Telford & Wrekin Safeguarding Adults Board

EXECUTIVE SUMMARY

Summary report into circumstances surrounding the death of Adult C

Telford & Wrekin Safeguarding Adults Board
February 2020

Executive Summary

This report provides the outcome of a review undertaken, in accordance with Section 44 of the 2014 Care Act into the death of Adult C. This report is brief in accordance with the family's wishes.

Adult C was diagnosed with a number of long standing health problems which impacted on her health and care needs throughout her life. She was a wheelchair user with mobility issues and a lack of sensation in her lower body. She was at risk of developing pressure ulcers and required assistance managing urinary and faecal incontinence. In addition, she was dependent on others for many activities of daily living such as getting in and out of bed, getting dressed and bathing.

Adult C was admitted to hospital in May 2017 in a drowsy state and with significant skin breakdown. Tragically she died five days later. She was aged in her 30s at the time of her death and immediately before her admission to hospital she had been living with her mother, sister and baby niece in the family home. Adult C's mother was identified as her main carer.

Adult C was registered with a Telford GP practice and was on both the epilepsy and learning disability registers. The Community Nursing Team monitored Adult C's continence care by undertaking an annual review

Adult C had been known to Adult Social Care for a number of years, and received periods of respite care amounting to 22 nights per year. She also received two hours support each week to access the community until this this was cancelled by the family in March 2016.

Adult Social Care had no further contact with Adult C following the cancellation of her support package however, in November 2016 (6 months prior to her death) she accessed a period of respite in a care home.

In the months prior to Adult C's death her sister had become pregnant. Health and children's social care services were involved in supporting Adult C's sister. The Children's Social Worker contacted the Adult Safeguarding Team reporting concerns that Adult C was spending a lot of time on her own and that her mother had health problems. The Children's Social Worker was advised to complete a professional referral form and return this to the adult assessment team. The Children's Social Worker did not complete and return the referral form.

Children's Early Help Workers and a Health visitor had visited the family home several times in the months prior to Adult C's death but Adult C was not seen during any of these visits. An Able Living Assistant had also visited the home in March 2017 to service Adult C's hoist, and a Homecheck visit was made by the Housing Trust. Adult C was not seen during these visits. The Tenancy Support Team had planned a further home visit but this was postponed due to Adult C being in hospital.

Conclusions

Adult C was a vulnerable adult with a variety of health and social care needs. During the last few weeks of her life, she experienced a significant deterioration in her health, and particularly the condition of her skin care. This review has not established exactly what

circumstances resulted in this tragic situation but it is considered that the following factors may have contributed and these are summarised below.

After Adult C's Social Care support package was cancelled, her care was provided by her family and no-one from any agency had on-going involvement with her. There was no pro-active review or monitoring of her health and welfare and it was left entirely for her or her mother to seek help if they were not managing. Although Adult C was believed to have capacity to make decisions regarding her care, there appeared however little consideration of whether she or her mother had the knowledge or skills to know when to ask for help, who to contact if they were struggling or the possible consequences of Adult C not receiving appropriate care.

Agencies never considered Adult C to be at risk of neglect or self-neglect and did not identify that she or her mother needed help to maintain her health. This SAR has found that the continence care for Adult C had not been reviewed or monitored sufficiently and that her anti epilepsy meds had not been reviewed sufficiently. The reviews of these aspects of her care that had taken place had not identified these difficulties. .

Adult C's GP practices did not provide regular monitoring of her complex health conditions. The actions agreed when another GP Practice took over the patients of Adult's C's practice were not implemented in respect of Adult C. It appears that it was assumed that if no-one made contact with the Practice then everything was fine. It was also assumed that the Community Learning Disability Team was monitoring Adult C who were no longer involved.

It is important to consult with both service users and their main carers when undertaking assessments and reviews and making decisions about future care. There are examples of good consultation taking place but Adult C should have been consulted before her social care package ceased. This should have included establishing why she wanted it to cease and whether she understood the implications. In addition, formal care providers such as the care agency managing the care home should have been invited to contribute to Adult C's social care review.

Appropriate consultation with Adult C and her mother as part of the continence review may have identified that Adult C's continence care was inappropriate.In undertaking this review it has been difficult to establish the facts about Adult C's continence review in 2016. This is because the records do not include basic details such as the date of the review, who was consulted and whether the consultation was face to face or by phone.

The second factor that is considered likely to have contributed to the deterioration in Adult C's health and wellbeing was her sister's pregnancy followed by the birth of Adult C's niece. Adult C's mother and sister do not believe that this adversely affected their ability to care for Adult C but it will inevitably have changed the dynamics of the household and had some impact on their availability. Consideration of the whole household would have strengthened the input of H&SC.

Notwithstanding the above, it was good practice on the part of the Children's Social Worker to refer Adult C to Adult Social Care and unfortunate that no assessment took place. Where referrals indicate that a vulnerable adult may be at risk of harm, Adult Social Care should act

even if the adult at risk has not been asked whether they consent to the referral. In addition, once a referral is made, the service should ensure that it is forwarded to the correct team, rather than expecting the referrer to make a new referral.

Recommendations

Recommendation 1: The Telford & Wrekin Safeguarding Adults Board (TWSAB) should request a report from the Telford & Wrekin Clinical Commissioning Group (TWCCG) regarding how GP practices are performing against guidelines regarding annual health checks and medication reviews.

Recommendation 2: The TWSAB should request a report from the TWCCG and Shropshire Community Health NHS Trust (SCHT) which considers the evaluation of continence / urology type equipment being prescribed by SCHT and the other changes made by SCHT to the provision of continence equipment and reassessment / review of continence care.

Recommendation 3: The TWSAB should develop a multi-agency process to ensure that the welfare of vulnerable, disabled adults is monitored when their health and social care needs are primarily being met by informal carers and they are not receiving any regular input from Health or Social Care Services. This should include an assessment of the ability of any informal carers to meet the needs of the service user and periodic reviews that include contributions from the service user and carers who are providing any of the services that are being reviewed.

Recommendation 4: The TWSAB should share relevant learning from this review with Telford & Wrekin Safeguarding Children's Board. In particular, around the need for Agencies to consider the whole household when undertaking assessments and for social work staff within Children's Social Care to have an understanding of Adult Safeguarding.

Recommendation 5: The TWSAB should make arrangements to dissemination the learning from this review as appropriate.

Recommendation 6: The Shrewsbury and Telford Hospital NHS Trust (SaTH) should develop a process for multi-disciplinary handover meetings on hospital wards that minimises the likelihood of patients or visitors overhearing confidential or sensitive information.

All partners have accepted the recommendations and can confirm all required actions are now complete.