Anna Safeguarding Adult Review - 6 Step Briefing

The Background

Anna was an 86 year old woman who died in hospital with severe and ongoing neglect, which had led to physical deterioration. She spoke Punjabi and did not speak English. Her death was tragic and distressing. Descriptions of her physical state at the time of her admission to hospital are harrowing to read and deeply affected practitioners and managers involved in this review.

Anna received a package of care to provide some support during the week. Her daughter Tilia was her carer and acted as her interpreter. Tilia had been described as having 'care and support needs' of her own and yet this was not fully appreciated when supporting Anna. There was no further assessment of care and support and no discussion about an assessment of Tilia's mental capacity. It was only after Anna's death that a thorough assessment was undertaken with Tilia, where it became apparent that Tilia had significant care and support needs of her own. The author's meeting with Tilia sadly highlighted the findings in this review that it would have been difficult for Tilia to have provided care to her mother.

The Incident

Anna was admitted to Southampton General Hospital in August 2022 after her daughter Tilia called the South Central Ambulance Service, having been advised by carers to phone in relation to a pressure sore under Anna's arm. On arrival, Anna was malnourished, having reportedly not eaten for days. She also presented with matted hair, had a large pressure sore on her lower back and was covered in faeces and urine. She had been sleeping in her chair, as was her custom, but for over a month did not move from the chair, and neighbours reported hearing her banging on the floor and crying. Anna died in hospital as a result of her physical deterioration.

The Review

The Southampton Safeguarding Adults Board (SSAB) Case Review Group (CRG) recommended that this case met the criteria for a Statutory Safeguarding Adult Review. At the SSAB meeting held on the 7th December 2022 this was confirmed and a Safeguarding Adult Review was commissioned. The methodology focused on a practitioner event and a case review panel to work with the independent reviewer to clarify information specific to Anna, consider learning from other Southampton reviews and develop recommendations for changes to practice.

Key Lines of Enquiry

1. **The impact of ethnicity, knowledge of cultural competence and unconscious bias.** What is helping and hindering organisations to achieve person-centred care where families have diverse ethnic and cultural backgrounds / do not speak English as a first language / use family as interpreters?
2. **Understanding of when to raise a statutory safeguarding concern and assessment of safeguarding risk** - what might have been the barriers for people and the reasons that this case was not referred to SSAB sooner? What support, supervision, and training is provided to funded care agencies to know how to identify, and raise, safeguarding concerns for Anna?
3. **What are the organisational factors that make it harder or easier for agencies when family members who are caring for a relative have care needs of their own?** What about capacity/self-neglect?
4. **Understanding the lived experience and voice of people we are working with and their carers/family.** It was noted that Anna's children made decisions on behalf of Anna that were not in her best interest. Was the voice of Anna, along with her views and wishes, captured by agencies involved in her care?

Findings

Information Sharing and Communication: In 2016, Tilia was described as 'having care and support needs', but there were no further assessments of these needs, or discussions around mental capacity. It was only after Anna's death that an assessment was undertaken, which revealed significant health conditions which had not been raised during the review, or shared in safeguarding meetings.

There were 6 statutory safeguarding section 42 enquiries between 2017 and 2021 and a further enquiry raised by the hospital staff at the point of Anna's final admission to hospital. Health partners were not present at the meetings. Each meeting documented identical concerns around the cancellation of visits by funded carers, deterioration of the living conditions, concerns about Tilia's ability to be a carer and her own care and support needs. The outcome of the statutory safeguarding meetings was invariably to organise a deep clean and then latterly to request a housing move. In March 2022 the allocated social worker was withdrawn after 3 years - *'social workers have not been able to implement a behaviour change'.* This was not a multiagency decision. A multi-agency meeting at the closure stage is useful to ensure that the risk has been sufficiently reduced or removed before being closed.

Funded Care: There was an expectation that once the social worker had been withdrawn that the domiciliary care provider would flag deterioration in the home and be able to identify changes in health. This was unrealistic and the reality is that carers entering people's homes have limited time, training, and opportunity to build relationships. Tilia described the care provided to her mother as a 'cup of tea in the morning'. This raises serious questions about similar arrangements in which the domiciliary care provider is the only agency in contact with very vulnerable families. More robust reviews should be part of the monitoring process, with assurance that domiciliary care providers have an escalation process when they remain concerned about families and have not received feedback from adult social care.

Cultural and Unconscious Bias: The impact of racial bias and lack of insight about cultural competence was raised forcibly by practitioners at the learning event – '*if this was a white family would this have happened?*' Desensitisation to Anna's situation and presentation prevented curiosity about how Tilia was providing care. Concerns about the smells coming from Anna's flat were not reported because of 'fears' that this might look like racism, and the care providers took Anna's 'smiles' as agreement. We now know how Anna was screaming and banging on the wall to no avail.

Translation and Interpreting services: Practitioners raised concerns about the availability of face to face and telephone interpreting services. There was no professional challenge about the continued use of a family member even when concerns had been raised about the accuracy of translation.

Good Practice

The domiciliary care provider raised safeguarding concerns over several years and made attempts to gain access to the property.

Anna and Tilia had many meetings with social care who allocated a social worker who tried to work with Anna and Tilia.

There was good practice in safeguarding meetings with the presence of an advocate and an interpreter.

Useful links for Best Practice

- SSAB Self-neglect Guides
- Developing Cultural Competence
- Working With Cultural Competence and Cultural Humility
- Spot the Signs and Speak Out – SSAB Spot the signs of abuse campaign