Safeguarding Adults Review in respect of Robert Learning Briefing

West Sussex
Safeguarding Adults
Board
Making Safeguarding Personal

About Robert

Robert (anonymised name as requested by family) was a 61-year-old man who enjoyed arts and crafts, shopping, visiting cafes, attending church, social events, and holidays.

Robert was registered blind, and was mostly non-verbal, with a moderate/severe learning disability, and a diagnosis of schizophrenia. He also had recurrent depression and issues relating to severe constipation requiring recurrent hospital admissions.

Robert lived in a care home for over ten years, the last few of which involved a number of safeguarding concerns. Six weeks before he died, Robert moved to a different care home, but was soon admitted to hospital where he sadly died. The cause of Robert's death was inanition which is an exhausted state due to prolonged under-nutrition or starvation and a right fractured neck of femur.

Following Robert's death, a Learning Disabilities Mortality Review (LeDeR) found the need for improved coordination of care and the need for providing holistic support.

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

Review findings: what we need to do better

- Health oversight and coordination
- Person-centred planning
- Safeguarding responses
- Staff skills and knowledge

What we did well

- The learning disabilities (LD) team worked well within the multi-disciplinary team
- Comprehensive psychiatry reviews
- Holistic application of the Mental Capacity Act
- Some holistic and person-centred wellbeing reviews
- Regular contact with family members
- High standard of safeguarding concerns from the LD team

Key resources to help your learning

- Escalation and Resolution Protocol
- MSP Learning Briefing and Podcast
- Person-Centred Approaches Learning Briefing and Podcast
- Information Sharing Guide and Protocol
- Pan-Sussex Safeguarding Policy and Procedure

Questions to ask yourself

There were four key areas of recommendations which will be taken forward in a multi-agency action plan. This plan will be monitored to seek assurance that actions have been completed to improve practice and minimise risk. Please consider the following questions, to make sure your practice reflects the learning from this case.

Multi-agency working

- When working with adults, do you work collaboratively with all agencies, including the independent sector?
- If you have issues about a process/decision within your agency or with another agency, do you know how to raise these?
- Do you receive effective supervision and oversight, which is challenging as well as supportive?
- Do you ensure a holistic, comprehensive multi-agency review of complex cases, which considers all of the adult's needs?

Safeguarding

- Do you ensure that safeguarding plans consider the concern(s) for the adult and wider provider issues/risks?
- Do you report to the police, concerns which may be an allegation of a criminal offence?

Workforce skills and knowledge

- When agreeing care placements, do you consider staff knowledge, experience and skills, and the possible need for bespoke individual training needed to meet the adult's specific needs?
- Do you agree processes to identify and escalate concerns about an adult's deteriorating health conditions?

Communication

- Do you ensure that there are easily accessible and person-centred, multi-agency communication plans in place?
- Where there are communication plans in place, such as Hospital Passports, Red Bag Scheme, Learning Disability flagging systems, Summary Care Records etc. are these reviewed to consider their effectiveness?