X's family it appears that they are unaware of the outcome of all the relevant investigations undertaken in this case. Had the Making Safeguarding Personal toolkit been utilised as it is intended this would have kept the adult at the centre of the enquiry, and provided an outcome as far as is possible to relevant parties.

Questions for the SAB and partners:

- How can the Toolkit be embedded when safeguarding referrals are made and enquiries commence?
- How is Making Safeguarding Personal adhered to when Section 42 enquiries are undertaken?
- How is feedback from individuals or their advocates about the experience throughout the enquiry and their satisfaction with the overall process obtained? Is the system robust?

2. Agency Record Keeping

The quality and accuracy of record keeping completed by professionals involved in the review has not met expected standards.

Each agency has standards and expectations with regard to record keeping requirements and incident reporting, therefore the quality of record keeping is for each agency to review and address.

Questions for the SAB and partners:

- The business of the CSAB is to ensure that organisations have effective safeguarding policies and procedures in place to protect adults with care and support needs from abuse or neglect. What measures are in place to provide assurance that single agency safeguarding adults at risk recording is in line with CSAB policies and procedures?