lancashire safeguarding adults board

Adult F Safeguarding Adult Review Learning Brief
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Case Summary

Adult F was an elderly female who lived with her adult daughter, who had been her nominated carer since April 2016. Adult F also had a son, daughter in law and two grandsons who lived nearby. She was under medical supervision for several age related conditions and was in receipt of a care support package from Lancashire Adult Social Care.
Her daughter experienced a serious mental health episode and was detained in a hospital for several days under the mental health act. Unbeknown to agencies she had locked her mother in a bedroom. Although it was made known to some agencies, she had not herself disclosed that she was a carer and the information did not get passed on. Adult F was discovered by her grandsons five days later in a very poor state and was taken to hospital where, after a few days she started to improve.
Adult F's daughter was in contact with several agencies during her mental health episode, none of whom acted to ascertain her mother's wellbeing, despite her daughter's carer's status being known to some of the agencies. Tragically, Adult F died some weeks later of natural causes, albeit there was no causal link between her death and the previous incident.

The review highlighted three key areas for improvement, the report identifies these as 'missed opportunities', 'use of an interpreter and valid consent' and 'carer's assessment' the learning is summarised below and more detail can be found in the report on the LSAB website.

1. Missed opportunities for agencies to have acted to establish Adult F's' safety and wellbeing.
    - All professionals should be inquisitive and ascertain caring responsibility status of service users, this should be accurately recorded in a timely manner and shared appropriately;
    - In emergency situations, professionals should escalate concerns within their organisation when caring responsibility cannot be established. If you have questions regarding your agency's policy, please contact your safeguarding lead;

2. The use of interpretation services was not always evident in communication with Adult F.
    - Assumptions should not be made that patients do not understand English;
    - Service users should be asked directly and on their own whether they require an independent interpreter – do not assume relatives/ friends will always act in the best interests of the individual;
    - Where there are potential safeguarding concerns an independent interpreter should always be used;

3. There was no review of the carer's assessment which, had there been so, may have indicated emerging difficulties and that Adult F's daughter required more support to care for her mother.
    - The review highlighted that there is a backlog of carer's assessments and reviews; Adults Social care will put arrangements in place to remedy this and assurance will be provided to the LSAB;
    - Going forward, assessments and annual reviews for all service users will be timely, of a good quality and compliant with the Care Act 2014;

The full SAR report is available on the LSAB website.