Learning Lessons Briefing
'Joshua'

Methodology: Multi-agency tabletop review meeting

Practitioner Involvement: Practitioner records and notes were reviewed prior to the meeting

Scoping Period for the review: January 2019 to April 2023

The Review

Background Summary:

Joshua was a 19-year-old young man who had a diagnosis of Autism, Learning Difficulties and Epilepsy, he lived with parents and siblings, however, it is unclear who resided within the household due to complex family dynamics, including alcohol misuse and domestic abuse.

Joshua had complex health needs and was therefore under the care of specialist health services. Unfortunately, as he was reliant on others to support him to attend health appointments, he missed his health reviews and therefore did not receive the appropriate specialist care and support he required.

Joshua attended a special school between 2015 and 2021; however, he remained at home during the Covid-19 pandemic, during this time there were no safeguarding concerns, however, he had considerable periods of absences as the family frequently travelled throughout the country as members of the travelling community.

He enjoyed playing on his iPad, playing cards, being on his trampoline and swimming. Joshua responded well to simple language and prompts.

Joshua was found unresponsive at home by his mother, he was taken to hospital but unfortunately died as a result of sudden death in epilepsy. The coroner's report indicated that there was reduced levels of Epilim in his system at the time of death, this suggests that his Epilepsy may not have been well managed.

It was difficult to identify Joshua's capacity and his abilities and whether he administered his own medication, or whether his caregivers did this, due to the lack of parental engagement with agencies.

Learning:

1. Joshua was reliant on others to support him to attend appointments, documentation did not reflect this and noted “Did not attend”.
2. Not all professionals involved in Joshua’s care were involved in his EHCP health review meetings.
3. Not all professionals involved in Joshua’s care had the knowledge required to fully understand and engage with travelling families.
4. Documentation identified that professionals did not always know who was attending appointments, and did not display professional curiosity.
5. There was not a robust transition pathway for Joshua to support his move to adult health services.
6. There was inconsistency in the language used on letters shared between health services, i.e. some referred to Joshua having Learning Difficulties and others Learning Disability.

Recommendations:

1. All agencies to review and update their "Did Not Attend" (DNA) policy to include a discharge pathway and considerations for the assessment of mental capacity and people who need support to attend appointments.
2. Health agencies to explore and implement measures to ensure health professionals attend EHCP transition review meetings.
3. Wolverhampton Safeguarding Together Partnership to provide training resources to improve understanding and engagement with the travelling community.
4. All agencies to ensure professional curiosity is embed within practice to ensure a thorough understanding of family dynamics.
5. Wolverhampton Safeguarding Together Partnership to seek assurance from agencies that robust transition planning processes are in place, particularly for vulnerable cohorts, i.e. Children and Young People in Care / Care Leavers / SEND.

How can you make a difference?

Key messages from the learning to ask yourself for your practice are: -

- *Can I make changes to improve my own practice?*
- *Do I need to seek further support, training, or supervision?*