Trafford Strategic Safeguarding Partnership Safeguarding Adult Review

SAR John Review Briefing

Introduction

This summary/briefing is aimed at managers and practitioners working with vulnerable adults in Trafford. The key learning emerging from the Safeguarding Adult Review and recommendations are presented.

Overview of report

'John' has a diagnosis of learning disability and schizophrenia and had been residing in supported living accommodation with on-site 24 hour support for many years when a series of falls led to a number of hospital admissions during 2017. Following several unsafe discharges from hospital to his supported living accommodation, John had further falls leading to readmissions to hospital. John suffered serious injuries as a result of the falls.

Who was John?

- He no longer has contact with his family
- He is interested in the military and enjoys activities, films, books and museums associated with WW2
- He enjoys gardening, painting and the freedom to go out for walks or for shopping
- He enjoys visiting friends
- Diagnosis of learning disability and schizophrenia
- Specific needs around communication. He could easily be misunderstood by people who do not know him well.
- Finds changes of routine difficult and becomes frustrated if he feels too restricted.
- He finds health appointments difficult, particularly injections.

Legislative Authority for Review:

This Safeguarding Adults Review was authorised under S44 (1&3b) of the Care Act 2014:
Section 1: An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)
Section 3b: (b): The SAB knows or suspects that the adult has experienced serious abuse or neglect.

Trafford Strategic Safeguarding Partnership

Good Practice:

- Care provider taking John to urgent care centre following concerns about excessive sleepiness.
- Salford Royal referral to mental health liaison to better understand why John was agitated in hospital
- Care provider support to John whilst in hospital.
- Managing John's discharge within TGH complex discharge unit

What the Independent Review Found

John's voice

- Not prominent.
- Majority of colleagues involved in his care didn't know him well
- Staff found it difficult to communicate with him or assess the level of pain he was experiencing
- Relevant prior incidents not always communicated by carers
- When regular carers arrived in hospital, he became more settled
- No patient passport until TGH transfer

Advocacy

- Advocacy (IMCA) not considered by Royal Preston or Salford Royal
- TGH referred John for advocacy but there was a waiting list and difficulty experienced in providing IMCA support at the right times.
- Carers from the care provider advocated for John but may have needed more support to do this consistently.

MCA

- John's learning disability recognised by hospital staff but impact of this on his capacity to consent to care & treatment etc. often not considered.
- Consent often inferred by hospital staff because John did not object.
- MCA may have been misunderstood by some hospital staff as applying primarily to patients deemed uncooperative or attempting to leave

DOLs

- Hospitals reacted to challenges of DoLS in subtly different ways
- Omission of MCA assessments, Best Interests meetings, IMCA referrals left John in quite a powerless situation

Trafford Strategic Safeguarding Partnership

What the Independent Review Found continued

Safeguarding Adults Procedures

- Safeguarding referral following John's admission to MRI and transfer to Royal Preston overlooked.
- Safeguarding referral submitted by Salford Royal not logged locally and therefore not followed up.
- Care provider, then TGH submitted further referrals.
- Trafford ASC did not follow policy and the referrals absorbed into overall response to John's case.

Medication

- Were John's symptoms fully considered by his GP before the dosage of Oxazepam was increased in January & May 2017?
- The potential increase in falls risk of increasing the medication does not appear to have been considered.
- Very concerning that John's repeat prescription of 15mg Oxazepam not discontinued which put John's life at risk.
- Care providers did not question the situation although they took him to the UCC when concerns about excessive sleeping arose

Discharge planning

- Between 4.6.2017 and 11.6.2017, John was readmitted to hospital three times shortly after being discharged.
- Considered to medically fit for discharge on each occasion.
- Lack of:
  - attention to the mechanism of injury
  - curiosity about the risks John may be exposed to in his placement.
  - attention to prior safeguarding concerns
- Hospital and community services operate at a different pace
- Challenging to co-ordinate efforts of CLDT (health), (social care), care provider and commissioner
- Recognised that unnecessarily prolonging John's hospital admission would increase his agitation
- Lack of clarity over how to commission care provider support in hospital
- TGH not an acute hospital so Trafford residents often discharged from out of area hospitals.

Reasonable Adjustments

- All public authorities must make reasonable adjustments to ensure their services are accessible and effective.
- TGH commissioned the care provider to supply carers familiar to John
- TGH used a patient passport to inform care planning for John
- Post traumatic amnesia assessment not carried out as John unable to answer questions.
- John provided with major trauma leaflet as unable to understand information provided by trauma co-ordinator

Trafford Strategic Safeguarding Partnership

What needs to be done now to prevent similar incidents

1. That TSSP obtains an enhanced appreciation of the nature and extent of unsafe hospital discharges by monitoring safeguarding referrals arising from them.
2. That TSSP obtains assurance about the effectiveness of the links between community based services such as Trafford CLDT (health) and (social care) and the out of area hospitals from which Trafford residents are most likely to be discharged.
3. That TSSP obtains assurance that adult safeguarding referrals are responded to in accordance with multi-agency policy.
4. That TSSP obtains assurance that clarity exists over the commissioning of in-hospital support by the patient's provider of care and support within the community.
5. That TSSP obtains assurance that the commissioners of placements for people at risk of falls include the effectiveness of falls policies in placement commissioning and monitoring.
6. That TSSP obtains assurance that providers of placements for people at risk of falls have robust falls policies in place supported by appropriate staff training.
7. That TSSP obtains assurance from NHS Trafford Clinical Commissioning Group in respect of the safe prescribing and administering of medication when the safeguarding referral John's GP practice has been advised to make has been investigated.
8. That TSSP shares a copy of this SAR overview report with each of the hospital trusts involved in this case and seeks assurance from each trust in respect of the actions being taken to improve the application of the Mental Capacity Act.
9. That TSSP seeks assurance from the hospital trusts involved in this SAR in respect of recognition when advocacy support is required and the availability of such advocacy support.
10. That TSSP obtains assurance from the relevant hospital trusts over the steps taken to ensure that Deprivation of Liberty Safeguards are appropriately applied within those hospital trusts.
11. That TSSP obtains assurance that patient passports are initiated and maintained in respect of all adults with learning disabilities.
12. That TSSP seeks assurance that the agencies involved in this SAR have reviewed the reasonable adjustments made for people with learning disabilities in the light of the learning which has emerged from this review.
13. TSSP may wish to consider a formal apology to John for the failings which contributed to the significant harm he suffered during the period covered by this SAR.
14. Given the range of learning which has emerged from this SAR it is recommended that TSSP arranges for a case study based on this SAR to be prepared in order to disseminate learning as widely as possible.

Further Information

- The SAR overview report on the John review and this briefing is available at:

https://www.traffordsafeguardingpartnership.org.uk/Safeguarding-Adults/Safeguarding-Adult-Reviews.aspx

- Published SARs are available from the SCIE SAR repository at:

https://www.scie.org.uk/safeguarding/adults/reviews/library

- TSSP multi-agency safeguarding procedures are available at:

https://www.traffordappp.co.uk/contents-tssb/

TSSP contact details:
Trafford Town Hall, Talbot Road, Stretford, M32 0TH
Tel: 0161 911 8687
Email: TSSP@Trafford.gov.uk
Website: www.traffordsafeguardingpartnership.org.uk