7 Minute Briefing - Craig

Hull Safeguarding Adults Partnership Board

Care Act 2014 Safeguarding Adults Review

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The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The purpose of the SAR is to promote effective learning and improvement to prevent future deaths or serious harm.

Craig died on 7 April 2025. A referral for a SAR was made to the HSAPB Panel who agreed to a Learning Review through the Line-of-Sight process to identify any learning.

Purpose of this review

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To explore if members of the HSAPB worked effectively together to understand and manage the risks to Craig.

To assess if the members exercised professional decision-making consistently, recognising and responding to Craig's lived experience and increasing risk of harm.

Background

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Craig had a complex medical history, including multiple strokes and severe sepsis that led to bowel removal, a stoma, and dependence on a Total Parenteral Nutrition (TPN) line for nutrition. He initially received help changing his TPN bag from the Clinical Nurse Specialist (CNS) team. Craig's relative received training and subsequently took over the daily administration. However, following a disagreement between Craig and his relative the relative withdrew their support with the TPN. Craig subsequently threw away the TPN equipment.

Although Craig had multiple needs, he did not meet the criteria for a variety of services and thresholds. He experienced ongoing challenges in engaging with services and was not always able or willing to accept support or treatment. There were also occasions where interactions with those providing care became difficult. This pattern was evident in the week prior to his death, during which he did not attend hospital as advised, self-discharged after being admitted and did not take up offers of help and support. A further complexity was the final days of Craig's life occurred over a weekend. Support was provided by out of hours teams. It was felt if this period had been on a weekday a multi-disciplinary team meeting would have taken place. The review however, concluded that this would not have changed the outcome for Craig.

Concerns

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In the period prior to his death Craig;

- was presenting differently, was suicidal and potentially in a mental health crisis;
- had pulled out his cannulas and feeding tube. As a result, he did not receive a TPN feed for 6 days and was at significant risk of infection and/or death.
- self-discharged from hospital when he needed lifesaving treatment.

Was it recognised he was presenting differently, suicidal and likely in a mental health crisis?
Was the response of professionals appropriate?
Was there any contingency if family members stopped administering his TPN line.

Recommendations:

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1. Develop training on the application and understanding of mental capacity and executive functioning, with particular reference to;
   - Assessments being time and place specific
   - Consideration of a person's wider circumstances through a trauma informed approach. To include physical health and any brain injuries
   - Empower staff to question a person's mental capacity and be satisfied that they have true capacity
   - Assessments being fully documented to record why someone is assessed as having capacity.
2. Consider improving contingency planning for similar circumstances where support networks are at risk of breaking down.
3. Review MARM process and if parameters need to change to cater for complex cases like this. Consider the creation of a 'High Risk Panel' to safeguard those most at risk and provide wrap around support.
4. Consider a risk escalation process to raise significant/long lasting risks to senior managers for oversight and potential chairing of high risk MARM's.
5. Guidance issued to staff to fully record the reasons behind decisions to assist in out of hours and weekend situations.
6. Review agencies weekend and out of hours provision.
7. Review access to and sharing of information concerning safeguarding of individuals.

Good Practice

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1. Evidence of MDT decision and escalation of concerns to Safeguarding for support and advice

2. Use of Right Care Right Person (RCRP). Utilising RCRP and the toolkit effectively enabled a prompt and proportionate response for the appropriate service to provide the relevant care.

Further information – links

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S.11 of the Care Act
Care and support statutory guidance
Assessment of needs under the Care Act 2014
S.11 – Refusal of assessment
Mental Capacity Act 2005
Mental Capacity Act
NHS Mental Capacity Act
Using the MCA
Professional Curiosity
Total Parenteral Nutrition (TPN)
Understanding Parenteral Nutrition
NHS - Help for suicidal thoughts
Suicide help
MIND – Suicidal thoughts and suicide prevention