WOLVERHAMPTON SAFEGUARDING TOGETHER
7 MINUTE BRIEFING: Eliza

Background

An individual was found deceased in their home after they had been dead for a considerable amount of time, family members were living at the property and had not reported the death. The family were known to services, albeit individually. They disengaged and were very isolated from services and their community – no extended family were identified. Agencies were working to try and give the individual the support they needed, there were home visits, safe and well checks and care planning was in place – They did agree to go into a residential placement but changed their mind, it is unclear whether the family had an influence over this decision. As the individual was deemed to have capacity, legally nothing could have been done to remove them from the address to safeguard them.

Learning Identified

- The GP practice assumed, because they had not received any notifications and had no replies to any letters or phone calls that the patient had moved to possibly live with family as this is not uncommon.
- The GP practice had not received any letters that would have raised alarms, and the GP practice were unaware of any mental health problems.

Learning Identified

- Family members were not registered at the practice, so it was assumed that the individual lived on their own.
- It was later identified that a family member had significant mental health problems.

Learning Identified

- Professional curiosity - While it is perfectly acceptable for another adult to be the point of contact when carrying out repairs (not necessarily the tenant, if it is an adult) there needs to be consideration of any vulnerable people in the property.
- GP's and community services should have been invited to the MDT meetings; this could have potentially reduced any risks.

Good Practice

- It is worth commending the work of the tenancy officer who was persistent and requested a safe and well check to be carried out by WMP and submitted a SA1 due to her concerns.
- The housing director has recently mandated that when carrying out the yearly checks, gas engineers must enter all rooms in a property that have a radiator; this wasn't the case before, and they would only request access to the boiler.

Good Practice

- Good practice was identified regarding assessment of mental capacity.
- Police carried out a safe and well check and advised the District Nursing Service that they had seen the individual and they had refused any community services stating that they would call their GP if they needed anything.
- The GP Practice carried out a Significant Event Investigation and have identified learning for the practice.

Change in Practice

We need to acknowledge that a considerable amount of time elapsed prior to the deceased being discovered. It was identified that practice has significantly changed and improved over time:

- Housing have introduced mandatory checks on all rooms within a home when carrying out gas checks.
- GP Practice staff continue to highlight missed appointments and action them following a 3rd missed appointment and have access to clinical web portal and use it regularly to follow patient's journey.