Trafford Strategic Safeguarding Partnership Safeguarding Adult Review

SAR Ryan 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

Ryan was 30 years of age when he died. He was found deceased in the bathroom of his own tenancy flat by his care support worker. The circumstances of his death were investigated by the police and he was given a post-mortem examination. This examination concluded that Ryan may have died as a result of an epileptic seizure. Ryan was born with a rare genetic disorder that affected multiple organs and systems of the body. He was an insulin dependent diabetic and he had significant problems with his eyesight. In addition Ryan had a learning difficulty and mental health problems. Ryan suffered from epilepsy that became more serious as he got older, towards the end of his life he suffered from a number of tonic clonic seizures.

Ryan’s accommodation was provided by a commissioned care provider who also provided the support package that was required in his daily life to achieve the level of independent living that was important to him. This also consisted of a sleep-in member of staff available for night time duties if required, this member of staff lived in separate rooms within the same block of flats. The care provider had worked with Ryan for the 4 years prior to his death.

Ryan’s care plan involved providing “just enough support” to him to accommodate the least restrictive options available. This philosophy underpinned the use of the assistive technology that was deployed to remotely monitor and detect Ryan’s epileptic seizures but failed to alert staff on the night of Ryan’s death. This Safeguarding Adult Review looked in detail at the care and support provided to Ryan and the circumstances that surrounded his death.

Legislative Authority for Review:

This Safeguarding Adults Review was authorised under S44 (4) of the Care Act 2014:

“An SAB (the TSSP in this case) may arrange for there to be a review of any other 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).”

The provision of Section 44 was used because it was not apparent from the outset that a multi-agency failing had contributed to Ryan’s death. However Ryan’s death involved an apparent failure in an aspect of assistive technology. The use of this assistive technology and any potential learning from this case, was felt to be sufficiently important to this developing area of care provision that a formal review was required.

Good Practice:

- Ryan's wishes for a 'bachelor pad' were met by allocation of a tenancy in appropriate community-based accommodation that enabled his independence, met his wish for privacy, and had 24 hour on-site staff support.
- There is evidence that the multi-disciplinary team including his care staff met together on a number of occasions to problem-solve and to carry out statutory and progress reviews.
- He received support from a consistent staff group, who also continued to work with him and take him out during his hospital stay.
- There were timely multi-professional risk assessments following his first seizure in October 2016 and care staff moved quickly to source advice and assistive equipment.
- Using a person-centred, least-restrictive practice framework, in the knowledge of how autism and the importance of quiet and alone time was for Ryan, the search for innovative technological solutions to try to keep him safe was good practice.

What Happened

- Ryan was at risk from his epileptic seizures.
- This risk was managed using a technological innovation that consisted of 'sensor wrist watch' that was intended to pick up physiological signs associated with a tonic clonic seizure.
- The system was dependent upon an alert signal from the 'sensor wrist watch' being sent via an IPAD device to dial up a pre-allocated phone held by the on-duty member of support staff.
- The alerting of this member of staff using this system was the means by which potentially life-saving support would be supplied.
- The 'sensor wrist watch' is a rechargeable battery operated device, as is the IPAD.
- The 'sensor wrist watch' also has to be worn to be effective.

Assuming the technology deployed did what it was designed to do, ie to be activated when a tonic clonic seizure took place, it can be envisaged that the system is reliant upon the device being worn and the rechargeable elements being powered up. Police evidence was that Ryan was wearing his watch at the time of his death, but the watch appeared to be discharged, as did the IPAD device. Thus the technology deployed to provide the epilepsy warning could not have worked.

What the Independent Review Found

- The most significant area where different practice might have led to a better outcome for Ryan was in the depth of the risk assessment process for use of the epilepsy alert watch and associated technology. Much of the practice in relation to the use of supportive technology prior to use of the epilepsy alert watch was good.
- The epilepsy alert watch and iPod link were new technology but their introduction was agreed after professional discussion and conversations with Ryan and his parents. The watch was technology the staff believed Ryan would agree to wear as he liked wearing watches. The 'standard' technology was not adequately reducing the risks posed by an increasing number of seizures.
- Staff were shown how to use it and there is evidence that the importance of charging the watch and the iPod was communicated to staff. There were some initial issues with Ryan denying that he needed to wear the watch but he became more compliant as the alternative was having staff in his apartment, which he did not want.
- With that universally elusive gift of hindsight it is acknowledged by agencies that a more detailed risk assessment might have provided a more balanced evaluation of the benefits and residual risk associated with this equipment and less optimism about a technological solution. Such an approach, taking account of Ryan's compliance/cognition issues, informed by Ryan's past behaviours and the views of family, might have led to a longer trial period with night staff
- There is evidence that Ryan's parents, particularly his mother, were actively involved with him and agencies, including presence in a number of meetings with professionals. Whilst it is very clear that his family wanted the very best life possible for Ryan they, very understandably, wanted him to be safe. They expressed their views that they believed Ryan needed 24 hour staff presence on a number of occasions following his discharge from Greenways. This view was based on their experience, in that he seemed to recover well there and was generally compliant with the support he received.
- In the independent authors experience it would have been very difficult to find accommodation and support that would meet his needs, and importantly his wishes, better than that which was provided at his apartment.

What needs to be done now to prevent similar incidents

- Trafford Strategic Safeguarding Partnership (TSSP) should provide guidance on workforce development for partner agencies who work with adults who are potentially vulnerable, to consider the findings and learning from this SAR, particularly in relation to risks associated with epilepsy and technological solutions to support people in need of health and social care services.

- All partners within the TSSP should provide assurance to the TSSP that they have a programme of staff training that includes practice based workshops on use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards DoLS), including Deprivation of Liberty in a Domestic setting (DIDs).

- All partners within the TSSP should provide assurance to the TSSP that mental capacity considerations and assessments of life threatening risks arising from physical health, mental health, cognitive and social difficulties are carried out, recorded, and appropriately shared by well-informed staff. Consideration should be given to joint assessments for people with complex needs and high risks.

- TSSP to request that NHS England should consider commissioning a research project to bring together information and evidence based practice in relation to assistive technology for people who are at risk of serious harm as a result of their disabilities.

- TSSP to request that Trafford health and care commissioners explore with the expert local provider of technological equipment, Trust Care, whether a loan service can be set up to prevent delay in issuing appropriately risk assessed equipment to individuals and provider organisations.

- All partners within the TSSP should provide assurance to the TSSP that safeguarding case file audits show evidence of open, regular, and recorded discussions with the person at risk and their families (subject to service user consent and/or compliance with data sharing protocols) about how safety risks are balanced with the potential unhappiness and risks to mental health associated with a restriction of lifestyle to manage risks.

- TSSP should provide guidance on workforce development for partner agencies for all staff with responsibilities for care of people who may be vulnerable and who need to be aware of changes in presentation and impact of epileptic seizures, which are noted for their unpredictability (though some people are able to 'sense' warning signs). Seizures can be life changing and sometimes lead to loss of life so speed in identifying new and increasing life threatening seizures that appear without any obvious trigger should quickly receive specialist attention.

- TSSP should provide guidance on workforce development (using evidence from CQC inspections, NHS Quality and Surveillance Group information, LeDeR reviews, safeguarding notifications and complaints information) for local health providers, including hospitals, in relation to the requirement for 'reasonable adjustments' to be made in the delivery of care

Further Information

- The SAR overview report on the Ryan 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/

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