Barry – Safeguarding Adult Review

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BARNSLEY SAFEGUARDING ADULTS BOARD

Ground Rules

- Be respectful to each other- what we say, what we write.
- Maintain confidentiality- share the learning not the comments
- The issue of Safeguarding Adults is a sensitive subject. If you feel you need to leave the room, do so and re-join when able to
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  The trainer will be available, after the session, if you would like to contact them and talk to them about anything which has caused you upset or distress.

When do we conduct a SAR?

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has sustained a potentially life-threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect;
- **and one of the following:**
  - Where procedures may have failed, and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;
  - Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;
  - Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk
- ***Their purpose is to learning from what went wrong/could be improved and to share that learning to improve practice and outcomes.***

What SARs are we considering?

- Barry – Tameside Adults Safeguarding Partnership Board. 2021 https://www.tameside.gov.uk/TamesideMBC/media/adultservices/Exec-summary-Barry-Final-(002).pdf
- Barry was diagnosed with vascular Parkinson's symptoms in 2012, he developed cerebral vascular disease resulting in many mini stroke. He lived with left sided palsy and swallowing difficulties. He was later diagnosed with vascular dementia
- He was primarily cared for by his wife and they were described as very close. They had no children and few extended family members
- In 2017 he was admitted to hospital and discharged into a nursing home, against his wishes
- He died in hospital in 2018
- The post-mortem recorded Barry's death as hospital acquired aspiration pneumonia.

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Barry

- Barry and his wife(JH) had lived in their home for over 40 years. He ran a local business and was well established in the local community. The couple had shared hobbies They had no children and a limited extended family
- Barry was very independent and struggled with his diagnosis. His wife's role as his main carer eased some of the frustration for him
- JH had her own mobility issues and they had received equipment to aid daily living including a ceiling track hoist
- Inconsistent and at times poor communication meant the couple did not understand the disease prognosis and led to Barry to believe he was being poisoned and refusing treatment. He was deemed as "non compliant"

Barry(2)

- Assessments of Barry's ability to make decisions about his treatment and care were not routinely completed and often poorly recorded/shared
- No multi agency agreement about Barry's mental ability to make decisions impacted on the effectiveness of the response . Belief that mental health services should complete all assessments (psychiatrist)
- Best interest meetings were called but failed to make decisions as his mental capacity to make particular decisions had not been fully assessed
- Practitioners did not understand that if they are recommending/making a specific intervention that they were responsible for the mental capacity assessment and decide if Barry could make that decision?

Barry (3)

- Neither Barry or JH meaningfully engaged in treatment decisions, as no key worker or advocate allocated to support them. They were often invited to meetings but were not given a "voice" or not invited at all
- Confusion around covert medication – was used in hospital but refused by the GP once he moved into a nursing home
- Key turning point in 2017 linked to insertion of PEG, preventing him eating or drinking and a move into 24 hour care which neither he or his wife wanted. JH did admit that she would struggle to care for him. The impact of the PEG and associated discomfort was not well explained to either Barry or his wife. This increased his suspicion that staff were trying to poison him
- Support for JH, as his carer, was not consistent and she was left to organise contact with dietetics to help her with PEG feeding. This delay led to Barry becoming dehydrated and may have contributed to his admission to hospital

Key learning

- Health staff were not confident in completing mental capacity act assessments and wanted to pass these to mental health colleagues
- A key worker was not allocated to coordinate the large number of organisations involved in supporting Harry and his wife
- Key workers were in place but they only represented their organisation
- No access to an advocate – Care UK define the role of an advocate as "*To offer independent support to those who feel like they are not being heard and to ensure they are taken seriously and that their rights are respected. It is also to assist people to access and understand appropriate information and services" (2017)*

Key learning

- No overarching health and social care plan, meant duplication and gaps existed
- The move into nursing care resulted in a change of GP, both Barry and his wife had a longstanding relationship with their GP and practice. A referral by the new GP to the "old" team for support with communication was rejected as it seen as a task not an assessment
- A decision was reached at a multi agency meeting to explore returning Barry home in the final months before his death, despite JH stating at the meeting she could no longer care for him, this was still pursued.

Resources

- Mental Capacity Act E-Learning
- Barnsley Advocacy services - https://www.rethink.org/help-in-your-area/services/advocacy/rethink-north-advocacy-hub/
- Support for carers - https://www.barnsley.gov.uk/services/adult-social-care/information-for-carers/
- Further BSAB Training

Thank you for attending

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