Derbyshire Safeguarding Adults Board

Learning Brief for practitioners
Safeguarding Adults Review SAR20A: Thomas

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Learning Brief: Safeguarding Adult Review: Thomas

Derbyshire Safeguarding Adults Board carried out a Safeguarding Adult Review (SAR) following the death of, 'Thomas'. Thomas died from a fall sustained during conflict with, 'Daniel' while both were resident at a Council short breaks centre for adults with learning disabilities.

A SAR is a statutory duty under the Care Act 2014. The aim of a SAR is for agencies to learn from serious incidents and deaths of adults with care and support needs, to reduce the likelihood of similar incidents from occurring.

Background

Thomas was in his forties when he died. He was well known to Health and Social Care services. Thomas had a learning disability, an autistic spectrum condition and a diagnosis of a bi-polar affective disorder. These complex needs made the world a challenging place for Thomas. He often struggled to communicate his needs and could become highly anxious. Thomas used alcohol in a problematic way. This added to his difficulties and his behaviour could be aggressive and challenging for others to cope with.

Thomas had been supported to try and live independently but unfortunately; these arrangements rapidly broke down and had led to long term hospital admission. Thomas was highly reliant on his mother who was a major support in his life. However, Thomas could become angry and physically aggressive toward her. Her role as carer became more difficult as she became older and became a carer for other family members.

Thomas moved to The Centre as a short-term crisis admission, following the breakdown of his independent accommodation. Health and Social Care worked together to try and support him and source alternative accommodation, but Thomas remained at The Centre for nine months.

The Centre was designed for short breaks for adults with learning disabilities. However, other people with highly complex needs, were also admitted to The Centre in crisis. One such person was, 'Daniel' Very sadly, Thomas and Daniel became involved in a conflict. Daniel punched Thomas causing him to fall. He sustained an injury from the fall and died soon after.

The Crown Prosecution Service determined that Daniel had acted in self-defence.

Findings

- **Direct Practice**

The review recognised that professionals had worked hard to try and meet Thomas and Daniel's needs. There were some good examples of multi-agency working between professionals. However, there was a need to convene multi agency meetings more regularly as risks increased. Agencies did not use the escalation pathways and structures that had been established for adults with learning disabilities and behaviours that could challenge.

In general, individual agencies had appropriate care plans in place although, for some, the risk assessment needed to be updated to reflect changing circumstances. The multi-agency approach would have been strengthened had an over-arching care plan been used. This would have helped Thomas, his mum and individual practitioners, understand the roles of all involved.

Although practitioners were aware of the risk of violence toward Thomas' mum and took steps to minimise it, this should have been managed in line with best practice for domestic abuse – police were the sole agency that responded in this way. Carers may not always distinguish between challenging behaviours and offending behaviours and understandably, be protective of their loved one. However, learning from Domestic Homicide Reviews reinforces the need for improved risk assessment and risk management.

- **Systems Factors**

The lack of appropriate resources to meet the needs of adults with complex needs was the most significant factor. There was an absence of crisis accommodation and specialist services. Adults with complex needs and behaviours that challenged, came together in crisis circumstances. This created a high-risk dynamic within an environment that was not designed, nor able to meet their needs.

Learning for all professionals

The value of multi-agency working was demonstrated. However, when risks are escalating, this should be managed more formally through use of multiagency meetings and escalation procedures.

A whole-systems approach to care planning is most likely to deliver comprehensive care and becomes increasingly important, the more complex the care needs are.

Professionals need to be vigilant in identifying domestic abuse *of* carers as well as *from* carers of people with learning disability and mental health needs and use the tools and resources from Domestic Abuse services.

Learning for commissioners of Health & Social Care services

Commissioning services to meet the needs of a small cohort of adults with highly complex needs is very challenging. The review demonstrated that the plans contained within the, 'Building the Right Support' strategy, need to be delivered at pace. This is likely to be best achieved through joint commissioning arrangements.

Front line practitioners need to be supported in the interim through a clearer complex care pathway that includes shared care plans; an escalation pathway; joint care co-ordination arrangements; knowledge of specialist resources available and developing workforce competence in working with people with dual diagnosis/complex needs.

Good Practice

Despite the tragic outcome, there were many areas of good practice. There was consistent evidence of person-centred care – keeping Thomas and Daniel's wishes to the forefront and supporting their decision making. Practitioners consistently tried to support Thomas to live independently and were responsive to his, and his mother's needs.

There were positive examples of collaborative working between services and professional disciplines, supporting each other in their endeavours to provide the best care they could to Thomas and Daniel.

Next steps

The primary purpose of SARs is for agencies and practitioners to learn and improve the services provided to people. Reflect on the findings from this review and consider what you can do to make a difference to the service that you provide.

The review made a number of recommendations that the DSAB has developed into an action plan. The DSAB will be working across agencies to seek assurance that the learning is making a difference to the lives of adults such as Thomas.