Wolverhampton Safeguarding Together (WST) Learning Lessons Briefing

Safeguarding Adult Review - Thomas

The Review

This Learning Lessons briefing was written as a result of a Safeguarding Adult Review (SAR) being facilitated to review the experiences of a young man we will refer to as "Thomas".

Thomas, a 29-year-old Autistic man, was diagnosed with mild learning disabilities, Attention Deficit Hyperactivity Disorder (ADHD) and Emotionally Unstable Personality Disorder. The SAR followed the methodology of Serious Event Analysis.

The timescale of information reviewed was between April 2020 and 9 November 2021.

The SAR considered the findings and key learning themes arising from information provided by agencies who had been supporting Thomas. It was agreed by partners involved in the SAR, that the family of Thomas would not be involved.

Information was provided by, the Hospital Trust, West Midlands Ambulance Service (WMAS), Black Country Health Foundation Trust (BCHFT), Integrated Care Board (ICB), NHS England (NHSE), Adult Social Care (ASC) from two Local Authorities and the social care provider who supported Thomas, all of whom had contact or involvement with him during his life and just prior to his death.

The SAR panel also reviewed information obtained from a 'Learning from lives and deaths – People with a learning disability and autistic people' review (LeDeR), and the Ambulance Service Significant Incident Report (SI).

The SAR took place over three meetings in November 2023, January 2024 and February 2024. The meetings had good attendance and engagement from all partners with a restorative approach to high support and high challenge, and an openness to learning.

The key lines of enquiry for the Review:

- What involvement agencies had in the multi-disciplinary team in planning for Thomas's discharge from hospital into the community?
- What assessments took place in planning for discharge?

- Were all agencies included in the decision making around the suitability of the placement?
- What oversight did agencies have of the placement?
- What action has been taken to ensure that GP information is shared when a patient transfers to a new practice?
- What did agencies contribute to Care Plan reviews and were Thomas's views and voice heard?
- Was support in the community adequate to meet Thomas's needs?
- What action was taken when referrals were made to Wolverhampton Multi Agency Safeguarding Hub (MASH)
- What impact did Covid-19 have upon supporting Thomas's needs?
- How did agencies ensure timely information sharing?

Scrutiny of actions taken by professionals and agencies, including areas of good practice and key learning themes, were considered and reviewed by the SAR panel.

The purpose of this briefing is to share the learning from the review.

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?*

Background Summary

Thomas was described as the life and soul of the party, bubbly, and a friendly character.

Thomas was a 29-year-old man, who at the time of his death was living in Wolverhampton in a supported living tenancy. Thomas moved into his new home in 2021 after several years receiving treatment in a low-secure hospital.

Thomas had a complex relationship with family but had contact with them and they were involved in his life. Professionals who took part in this SAR and knew him well spoke with warm affection about Thomas; he clearly had a positive impact on their lives.

Thomas was always supported when in his home and when he went out and about in his local area. He had support from a number of health and social care professionals to advise and assist him to lead as good a life as he could, and to do things that were important to him.

Thomas had several mental and physical health issues that he needed support to manage.

Thomas died during the national Covid-19 pandemic, and whilst that was not the cause of his death, we must acknowledge that some practices were necessarily different, due to the circumstances, guidelines, and context of the time. (Thomas was discharged from psychiatric hospital in 2020 and died in 2021).

There was considerable planning during the time leading up to Thomas' discharge from hospital in 2020. The multi-disciplinary and hospital team supporting Thomas were all involved. Family was also involved in his life, and decisions made. Thomas moved into Wolverhampton, although Wolverhampton Council were not the placing or funding authority. Thomas registered with a GP in Wolverhampton. Thomas had support from various health professionals and the care provider chosen to support him in his accommodation.

There is evidence that considerable thought and assessment took place to ensure that the care, support and accommodation could meet Thomas's needs. The care provider was involved in that planning and the transition from hospital to his new home.

However, upon moving it should be acknowledged that some aspects of his accommodation did not work for Thomas, nor best enable him to meet his needs. This included challenges with: - sharing accommodation and kitchen space, access to a bathroom where needs could adequately be met, and ensuring that information sharing was adequately facilitated, (for example, that the new GP was aware that Thomas had a learning disability).

Some of the challenges listed above that required action, were reported through a number of safeguarding referrals into the Wolverhampton Multi-Agency Safeguarding Hub, for consideration about whether the criteria for a Section 42. Care Act 2014 enquiry was met. Whilst Wolverhampton Council (as already mentioned) were not the funding or placing authority, Thomas was living in their Local Authority (LA) area, and therefore responsible for co-ordinating safeguarding enquiries or causing others to make enquiries, to safeguard adults from abuse or neglect in their area.

The care, support and accommodation that Thomas needed, was funded by health. Adult Social Care (from the placing authority area) were involved in decisions about his care, support, and accommodation. The roles and responsibilities of Adult Social Care and Health colleagues were at times unclear, particularly about who was responsible for commissioning the care, support and accommodation, who was responsible for keeping the care, support, and accommodation under review, and who risks and issues were escalated to and acted upon. The authority where Thomas was living had not been contacted by the placing authority or health professionals about his move to the area.

There seems to have been a lot of health professionals support and focus on behavioural needs and mental health. There was less consideration about how to manage physical health needs, diet and use of food to manage emotions and feelings.

The care provider was supporting Thomas to navigate and manage complex personal relationships and risks that required a multi-agency approach.

The family dynamics were complicated at times, and there appear to be occasions where better legal literacy by agencies could have supported and safeguarded Thomas more effectively, in particular use of the Mental Capacity Act 2005. Risks and issues that could be managed within a hospital environment, with the legal framework of the Mental Health Act 1983 (2007), could not be as well managed in the community.

Some professionals involved in Thomas's support, felt frustrated that safeguarding issues were being raised but not being addressed. A lack of understanding about where to escalate concerns was evident.

After Thomas' death, a Serious Incident review was completed by West Midlands Ambulance Service, and a Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) review was also carried out. This Safeguarding Adult Review (SAR) was undertaken to address any additional learning not covered by the aforementioned reviews.

Key findings and recommendations arising for WST Safeguarding Partners and Voluntary Organisations of the SAR. They outline the learning which needs to be considered for effective change

Key Finding 1 – Clear, and robust multi-disciplinary plans are made to support, positive and safe in-patient to community discharges. This should include, at the earliest opportunity a lead professional and clear roles and responsibilities across all health and social care professionals involved in the Multi-Disciplinary Team around the person. The person's voice must be heard.

Key Finding 2 – All agencies should ensure that they practice within legal frameworks required to protect and uphold the rights of adults with a learning disability (and autistic adults) when they live in their own home/in their community. Agencies and professionals should ensure they have sufficient legal literacy, appropriate to their role, to support decision making. Upholding the rights and safeguarding adults with care and support needs, may be managed through different the legal frameworks in the community, than those within in-patient settings.

Key Finding 3 – All health and social care professionals involved in a person's discharge planning, should include consideration of risks and issues that require alternative management plans in the community (different to plans in place in in-patient environments). This could include consideration of managing relationships/contact with family, finances, and use of food to manage emotions and feelings. Dates for discharge should be agreed when a care and support plan is agreed, appropriate to manage community risks. This should be subject to review.

Key Finding 4 – The communication between Local Authority Safeguarding Team, Social Work Teams and Commissioning Teams should be clear and timely. Concerns received by the Local Authority (where the abuse or neglect has occurred) should assure themselves that the placing/funding authority are aware of the concerns and that a named officer in that LA is leading on actions. Placing authorities (particularly

within the Black Country area) should inform the relevant commissioner in the receiving local authority (the council) that they will be supporting someone to move into ("be placed") in that area, in advance of the move. Health professionals should make the same undertaking with all relevant health teams in the receiving area too. Sharing of such information is crucial to a safe transition.

Key Finding 5 – The Local Authority (where the abuse or neglect has occurred), where multiple concerns are raised about the same person or the same issue, should triangulate those concerns raised. This means that the Safeguarding Team/MASH should ensure that repeat concerns are recognised, acted upon appropriately and escalated where necessary. An outcome/report should be followed up by the LA where abuse or neglect is occurring, to ensure appropriate action is taken by the placing/funding authority. Similarly, any safeguarding enquiry reports and plans, should include and be shared with the placing/funding authority. The referrer should be informed of the outcome too.

Key Finding 6 – All partners working to the West Midlands Adult Safeguarding Policy and Procedure should familiarise themselves with the safeguarding arrangements and their responsibilities. All partners should know how to escalate concerns about risk and safety within their own organisations, and with other partners.

Key Finding 7 – GPs should be made aware of any adult open to their practice who has a learning disability, and care providers, social workers, and health professionals should ensure that annual health checks are being offered.

Implementation

An action plan has been developed which will be overseen by Wolverhampton Safeguarding Together' s One Panel.