Safeguarding Adults Review Learning Brief for an adult known as 'Mr Brown'

About this briefing – Safeguarding Adults Review (SAR) criteria has been met for an adult known as Mr Brown. This learning brief aims to summarise key learning from an NHS Trust internal review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners so that learning can be embedded. This is a learning brief on what was found and how you can make a difference to protecting other adults like Mr Brown from experiencing abuse or neglect.

As a Bexley SAB partnership, we ask you to please take time to reflect on the findings and consider how you can learn, develop, and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

Care Act 2014

What is a Safeguarding Adults Review? - A Safeguarding Adult Board, as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

(1) *A SAB* ***must*** *arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether the local authority has been meeting any of those needs) if:*

(a) *there is* ***reasonable cause*** *for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,* ***And*** ***(b)*** *condition 1* ***or*** *2 is met (see below)*

(2) Condition 1 is met if: -

(a) *the adult has died,* ***and (b)*** *the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)*

(3) Condition 2 is met if: -

(a) *the adult is still alive,* ***and (b)*** *the SAB knows or suspects that the adult has experienced serious abuse or neglect.*

About the review process – The sad circumstances of how Mr Brown died came to the attention of the Bexley SAB in April 2024. A Safeguarding Adult Review panel made up of representatives from Safeguarding leads from local statutory agencies agreed that the circumstances for a Safeguarding Adult Review had been met. The agreed criteria for the review were to use scoping information already presented to the panel and the use of a Serious Incident (SI) review carried out by the acute trust who managed Mr Brown. Following completion of the review recommendations to improve practice were made. These recommendations were agreed by all agencies involved and endorsed by the independent chair of the board.

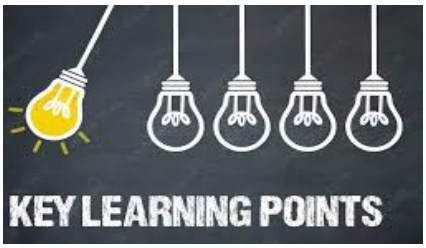
Pen Picture of Mr Brown – Mr Brown was 73 years old at the time of his death. He died in hospital; his medical record showed him registered as learning disabled with autism and epilepsy. He was unable to speak and lived in a care home where he was fully dependent upon the support of care staff for all daily needs.

Hospital staff raised concerns about Mr Brown's death, and his death was recorded as unexpected by the hospital. In these circumstances a Serious Incident (SI) report is raised, and an internal investigation is undertaken. In addition to this the internal review the incident was reported to the Bexley SAB following the processes outlined for a SAR. In addition to this the hospital raising this have ensured lessons learned within their own review have been put into policy and practice.

Summary of Findings – Mr Brown was admitted to hospital as he had been experiencing seizures. At this time and relevant to the seizures, Mr Brown was epileptic and prescribed antiepileptic medication. His seizures continued and his medication was appropriately increased. Mr Brown continued to have seizures, and his medication was appropriately increased, however administration failings and staff numbers led to the increase in medication not being maintained as it should, and no further review of his medication was carried out. Mr Brown's temperature rose to unacceptable levels, and this was treated with a prescription of Paracetamol.
. In the late hours of Christmas Eve 2023, Mr Brown suffered a cardiac arrest; he underwent cardiopulmonary resuscitation which was sadly not successful, and Mr Brown died just after midnight on Christmas Day 2023. The medical cause of death was given as hospital acquired pneumonia. The Scoping Information provided to the SAR subgroup identified that several agencies were working with Mr Brown prior to his admission in December 2023.

Bexley's Adult Social Care (ASC) Team provided information that highlighted Mr Brown first became known to them in 2010 and that several safeguarding concerns regarding Mr Brown had been raised regarding his care home placement and medication management. Information presented highlighted that these raised concerns were never allocated for further investigation as preliminary investigations identified that ASC triage team were satisfied that improvements to Mr Brown's care had been made and that the action of the care home had been appropriate in dealing with the concerns raised in the safeguarding referral. This review identified that actions put in place by the care home reflected limited information being reviewed and the actions to mitigate the risk to Mr Brown did not take into consideration input from his GP or consultant. Mr Brown's brother considered that his injuries and failing health were being caused by his increasing age and brittle bones. This was considered to be a missed opportunity.

Mr Brown was further supported by occupational & physical therapies and upon inspection no concerns by these services were recorded. An inspection of ASC Quality Assurance Team records showed no record of any recent checks at the care home regarding Mr Brown specifically, but checks about the care home were open, this demonstrated that ongoing work with regarding the quality of the care within the home were ongoing. Mr Brown had only recently registered with his GP (2023) however, there were outstanding appointments which had not been attended or followed up. The Community-Based Adult Learning Disability Team reported that Mr Brown had been known to them, but not at the time of his death; they reported that Mr Brown did have a Hospital Passport when they worked with him up until 2022.



Key Learning Points from the Acute Trust –

1. The importance of robust clinical handover process to ensure patients are reviewed in a timely manner. Patients who are acutely unwell should be reviewed face to face and not virtually.
2. The importance of nursing staff, particularly senior nursing staff being aware of the management of complex conditions such as epilepsy and can adequately identify patients who need urgent clinical review.
3. The importance of recognising that patients with learning disabilities and/or autism who cannot communicate their needs, require additional support to do so.

Identified Good Practice –

1. Community-based Adult Learning Disability Team has provided and evidenced usage of Mr Brown having a Hospital Passport.

Recommendations for Partners to consider –

1. Family members should be involved as far as it is safe to do so and professionals should include professional information on all assessments and sharing of information to verify thoughts and opinions.
2. When s.42.1 of the Care Act is met, the Local Authority is required to make an enquiry. ASC should consider auditing conversions of Adults with Learning Disabilities. Note: the SAR-ALD Thematic Review from 2024 highlights additional actions for ASC regarding ALD and safeguarding.

Themes identified –

1. Understanding s.42.1 and s.42.2 duties and responsibilities.
2. Sharing information to professionals and risk management because agencies involved did not share information or utilise information whether inter-intra agency as much as they could have done to support Mr Brown.
3. No evidence that Mental Capacity Assessments were completed with Mr Brown.

Questions with Resources –

1. How confident are you in raising a safeguarding concern to the Local Authority? Screeners@bexley.gov.uk or in an emergency 999.
2. How confident are you when s.42.1 needs to convert to s.42.2 of the Care Act 2014 and initiate a safeguarding enquiry?
3. How well / confident are you with applying the Mental Capacity Act? https://www.safeguardingadultsinbexley.com/wp-content/uploads/Mental-Capacity-Act-Toolkit-2.pdf
4. Are you aware that Bexley SAB has completed over 10 SARs with ALD within them? How are you seeking assurances you know what to do if you have a concern or where to go if you are not getting the help, you and/or the adult at risk requires?

Bexley Safeguarding Adults Board

For more information, please visit your Bexley Safeguarding Adults Board website for a range of FREE training, workshops, 1:1s and toolkits for you to use. www.safeguardingadultsinbexley.com