Jersey

Safeguarding Partnership Board

A Learning Report

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THE AUTHOR

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1 INTRODUCTION

1.1 Terms of Reference

This Serious Case Review concerns the effectiveness of inter-agency practice in relation to the end of life care of a resident in Jersey.

The Panel for this Serious Case Review was:

Chair: - Assistant Chief Probation Officer

Independent Overview Author

Health and Community Services: Chief Nurse
IMR author: Named Nurse Adult Safeguarding

FNHC: Operational Lead for Adult Services
IMR author: Clinical Effectiveness Facilitator

Jersey Hospice: Director of Palliative Care Services
IMR author: Deputy Director of Palliative Care Services

Health and Community Services:
IMR author: Head of Service – Adult Community & Support Services

GP: Named GP for Safeguarding

2 METHODOLOGY

2.1 Serious Case Reviews in the States of Jersey: Context

Jersey is a British Crown Dependency, and is defended and internationally represented by the UK government. However, the island has its own legal and professional systems, including those concerning health and social care and therefore safeguarding adults. Safeguarding adults in Jersey is consequently governed by a policy framework, which is largely based on the legal framework and best practice in England.

Serious Case Reviews – The Safeguarding Boards in Jersey are not statutory bodies but are clearly committed to learning and reflection and they conduct Serious Case Reviews through an agreed Memorandum of Understanding with all Board partners. The published criteria for a Serious Case Review are as follows:

> '*A Serious Case Review should be considered when:*
>
> a. *There is reasonable cause for concern about how the Safeguarding Adults Partnership Board (SAPB), members of it or other persons with relevant functions worked together to safeguard the adult;*
>
> *and*
>
> b. *Condition 1 or 2 is met.*
>
> *Condition 1 is met if — (a) the adult has died, and (b) the SAPB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*
> *Condition 2 is met if — (a) the adult is still alive, and (b) the SAPB knows or suspects that the adult has experienced serious abuse or neglect'*[1].

The decision whether to undertake Serious Case Review is the responsibility of the Independent Chair of the Boards, Glenys Johnston OBE. In discussion with the Serious Case Review subgroup it was agreed that the circumstances of this case met the criteria and Mrs Johnston commissioned the review.

2.2 Safeguarding Adults Review: Overall Approach

This Serious Case Review was informed by analysis of:

- Agency chronologies of events;
- Agency Individual Management Reviews;
- Discussions held at multi-agency Serious Case Review Panel Meetings;
- Reflection on relevant policies and procedures and consideration of the efficacy of relevant agencies' adherence to those requirements;
- Interviews with family members.

[1] Jersey SAPB Safeguarding Adults Procedures http://www.proceduresonline.com/jersey/adults/index.htm

A Practitioner Event and a Senior Manager Event were held at which multi-agency representatives considered the learning that the review highlighted, both operationally and strategically to improve safeguarding adults practice and systems in Jersey. The conclusions from these events have informed the Serious Case Review findings.

Even in the most difficult of circumstances there can be good practice; this review has sought to identify good practice as well as areas for development. Good practice is more than simply complying with expected standards of professional practice or legal requirements but should aim for practice that is considered to exceed those requirements. Where good practice has been identified, it is detailed in this report.

From previous Serious Case Reviews the Safeguarding Partnership Board has identified six overarching headings that describe the key areas that will drive improvement:

1. Quality of assessments/recordkeeping;
2. Voice adult service user;
3. Management, supervision, training;
4. Information sharing, multi-agency working and reporting;
5. Legislation/legal process;
6. Procedural processes/pathway.

The Safeguarding Partnership Board is focusing on these six areas of improvement through its training, learning events and focused initiatives. Consequently, this Serious Case Review's analysis of practice is in respect of each area.

2.3 Review Principles, Hindsight and Positive Reflection

The primary purpose of this review is of learning lessons, Serious Case Reviews are not investigations or concerned with disciplinary issues, these are for the police, the coroner and operational directors to address, in Jersey they are governed by a set of published principles.

3 CONCLUSIONS

The conclusions suggest seven areas where systems were less than optimal in the case reviewed:

1. Assessment and care planning including pressure care;
2. Pain management;
3. Professional relationships and boundary development between professionals the subject and their family;
4. Information sharing and escalation as the subject's health deteriorated;
5. Absence of Safeguarding Alerts;
6. Voice of the client;
7. Quality of supervision and oversight.

4 LEARNING THEMES

This Serious Case Review has identified some clear and significant learning themes for consideration by the Jersey Safeguarding Adults Partnership Board. These are as follows:

- The need for quality safeguarding supervision to enable reflective practice and to support frontline practitioners undertaking challenging roles;
- The insufficient levels of 'professional curiosity' needs to be rectified within the culture of service delivery agencies;
- The need for improvement in multi-agency working to move agencies away from a silo approach to working towards one where effective inter-agency working is embraced as a positive way of working and supporting adults at risk. The Safeguarding Adults Partnership Board has a role in supporting a culture where valuing different agencies' knowledge and expertise and bringing these together in a multi-agency forum is seen as a positive;
- The need for all safeguarding agencies in Jersey to understand their duties and responsibilities in safeguarding adults and in particular to be clear about the importance of safeguarding being a positive step, not a punishment;

- The need for frontline practitioners to better understand the Capacity Policy and to be clear that simply because a person has capacity to make a decision that may be deemed unwise, it does not mean that the practitioner does not have a duty to explain the risks and implications of that decision;
- The importance of a multi-agency agreed approach to managing the interface between harm and adult safeguarding.
- Modification in practice and culture are required to hear the client's voice – one example would be to develop the model of MSP immediately - see above
- A culture of not escalating concerns needing to be addressed

A lack of a clear statutory basis for the work of the Safeguarding Board and adherence to its policies and procedures including adult safeguarding requires all key safeguarding agencies; indeed those that have featured in this Serious Case Review, to make even greater and sustained efforts to ensure a joined-up, inter-agency approach to safeguarding those at risk of harm in order to achieve a robust system that achieves its purpose.

The learning themes set out are clear indicators of risk in the safeguarding system that the Board should continue to address, if it is to achieve positive outcomes for adults at risk in Jersey.

5 RECOMMENDATIONS

Recommendation	Agency	Measurement
1. All health and social care agencies should consider an appropriate system of care pathway coordination, where one named individual is responsible and accountable for the effective delivery and coordination of care.	All	Audit Patient's voice
2. Health and social care agencies must consider how information sharing might be enhanced, with an electronic system of flagging patients who are considered to be adults at risk.	All	Audit
3. A baseline audit of the prevalence and effectiveness of MDT meetings should be conducted to enable a new and effective MDT system to be implemented.	SAPB	Audit
4. The new Island wide Pressure Ulcer Policy/Procedure should be implemented as soon as possible. The UK Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry document should be integrated into the above policy, if this has not already happened.	All & SAPB	SAPB assurance
5. Making Safeguarding Personal and the implications of the service user voice should be fully integrated into practice when working with adults at risk.	SAPB	Peer review
6. Policies/procedures alongside professional skills should be developed to enable practitioners to set clear boundaries between their expectations of families, and their expectations of professional care. The policies/procedures should be aligned to escalation procedures.	SAPB	Peer review
7. An examination of the culture of Safeguarding is required on the island. The use of 'Safeguarding Alerts' and their construction as punishment requires immediate challenge and a rapid enculturation towards their positive use for prevention and protection	SAPB	Peer review
8. A section on the IMR form should be dedicated to allow a short life biography to be attached.		
9. An assessment of how supervision related to safeguarding practice should be conducted by all agencies involved in situations of safeguarding need.	All	Report to SAPB

6 GOOD PRACTICE

It has been difficult to note good practice in this review, however, the practice of a staff nurse stands out as having performed in an exemplary way and should be acknowledged for their, reflection, escalation and perseverance.

Dr Paul Kingston

Independent Reviewer

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Manthorpe, J and Martineau, S. (2017) Home Pressures: failures of care and pressure ulcer problems in the community – the findings of serious case reviews. The Journal of Adult Protection, 19 (6):345-356.