Safeguarding Adults Review (SAR) – Executive Summary

Subject: M22

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Nottinghamshire Safeguarding Adults Board wishes to place on record its sincere thanks to the family of Adult M who worked closely with the Board and Independent Reviewer and Author. They provided valuable information and an insight into the life of Adult M which was used to help shape and inform this review. This Safeguarding Adult Review would not have been possible to undertake without the co-operation, open reflection and information supplied by those agencies who provided care and support for Adult M. This contributed significantly to the production of the final report and helped to identify recommendations for improvement. The input and professional support provided by the Safeguarding Adults Board managers and support staff have been invaluable throughout this process.

Introduction

The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and explore examples of good practice where this is likely to identify lessons that can be applied to future cases. The purpose of the Review is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

Overview

This Safeguarding Adults Review has been commissioned by Nottinghamshire Safeguarding Adults Board in response to concerns around multi-agency working and missed opportunities to support and engage with Adult M.

Adult M had well-documented issues in his life involving substance misuse and these impacted on his physical health. This led to complex medical needs, resulting in Adult M undergoing leg amputation. His son became his carer at home.

An assessment carried out by an Occupational Therapist identified that major adaptations were necessary at his home as he was unable to access the upstairs of the property. A further assessment was carried out by a Social Worker, who advised Adult M and his son to decide what support they felt was required and agreed to contact Adult Care Financial Services to request support for Adult M in completing the forms. A Carer's Information Pack was provided and there was ongoing communication with regard to a move to a more appropriate property. This was followed by completion of a Carer's Assessment for Adult M's son. It was agreed that Adult M's son would continue to be the primary carer until they

were able to move into more appropriate accommodation at which time Adult M would be able to be more independent.

Over the coming months, Adult M was diagnosed with phantom limb pain by the GP, followed by cellulitis at hospital for which he was prescribed antibiotics. A short time later, in December 2021, he was noted by the GP to have wounds to his legs, and he attended a practice nurse or health care assistant on a number of occasions to have dressings changed. The GP arranged with a tissue viability nurse for a referral to the vascular surgical team for advice and support with ongoing skin damage. Adult M continued to report that he was experiencing pain in his stump and hip, as well as a burning sensation which was increasing. He reported that he was drinking regularly and that his appetite was poor due to the significant pain. The Tissue Viability Service identified non-blanching pressure damage and recommended a specialist mattress.

In January 2022 Adult M was suffering ulcerating wounds to his left thigh, and he attended the practice nurse for wound dressing. Following a review by the GP in mid-January, the GP advised that Adult M required IV antibiotics and he was transferred by ambulance to hospital for treatment, where he also received nutritional support. During this period, Adult M also received the keys to his new property, and his son made arrangements for their belongings to be moved. On discharge from hospital, a district nurse referral was made to provide support with management of wounds to his hips and stump.

During February 2022, home visits were undertaken by various teams. On a joint visit with Adult Integrated Care, an assessment by the Specialist Tissue Viability Nurse raised concerns that Adult M appeared very unwell, and advised that he required admission to hospital. However, Adult M refused on the basis that he should not have been discharged previously, and following a mental capacity assessment Adult M was deemed to have capacity to make the decision. He was made aware that he could die from his wounds, and his son was encouraged to call 999 should he deteriorate further. The GP also contacted his son later on the same day and strongly advised that Adult M should attend hospital as soon as possible due to the risk of sepsis.

The following day, an ambulance was requested by the GP to transport Adult M to hospital. However on arrival he refused to have his wounds examined. He was assessed as having the mental capacity to make the decision and was discharged with a course of antibiotics.

During a visit from an Occupational Therapist a few days later it was noted that Adult M appeared thinner and weaker than he had a few weeks previously. His son also expressed concern that he was having to help Adult M more. He was able to transfer himself onto his wheelchair, and he confirmed that the district nursing team was attending to his leg every two days. Adult M stated that he did not wish to go back into hospital. The Occupational Therapist contacted the duty Social Worker requesting an assessment for further support for Adult M. The Social Worker allocated to Adult M made repeated attempts to contact Adult M but was unable to do so.

In March 2022 a Tenancy Sustainment Officer visited, and noted that Adult M appeared frail, but Adult M stated that he was ok and felt that his infection was responding to treatment. His son stated that the district nurse was visiting every other day.

A number of home visits occurred during this period involving routine dressing and wound care. No mention was made of any deterioration of Adult M's health. However, in early April the GP was contacted by the Community Nurse who reported that they had visited Adult M and he looked very ill. He was refusing to have his dressing changed and refusing food and water. A few days later, Adult M's son called 999 and an ambulance was dispatched to Adult M's home. The ambulance staff found Adult M to be very poorly and barely responsive. He was taken to hospital, and sadly died the following day, with the cause of death recorded as sepsis.

Recommendations and Learning from the review are summarised below, but access to the full report can be requested by contacting Safeguarding1.Adults@nottscc.gov.uk

Recommendations

1. Nottinghamshire Healthcare Trust should review the current structure of the community teams to establish if they are correctly resourced to meet the growing demands placed upon the service.
2. The importance of Mental Capacity Act (MCA) assessments when dealing with vulnerable patients should be emphasised to staff as a priority. The escalation policies and the availability of online toolkits (self-neglect, non-engagement) and other resources to assist the risk management process should also be highlighted.
3. Nottinghamshire Safeguarding Adults Board, through the development of their prevention strategy, should promote the importance of holding multi-agency meetings

to share information and develop multi-agency risk management plans to manage or mitigate the risks posed to vulnerable adults.

4. The transfer of care hubs should link in with other agencies where appropriate to ensure that people are properly supported when discharged from the acute setting.
5. Nottingham & Nottinghamshire ICB to progress work on the Eco system plan to evaluate interoperability and information exchange between the Health & Social Care Sector.
6. Ensure that carers' needs in relation to Severe Multiple Disadvantage are recognised as part of the assessment and whole family process utilising a multidisciplinary approach to support people within this group and prevent self-neglect. Improve data recording to determine the impact of this area on carers and inform future service and support planning.