

TD Safeguarding Adults Desktop Review Learning Briefing



About TD

TD was a 63-year-old man who lived in Abbots Lawn Nursing Home from May 2018. He had acute mental health needs, including a diagnosis of schizophrenia. He also had complex health needs for which he required a range of services. TD had a number of mental health inpatient admissions. During one stay he met his life-long partner. Initially they lived together, however, subsequently they moved into separate accommodations. TD experienced a couple of moves, before living at Abbots Lawn.

TD died in St Richards Hospital in November 2019 and, in the eight months prior to his death, there were concerns about the following abuse and neglect:

- pressure damage to sacrum, heels and rib area
- being found on the floor with weeping eyes
- alleged assault by staff member

In preparing for an Inquest into TD's death there were found to be concerns relating to risk management, safeguarding decisions, and actions.

Our Review examined actions of involved agencies to identify the learning required to ensure that future risk is minimised to other vulnerable adults.

Learning for you to take forward in your practice

Our Review identified the following general findings relating to all of the involved agencies:

- **Multi-agency risk assessment:** a lack of multi-agency information sharing, decision-making and risk management.
- **Safeguarding Adults thresholds and enquiries:** it was found that there was a lack of action to address risk factors and a lack of line management oversight and recording.
- **Mental Capacity Act training and recording:** Mental Capacity Assessments and Best Interest Decisions were not evident.
- **Service user voice:** the voice of TD, his partner and family, did not appear to be actively listened to.

Resources to support your learning

- [MSP Learning Briefing and Podcast](#)
- [Risk Assessment Learning Briefing and Podcast](#)
- [Information Sharing Guide and Protocol](#)
- [Escalation and Resolution Protocol](#)
- [Care Act](#)
- [Mental Capacity Act](#)
- [Pan-Sussex Safeguarding Policy and Procedure](#)

Questions to ask yourself in relation to the recommendations

The Review made five recommendations, which have been developed into a multi-agency action plan. This plan will be monitored to seek assurance that actions have been taken forward to improve practice and minimise risk. Please consider the following summary, to make sure your practice reflects the learning from this case.

Multi-agency risk management

- Do you discuss/review risks during supervision or with colleagues?
- Do you hold timely multi-agency meetings to assess risk, share information, and decide together what actions are needed to reduce risk?
- Are you clear who is responsible for making sure agreed actions relating to risk are taken forward?
- Have you read our learning briefing on risk assessment and listened to the accompanying podcast?

Safeguarding adults thresholds and enquiries

- Do you know when to report a safeguarding concern and are you familiar with and use the Safeguarding Thresholds document?
- Are you aware of and confident of how to challenge safeguarding decisions of another professional or agency by using the Escalation and Resolution Protocol?
- Is risk a primary consideration of yours during safeguarding practice, and do you record this accurately and seek management oversight?

Mental Capacity Act training and recording

- Are you aware that mental capacity assessments and best interest processes must be considered for covert medication?
- Do you realise you have a responsibility to be aware of whether these processes have been followed, and flag if not?

Service user voice

- Do you make sure that the Adult is fully aware of safeguarding concerns and process, and that their views and wishes are sought at every stage?
- Do you use trauma-informed practice to avoid a purely medical intervention to mental health concerns?
- Do you fully engage with carers to ensure that they understand risks and how to support minimising these?