MSH Training & Consultancy Ltd

SAFEGUARDING ADULT REVIEW REPORT Mr G

EXECUTIVE SUMMARY APRIL 2021

This Safeguarding Adults Review (SAR) was commissioned by Royal Greenwich Safeguarding Adults Board in June 2020 after a criminal investigation and then a subsequent safeguarding enquiry into the circumstances of Mr G's death had been completed. The SAR considered the care provided to Mr G by a number of services, in the 2 years prior to his death in 2016 and also actions taken by agencies subsequent to this up to the point that the SAR was commissioned.

Mr G was 62 and had lived alone in a first-floor council flat at the time of his death. Mr G suffered from severe epilepsy following a brain injury. He was a wheelchair user when he had to go out for any distance and had a dropped wrist, with limited use of one of his hands. It was significant that he lived on the first floor of a council flat, in a building that did not have a lift. He was unable to leave the flat unassisted and had a series of falls possibly connected to his seizures, sometimes requiring hospital admissions. Mr G's mental health both in terms of his mood and behaviour deteriorated over time. He was supported at home by his sisters, although neither lived locally and he had a package of home care following an assessment by Adult Social Care Services.

He became increasingly depressed, possibly related to his social circumstances. He also sometimes refused the daily home care, which he was offered from 2 different Home Care Providers and at times he was unable to allow carers access into his property. His physical health further deteriorated, and he was found by his sister at home appearing to be barely conscious and acutely unwell after a seizure. She called an ambulance and Mr G was admitted to hospital, where he was found to be suffering from pneumonia amongst other signs of possible neglect at home, which prompted the ambulance service to raise safeguarding concerns about this. Mr G sadly died within 5 days of being admitted to hospital.

This SAR used a hybrid methodology involving agencies submission of chronologies of their contacts with Mr G from their individual records and a series of direct conversations with the key workers or managers from these agencies. An integrated chronology was then analysed with the practice appraised for learning from a series of Key Practice Episodes in the timeline. (2014-2020).

The agencies involved in this process were;

- 2 Home Care Providers (anonymised to HCP1 and HCP2)
- Queen Elizabeth Hospital (Lewisham and Greenwich NHS Trust)
- Oxleas Foundation NHS Trust
- GP Surgery
- London Ambulance Service

- Royal Greenwich Adult Social Care Services (JET Team, Hospital Social Work Team, Strategy & Performance Team and Specialist Social Work Team)
- Royal Greenwich Housing Department
- Metropolitan Police (Greenwich Community Safety Unit)
- Care Quality Commission

The main issues that were identified from this process were presented as 7 key findings, which used the analysis of Mr G's care in line with the SAR Terms of Reference. These illustrated a number of practice issues with potential wider implications for future work in the borough.

Several recommendations were then made in relation to each individual finding, these are summarised below under each finding and can be found in full in the final section of the full report.

1. Where adults are housed in accommodation that they are unable to leave, due to a disability, this should be formally recognised as unsuitable and a priority for action by both Housing and Adult Social Care Departments, who need to work together to ensure suitable alternative and accessible accommodation is provided. Where this is not done it leads to a further decline in the adults' health/wellbeing and exacerbates both the negative impact of the adults' disability and the risks to their safety.

   Recommendations suggest a series of measures to ensure that adults are appropriately supported by both departments, including sufficient advocacy/representation to follow up an assessed need to move to appropriate accommodation.

2. Adults with epilepsy, resulting in seizures and associated with falls leads to an increased risk of both cognitive and social decline, as well as poor overall health (including incontinence). This can affect compliance with medication and the adults' overall abilities to self-manage the condition, it requires regular monitoring, at least annually (including blood tests) and case management, including home visits by Primary Care Services, in line with Nice Guidelines[1].

   Recommendations identify changes in practice for several single health and social care services, including care providers, to address the complex issues around adult's abilities to independently safely manage their medication, including multi-agency monitoring and improved reviews of this area.

3. Where Adult Care Services identify the need for Home Care and either commission a new service provider or transfer a current package of care to a different provider, sufficient information on compliance and access difficulties is not always communicated to the proposed service provider. This can lead to unexpected barriers for the provider and result in ongoing difficulties meeting the adult's care needs.

   Recommendations consider the role of Brokerage, Home Care Services and Adult Social Care Services where there are problems with adult's receiving/accepting social care support, including formal escalation where these problems arise.

[1] https://www.nice.org.uk/guidance/cg137/chapter/1-guidance

4. Adults with chronic physical disabilities, such as epilepsy, are at an increased risk of mental health difficulties and overall cognitive decline, especially where they are housebound. There are not currently clear links between physical health and mental health services to ensure these difficulties are suitably assessed and managed in the community, although they may be in hospital. Also, cognitive decline may indicate the need for an assessment of mental capacity, where decision-making is in doubt, but this is not routinely undertaken.

   Recommendations explore the relationship between chronic health conditions impacting on an adult's mood/behaviour/capacity and how these issues are managed in community health services, including mental health services.

5. It is common practice in Adult Services for Safeguarding S42 Enquiries to be suspended if a case is also being investigated by the police to avoid the risk of interference with potential criminal evidence. The individual circumstance of the case needs to be considered and discussed between the police officer leading the investigation and Safeguarding Adults Manager to facilitate both processes occurring in parallel, if this is necessary and appropriate. Such a discussion would avoid delays, and identify areas for single agency investigation in order to avoid sub judice. It would also improve the efficiency of both Safeguarding and Criminal Investigations.

   Recommendations look at improvements to communication and practice between Police Officers and Adult Services Safeguarding Enquiry Staff to clarify decision making for parallel investigations, where appropriate.

6. The outcomes of either Adult Services' Safeguarding Enquiries or complaints investigations may lead to recommendations for improvements which are not always currently overseen sufficiently robustly to ensure these lead to real changes in organisational practice.

   Recommendations are made to ensure the learning from the investigation into one case to be suitably disseminated and monitored by the relevant agency, whether this is by operational, commissioning or complaints staff in Adult Social Care, in order to make measurable practice improvements.

7. When an adult dies and there is also an ongoing, or concluded Safeguarding Enquiry, investigating whether abuse/neglect occurred preceding the adults' death, this information is not currently always conveyed to the registered medical practitioner for them to report this onto the coroner, to consider whether an inquest is required.

   The final recommendation is a specific update on practice to ensure reporting of deaths are in line with current guidance for consideration of an Inquest by the Coroner.