Wolverhampton Safeguarding Together (WST)
Learning Lessons Briefing – Adult C

The Review

This Learning Lessons briefing has been created as the result of a Safeguarding Adults Review Committee (SARC) learning review completed in Autumn 2018 into the death of Adult C.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Background Summary

Adult C was 39 years old and diagnosed with epilepsy and schizophrenia. He lived with his partner, who was also considered to be his main carer, and had dogs who he advised were trained to place him in the recovery position, however this was never confirmed. He occasionally needed a wheelchair and also had falls sensors in place. He was known to several agencies, but his main contact was with services related to his mental health needs and he was under the care of the Complex Care Service of the Mental Health NHS Trust.

Adult C was admitted to hospital after an epileptic seizure and this co-incided with his partner also being in hospital for surgery. At the time of admission Adult C expressed many concerns about not coping at home alone whilst his partner was in hospital. Similar concerns about him being at home on his own had previously been raised by the duty community psychiatric nurse from the Complex Care Team who had made a referral to the Mental Health social work team in the local authority.

Adult C was later discharged home alone and the following day took an overdose. He called the Mental Health NHS Trust to report this and advised that he would not let ambulance staff in if they came to his property. By the time entry was gained, with the

help of the police, Adult C needed resuscitation. This was unsuccessful, and he sadly died.

Areas of Good Practice

- Hospital social workers saw Adult C and his partner separately when undertaking their assessments
- The mental health worker recognised the need to refer to adult social care
- The housing agency expediated a move to more suitable accommodation and made timely adaptations to the home to support Adult C's needs
- The ambulance crew responded in a timely way to the emergency call on the day Adult C died. They also called for police support and contacted the mental health team for more information
- Police officers demonstrated professionalism and bravery by entering the property using captor spray and shields for protection. They got the dogs under control and enabled paramedics to safely attend to Adult C
- The emergency duty team recognised an unmet need over the extended bank holiday period and referred to the outreach team who supported Adult C over the holiday period
- A misunderstanding within the telecare service regarding Adult C's request for more equipment was picked up by the manager and rectified. The telecare service were very responsive to calls from Adult C
- The GP contacted the Complex Care Team to discuss Adult C's request for a medication change
- The assessments in the emergency department by the hospital social workers and the psychiatric liaison team identified issues of concern and they attempted to address these and pass information back to the community team
- Adult C was transferred to the Clinical Decision Unit to give a longer time for assessment
- The Mental Health NHS Trust worked flexibly to accommodate Adult C, undertaking home visits and bringing forward appointments as required
- There was handover of information to the psychiatric liaison team from the hospital social workers on completion of their assessment
- Meals on wheels had information on their system to indicate that Adult C may need time to get to the door
- The independent living service left the referral open at the end of their intervention in case a need arose
- The hospital social worker liaised with the duty manager in the community team regarding next steps following Adult C's discharge
- The GP completed home visits when it was believed there were mobility issues in Adult C accessing the surgery
- There was a wealth of information in all records enabling agency review reports to provide good information for the review

Key learning themes arising from the review

1. Co-ordinated assessments

Adult C did not meet the criteria for the Care Programme Approach (CPA) so although he had a care plan that was shared with the GP, it did not cover all the areas that a full CPA plan would have done. He did not have the benefit of a Care Co-Ordinator within the mental health team and remained under routine outpatient review. At the point where Adult C's distress was increasing, it should have been considered whether CPA was appropriate. If his eligibility for CPA had been reviewed this would have led to a more coordinated approach and clarity about who was coordinating his care and support. It would have resulted in a multi-agency review and potentially could have expedited the social work assessment. If his needs had been fully understood it would have been noted that his needs were escalating and the criteria for CPA was now met.

Despite the level of seizures Adult C reported, there was no proactive involvement of the neurology team. Had this have happened his epilepsy care plan would have been shared and this would have led to a better understanding of his needs.

In addition, the referral to adult social care was not followed up in writing and led to wrong information being recorded. It was not clear what the issues were and the urgent referral did not result in a crisis response so ultimately Adult C did not have a social care assessment prior to his death.

Carers assessments were not offered at any point, even though it was clearly acknowledged that Adult C saw his partner as his carer. Had this caring role been recognised by any of the agencies involved and a carer's assessment offered, there may have been greater understanding about the level of dependency that Adult C had on his partner. It could also have been an opportunity to find out the partner's views about some of Adult C's behaviours which may have been indicative of abuse and control.

All services were working in isolation and there was not a coordinated or joined up response.

What has changed?

The Mental Health NHS Trust has indicated that the review of the CPA status did not happen because it was not seen that Adult C met the eligibility criteria and because his needs escalated quickly. The Mental Health NHS Trust is currently reviewing the CPA policy and will be taking steps to ensure that there is appropriate reviewing of CPA status from non-CPA to CPA at times of increased need.

There is a piece of work underway by the WST partners to develop a pathway for communication and co-ordination where a situation falls below the safeguarding

threshold. It is proposed that in cases where there are increased vulnerabilities and a person is often in crisis, that a multi-agency response will be utilised.

2. Information sharing

The absence of shared records led to difficulties in information sharing. Professionals involved could not see each other's records and this led to delays in communication and miscommunication of Adult C's needs.

What has changed?

There is a project underway locally to deliver a shared record across various health and social care providers. This will allow access for relevant professionals to view integrated digital care records via a clinical portal. As this develops it will be possible to share assessments and care plans in other agencies.

The Mental Health Trust is also planning to ensure that there is a shared electronic record across all its services and has made a single agency recommendation to ensure that WST receive updates on this issue.

Recommendations

1. WST should ensure that on receipt of referrals for Safeguarding Adult Reviews (SARs), the facts are verified to ensure accuracy during the decision-making process

2. WST should provide a learning briefing to all agencies regarding all the learning points from this review. An audit of evidence of circulation should be undertaken. The impact of the learning should be assessed by WST's multi-agency case file process

3. WST should seek assurance regarding the effectiveness of all types of referrals. This should include that telephone referrals are followed up in writing by whatever means appropriate by the services making and receiving referrals

4. WST should seek assurance that carers' needs are identified by all agencies and that carers assessments are offered to all those in caring roles as required by Care Act (2014). Carers assessments must include assessment of the interdependency between the carer and cared for person. Contingency arrangements for when the carer can no longer undertake the role must be considered in the cared for person's care plans etc

5. WST should ask all agencies who hold clinical responsibility for managing epilepsy to review their Management of Epilepsy Guidance and ensure that it considers current NICE Guidance

6. Based on the learning from this and other reviews locally and nationally, WST should ask for updates on the Insight Wolverhampton Shared Care Record at Partnership meetings. Once this is in place to include impact on cases via audit and/or case examples

7. WST should ensure that recommendations from the Adult B Learning Lessons Briefing regarding the development of a multi-agency engagement pathway are expedited, given the similar learning in this SAR

8. WST should ask police, ambulance and mental health services to explore current pathways to respond to a mental health patient in crisis and ensure that there is a coordinated response to such crisis situations