Kirklees Safeguarding Adults Board

'Adult O'

Learning from SAR

Safeguarding Adults Review led by Independent SAR Reviewer Lorna Warriner

Background

The Safeguarding Adults Review (SAR) Subgroup received a referral for Adult O, a female in her 20's who sadly passed away. Adult O had been living at her family home and was cared for primarily by her mother. Adult O had complex health needs from birth, including cerebral palsy , scoliosis , blindness, epilepsy , quadriplegia and she also had a profound learning disability.

The SAR subgroup reviewed records from the organisations who had worked with Adult O and found that it met the criteria for a review to be conducted.

Safeguarding Concerns

- No transitional process from Children services to Adult Services
- Awareness by some agencies mum had phobia of health professionals / hospital settings /dentists however no action was taken to support.
- Numerous missed appointments with Dentist / Hospital Paediatric Consultants / Dietetics/ Epilepsy clinic / home visits including gastrostomy tube and nutritional feeds follow up
- Concerns around loss of weight when not attending school and poor personal care
- Epilepsy medication not collected - GP did not identify this for 12 months
- Adult O not registered to have annual learning disability health checks from the age of 14
- Occurring pressure sores with no evidence of support / advice to reduce risk provided to mum
- Mum requesting but then declining day care due costs with no further exploration of this
- No Safeguarding advice or concerns raised for suspected neglect / acts of omission
- No Mental Capacity assessment or Best Interest decision completed
- Lack of multiagency information sharing and working together increased the risk of Adult O's health and social care needs not being met

Key Learning

- Adult O did not go through a formal transition process from children to adult services, which she should have had in accordance with The National Institute for Health and Care Excellence (NICE) guideline [NG43] for 'transition from children's to adults' services for young people using health or social care services' (2016)
- Both child and adult services, all agencies involved did not have an effective 'was not brought' organisational policy, or they were still working under an organisational 'did not attend policy.'
- When Adult O turned sixteen this would have been a time for agencies to assess her mental capacity regarding important life decisions and future care. When Adult O turned eighteen, her mum no longer had parental responsibility nor did she have a formal legal authority in the way of being a Court Appointed Deputy or Lasting Power of Attorney, to make health and welfare decisions – A MCA and best interest meeting should have taken place.
- No consideration by the agencies that she may have been deprived of her liberty and required a Court of Protection, Deprivation of Liberty (CoPDoL11) authorisation.

Good Practice

- As a child, Adult O attended a special education school, which promoted reasonable access to health services and provided an easily accessible environment for her to be seen.
- The Consultant Paediatrician made many attempts to engage professionals in the transition process in 2016 (when Adult O was aged eighteen years old).
- In August 2018, the GP followed up concerns that mum was not recognising signs of sepsis - a face-to-face appointment with Adult O and her mum was completed providing advice regarding catching and treating infection early, in the event that Adult O became unwell.
- Dietician identified that there was an emerging theme of not being able to see Adult O at home and contacted the GP to determine if they had any concerns.
- Mum offered but declined carers assessment – No information provided where to seek support if required
- A Hospital Learning Disability Matron visited her on the ward and made contact with several agencies to see who Adult O was known to. The Matron also referred to the Community Learning Disability Team
- A section 42 Safeguarding Adult Concern raised by Hospital trust due to concerns about physical condition

Kirklees Safeguarding Adult Board Response

- The KSAB commissioned an Independent Author to carry out the review
- All agencies involved with Adult O were required to submit a scoping document and chronology that encouraged early individual reflective learning. The chronologies and learning were then combined, and the Author, Chair and SAR panel identified further areas that needed to be explored by all agencies involved.
- This review was overseen by the Kirklees Safeguarding Adults Board (KSAB) Subgroup.
- A Practitioner learning event was held which provided an opportunity for the practitioners who were involved with Adult O and her family, to collaboratively reflect and identify learning in a safe and transparent space.

*Glossary of Terms used

Was not brought policy has a safeguarding focus and relates to patients who rely on others to take them to an appointment. Please see further Was Not Brought guidance
Safeguarding concern sometime referred to as a **Section 42** under the Care Act is the process to refer allegations of abuse and neglect of an adult at risk (someone with care and support needs)

The act of **neglect and acts of omission** can be intentional or unintentional and relates to when a person at risk is reliant on another person to provide care. Neglect and acts of omission can include ignoring a person's medical needs, failure to provide care and support and withholding the necessities of life, such as medication

If you need to raise a safeguarding concern contact Kirklees Community Health and Social Care Hub – call 0300 304 5555 or email GatewayToCare@kirklees.gov.uk

If any agency who was involved wishes to see copy of the report they are requested to contact ksab@kirklees.gov.uk