FRED

SAFEGUARDING ADULTS REVIEW
EXECUTIVE SUMMARY

September 2023

SECTION 1 – The review process.

1.1. In April 2022 the Cheshire West and Chester Safeguarding Adults board received a referral for an 70+ year old man who shall be known as Fred for the purposes of this review. A Safeguarding Adults Review (SAR) panel was convened as per policy and procedures and the decision of the panel was to conduct a discretionary SAR. A discretionary SAR is carried out when the criteria for a statutory SAR have not been reached, but partners are of the view that the case can provide useful insights into the way organisations are working together, to prevent and reduce abuse and neglect.

Two independent authors were commissioned to carry out the review, Sarah Williams who has a legal background and Kathleen Smith who has a background in health and more significantly – palliative care.

1.1.The agencies that contributed to this review are as follows;

Organisation	**Role**
NHS hospital trust A	Head of Safeguarding
NHS hospital trust B	Safeguarding Lead Nurse
NHS hospital trust C	Head of Safeguarding
Local Authority	Social Worker, Best interests assessor and Senior Manager for Adult Safeguarding
LSAB	Board Manager
Police	Serious Case Review Officer
NHS Integrated Care Board	Designated Nurse Adult Safeguarding
Hospice	Director of Care

1.2. Purpose and terms of reference.

Fred was described as a private man and for this reason, personal information has been removed from the publication. He was described as 'a true gentleman, an intelligent and informed man'.

At the time of the review, Fred was a man in his 70's who had a diagnosis of terminal cancer. He had no immediate family to support him, but did have a good friend, who he didn't want involved in some of the decisions about his care and treatment as he didn't want to burden them. Fred repeatedly told professionals that he wanted to go home, however he spent several months in a variety of hospital settings.

The main themes/issues that the review looked at were as follows;

- How well did agencies work together to safeguard Fred?
- Issues around the management of medication in the community – roles and responsibilities and how did this impact Fred?
- Hospital discharge protocols, how did any delays impact Fred who was terminally ill?

SECTION 2 – Agency contact and information learnt from this review.

Fred had a planned and voluntary admission in October 2021 into hospital (hospital C) which was outside of the area he lived. He was discharged on two occasions but re-admitted due to disorientation and confusion. In November 2021 he was subject to a deprivation of liberty authorisation. His wish was to return home, but an appropriate care package could not be sourced and he remained in hospital C against his wishes.

In December 2021 Fred was detained under section 5(2) of the Mental Health Act 1983 (MHA) and moved to another hospital (hospital B) when this came to an end, the independent doctor assessing him took a decision that he was not detainable under s3. Fred continued to say that he wished to return home, however Fred agreed to remain on the ward as an informal patient while a care package was arranged. Fred was assessed as needing 4 calls per day to administer pain medication, as he was assessed to be high suicide risk. There was a lack of consensus between agencies as to who was responsible for commissioning this.

Following a fall on the ward in February 2022 Fred was admitted to an acute hospital setting (hospital A) where he remained until March 2022 when he was admitted to a local hospice.

In April he was deemed eligible for fast-track funding from continuing health care, after which he returned home with support from district nurses and a care agency to support with medication management. He sadly died in May 2022 in hospital.

SECTION 3 – Key findings from the review.

Throughout the review the authors found evidence that practitioners who worked with Fred appeared to have his welfare at heart, genuinely cared about him and strove to keep him safe. Their fears in respect of his suicide risk, the risks if he returned home without a package of care

That a terminally ill man who wished to be at home stayed in hospital longer than was necessary due to a lack of consensus/protocol as to who is responsible to commission services where medication is the primary need.

That practitioners could have sought advice from their legal departments sooner to look into whether a community DoLS would have been suitable and a way to manage the medication risk in the community.

That whilst there was evidence of advance care planning this was not consistent across the patch.

SECTION 4 – recommendations

Recommendation 1: As per Resus Council guidelines, clinicians should engage with Advance Care Planning conversations, including those around DNACPR, with all patients with life-limiting or life-threatening conditions or at risk of sudden deterioration and cardiac arrest.

Recommendation 2: Advance Care Planning decisions should be clearly recorded on patients' records, where they are easily identified. Where systems do not enable relevant clinicians to access Advance Care Planning decisions on electronic patient records, partners (including OOA places) should provide assurance that staff routinely use other methods to liaise with partner agencies to receive information needed for care.

Recommendation 3: Health and Social Care partners should co-produce clearer multi-disciplinary discharge planning pathways for patients ending systemic cancer treatment or other life-sustaining/ life-prolonging treatments.

Recommendation 4: Partners should introduce or review Cheshire's cross-agency protocol to support a multidisciplinary approach to creating risk mitigation plans that include medication management.

Recommendation 5: Hospitals should consider how to implement reasonable adjustments to the environment to minimise the impact of hospital acquired delirium.

Recommendation 6: The LSAB should seek assurance that all partners have a rigorous Mental Capacity Act and Mental Health Act training package.

Recommendation 7: Health partners and Adult Social Care should raise awareness amongst doctors and AMHPs of range of care and support options available through different legal channels on least restrictive practice.

Recommendation 8: NHS Trusts should review the offer advocacy to informal mental health patients, in particular when they remain in hospital by consent following a formal detention under the MHA.

SECTION 5 – Conclusions and next steps.

A summary of the report and key findings has been presented to the LSAB. The recommendations have been agreed and an action plan will be formulated by key partners. This plan will be monitored and reviewed by the LSAB. A briefing for all partner agency staff will be developed and the learning shared across the wider partnership.