7 Minute Briefing – Mr C

1 Background:

A referral was made to Cheshire East Safeguarding Adults Board in December 2022 following the death of Mr C who died from self-injury due to extensive fire burns. The Safeguarding Board agreed that the criteria for a statutory Safeguarding Adults Review were not met as there was no evidence of Abuse or Neglect. However, due to the circumstances surrounding the case, there was an opportunity for reflection and learning.

Mr C was 82 when he died. He lived with his wife and had one son.

Mr C was diagnosed with Dementia in 2017 and his wife had been diagnosed with Dementia in 2016.

For the SAR, the panel looked at the factors affecting both Mr and Mrs C. It was noted that they had both been diagnosed with Dementia prior to COVID, but the COVID restrictions probably impacted on them.

The SAB is thankful to contributions from many agencies including Adult Social Care, GP, Macclesfield, and Wythenshawe Hospitals, Dementia Reablement Services.

2 The Purpose of a Discretionary Safeguarding Adults Review:

- Establish the facts that led to the death and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard Mr C
- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of Mr C and his family are heard regarding their lived experiences and the impact of Caring for someone with Dementia

3 Key Emerging themes:

Building trust: Mr C had a good relationship with his GP. It was noted that he was seen regularly in the Practice – including during COVID

Multi Agency Response: All agencies responded quickly with evidence of onward signposting to specialist support – i.e., Speech and Language/Physio/Dementia Reablement

Caring Responsibilities: Mr C's caring status had not been recorded as a "special category" on all recording systems. The Care Act gives Carers the right to receive support from their Local Authority if they have eligible needs and any Agency can make a referral for a Carers Assessment.

Mental Capacity: There was inconsistency in completing Mental Capacity Assessments and decision-making processes. For example, it could not be established whether an LPA was in place and some assessments were completed remotely.

Information and communication: Information was provided to Mr C's son. There was a missed opportunity to ask him Mr C about how he was coping/feeling

Gaps in Service Provision: Domiciliary Care was unavailable for 6 months. Mrs C was discharged whilst waiting for a package of care. It is commendable that Adult Social Care maintained contact with everyone waiting for a care package to be delivered.

Suicide Prevention: The risk of suicide was unseen

4 Recommendations:

The D-SAR made the following recommendations:

- A Carers Status should be noted in all case records
- Professionals should always seek evidence of Lasting Power of Attorney arrangements
- Decision specific Mental Capacity Assessments to be completed to evidence decision making
- Ensure that Carers are involved in Hospital discharge and are given appropriate information about their loved one's care needs. Don't be frightened to ask about how the Carer feels. Don't rely on a third-party information
- A clear pathway is required for Out of Area Hospital discharge arrangements
- Promote the use of Social Prescribers in Primary Care and Making Space to support Carers
- All agencies to offer Suicide Awareness Training to staff and ensure documentation reflects mental health and risk to self

5 Practice implications:

When anyone is identified as a Carer, it is essential to provide information and signpost to appropriate support. Equally it is important to listen to their unique story, recognise the impact of the caring role and to promote wellbeing.
When there is a concern for a person's safety, or they disclose suicidal ideation it may be necessary to override consent. Information sharing and accurate record keeping is essential.

6 Implementing change:

Discuss the themes with your team or service and consider how they may affect your practice. Determine what you or your team could do to act on these and implement any necessary changes.

7 Resources and further information:

Cheshire East Carers Hub:
enquiries@cheshireeastcarershub.co.uk
Or Text 07866821609
Age UK: enquireis@ageuk.org.uk
Cheshire East All Age Carers Strategy:
Layout 1 (cheshireeast.gov.uk)
Alzheimer's Society:
www.alzheimers.org.uk
Lasting Power of Attorney: Make, register or end a lasting power of attorney: Overview - GOV.UK