WOLVERHAMPTON SAFEGUARDING TOGETHER

Learning Lessons Briefing published following safeguarding review

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A Learning Lessons Briefing has today been published by Wolverhampton Safeguarding Together to share key findings from a recent Safeguarding Adults Review (SAR).

The review was commissioned by Wolverhampton Safeguarding Together to examine the experiences of a 90-year-old man, referred to in the review as ‘Stan', who passed away a few days after being discharged home from hospital.

Stan, who lived alone and had Alzheimer's Disease, was taken to hospital after suffering a fall at a care home where he was temporarily residing in December 2020, following a previous fall that October. He was assessed and discharged home the next morning.

However, agencies involved with Stan were not aware that he had been discharged to his own home, with the care home assuming he had been admitted by the hospital, and the Dementia Outreach Team believing he had returned to the care home.

A safe and well visit was conducted by the police and Stan was found unresponsive but breathing on the floor. He was taken to hospital but sadly suffered a fatal cardiac arrest on the way.

Wolverhampton Safeguarding Together's Safeguarding Adult Review panel considered there may have been missed opportunities to safeguard Stan and his death could have been preventable. The panel, and Stan's family, also questioned whether safe discharge processes were followed or effective, and these issues are reflected in the SAR findings.

The review makes five key recommendations:

1) For The Royal Wolverhampton Hospital Trust, the Black Country and West Birmingham Integrated Care Board and the care home to review the current admission and discharge processes to ensure incidents of this nature can be prevented from happening again.

2) For The Royal Wolverhampton Hospital Trust, the Black Country and West Birmingham Integrated Care Board and the care home to review and improve systems and processes in place to prevent reoccurrence.

3) For The Royal Wolverhampton Hospital Trust, the Black Country and West Birmingham Integrated Care Board and the care home to ensure all members of staff have completed professional curiosity training and seek assurance that this is embedded in practice.

4) To review and establish a process for serious incidents when there are multiple providers involved in any future incident and consider the effectiveness of information flow and exchange between provider and commissioner.

5) For Wolverhampton Safeguarding Together to seek assurance that commissioners, care agencies and hospitals agree and document their role in ensuring that there is continuance of care in circumstances where an adult with care and support needs is discharged from hospital.

An action plan has been developed and agencies have already started work to address the recommendations and provide assurance.

Richard Fisher, Chair of Wolverhampton Safeguarding Together Executive Board, said: “This was a tragic set of circumstances during the challenging period of the pandemic. The purpose of Serious Adult Reviews is to ensure that lessons are learnt and action is taken to address the shortfalls highlighted in the independent review and with family. It is important that relevant partners continue the work already being undertaken through the action plan and through the partnership working of Wolverhampton Safeguarding Together we will maintain oversight of this until we jointly have confidence that new measures are as affective as they can be. Our condolences go to the family of Stan, along with our commitment to ensure lessons are learnt from his loss.”

The Learning Lessons Briefing has been published on the Wolverhampton Safeguarding Adults Board website. For more information, please visit www.wolverhamptonsafeguarding.org.uk.

ENDS

Note to editors:

1/ A Safeguarding Adult Review is a multi-agency review process which seeks to establish the circumstances around an individual's death and determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame; it is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

2/ Section 44 of the Care Act 2014 requires a SAR to be carried out “where an adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board’s area has died as a result of abuse or

neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult".

3/ Wolverhampton Safeguarding Together Board provides strategic leadership for safeguarding work to ensure there is a consistently high standard of professional response to situations where there is actual or suspected harm. For more information, please visit www.wolverhamptonsafeguarding.org.uk.

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