



Derbyshire Safeguarding Adults Board

Learning Brief for practitioners Safeguarding Adults Review: J

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Learning Brief: Safeguarding Adult Review: J

The Derbyshire Safeguarding Adults Board (DSAB) commenced a Safeguarding Adults Review (SAR) in 2017 to learn lessons following the sad death of J, a resident of Derbyshire who died in 2015 at the age of 20. The SAR was completed by a panel of senior representatives of agencies who were involved with J and the information was scrutinised by two independent reviewers who produced the final report and recommendations. The panel worked together to examine and analyse service involvement. Views of J's family were requested and are included in the final SAR report, as were the views of professionals who worked directly with J at a practitioner learning event. The full SAR report and recommendations were agreed by DSAB members in June 2019.

Background:

J was white British and lived in his family home with his Mum and her partner and two younger half siblings until the age of 18. J's Mum described her son as being very social and explained that he enjoyed spending time with his family and was particularly close to his younger male sibling, describing them as having the same sense of humour and taking pleasure in similar activities. J attended a specialist school which supports children with learning difficulties from 1996 to 2013. He also spent time at overnight and weekend residential respite placements. At an annual review of statement in 2008 J indicated as part of his hopes for the future that he would like to find employment in a D.I.Y store.

J was born with a genetic condition which was diagnosed in 2008. This meant he was short in stature being 4 feet in height; he also had poor mobility and used a wheelchair, a walking frame and knee braces. He was doubly incontinent and wore pads throughout his life. He had a sideways curvature of his spine, corrected by surgery, and delayed/arrested puberty all of which resulted in him seeing a number of specialist services as a child. From 2006 J had experienced problems with 'trapped wind', abdominal pain, constipation and diarrhoea. He had been prescribed varying amounts of laxatives to manage his condition.

J left his family home in 2013 at the age of 19 to live in supported living accommodation following a safeguarding concern disclosed by J himself within his family home. A mental capacity assessment was undertaken to assess J's ability to understand and consent to a safeguarding procedure. This assessment concluded that J had the mental capacity to engage with the

safeguarding procedure and express what he wanted the outcome to be.

(Capacity is disputed by J's family)

During 2014 J had been seen at Chesterfield Royal Hospital Foundation Trust (CRHFT) on three separate occasions as an inpatient, twice with abdominal pain which resolved and he was discharged back to the care of his GP. In January 2015 staff contacted J's GP as he was again suffering from abdominal pain, diarrhoea and vomiting. The GP diagnosed probable gastroenteritis and telephone advice was given.

The following day J was not improving and staff eventually rang 999, he was transferred to hospital where he died the next day. His cause of death was given as bowel obstruction.

Findings:

- The supported living staff worked well with J to understand his wishes and tried their best to make sure that he received the care he wanted. They supported J's contact with his family. J enjoyed social activities and spent Christmas with his carers in his supported living placement. J was supported to attend all hospital and GP appointments and carers were proactive in dealing with J's health needs.
- The Mental Capacity Act was used differently by agencies involved with J. Adult Care undertook four capacity assessments and on each occasion found J to have capacity to make the decision required. Other agencies felt that their interactions with J gave them no reason to believe that he lacked capacity to make specific decisions and therefore they did not formally assess J. (Capacity is disputed by his family)
- The transition process for children into adulthood was not as robust as it could be, both from J's perspective, but also in helping the family to understand the potential adjustments that they would need to be aware of when a child becomes an adult. This includes the impact on parents who have been their child's advocate, and also the potential changes to finances and benefits within the family home when a child becomes an adult.
- There was a communication plan in place for J which detailed how he communicated generally (face to face, and over the telephone) but the plan did not include clear information about what J had consented to being shared with his family once he had left the family home.

Learning for all professionals:

- Information, materials and awareness for both young people and their parents/carers is needed about what 'preparing for adulthood' means, to help everyone understand at an early stage the positive and challenging aspects of transition. Families should be signposted to advice and practical support.
- Assurance is needed from all agencies that arrangements for young people and their families during the 'preparation for adulthood' are working effectively and that Health and both Children's and Adult Services are working together where appropriate to provide support.
- Multi-agency mental capacity assessment (MCA) and best interest training should continue to be developed. Professionals from partner agencies should commit to attending existing and future MCA training.

Learning for community support providers:

- Commissioned providers of community support for people with learning disabilities/difficulties should all access training on the management of constipation and recognition of sepsis.
- There should be an escalation policy in place and available to staff to use in an emergency and for significant incidents.

Good practice:

- ✓ All professionals worked hard to support J. but some practice was identified as particularly noteworthy. The support agency displayed proactive management of J's medical conditions. (This is disputed by J's family)
- ✓ There was clear evidence that making safeguarding personal was used appropriately in hearing J's voice and achieving his desired outcomes.

Next Steps:

All agencies and professionals are encouraged to reflect on the findings and learning themes and discuss the implications for their service and future practice. The DSAB has an action plan in place to track the recommendations made and will seek assurance that the learning is embedded.