

7 Minute Briefing Safeguarding Adults Review – Mr G

1- Background

Mr G was 62 and had lived alone in a first-floor council flat with no lift. Mr G was a wheelchair user and suffered from severe epilepsy following a brain injury. He was supported at home by his sisters, although neither lived locally and he had a package of home care. Mr G 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. Mr G was found by his sister at home appearing to be barely conscious 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. Mr G sadly died within 5 days of being admitted to hospital.

2. Why was this SAR undertaken?

Section 44 of the Care Act 2014 (and the Care and Support Statutory Guidance 2016) states that a SAR must be arranged when an adult in its area dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

3. Findings and Recommendations

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

Adults with epilepsy require regular monitoring, at least annually (including blood tests) and case management, including home visits by Primary Care Services, in line with Nice Guidelines

4. Findings and Recommendations

There should be a more joined up approach to Police investigations alongside S42 enquiries.

Ensure links between physical health and mental health services to ensure difficulties are suitably assessed and managed in the community,

5. Actions to take?

A joint Social Services and Housing Complex Case Panel to be implemented where complex cases are brought to the panel to agree a shared action plan .

New tender for home care providers to address gaps in current provision.

6. Questions to consider

Are any challenges to someone's care being at home communicated and understood by the home care provider?

Have you considered someone's long term physical health condition as having an impact on their cognitive functioning?

How can you support someone in inappropriate housing with their application for suitable housing?

7. Further Reading

For more information and to read the full report and executive summary please visit

www.greenwichsafeguardingadults.org.uk

If you have any further questions please e-mail

safeguarding-adults-board@royalgreenwich.gov.uk