Portsmouth Safeguarding Adults Board

Safeguarding Adults Review re Mr D

Executive Summary

May 2019

This document is a summary produced by the Mr D Safeguarding Adults Review Panel, based on the findings of a review conducted by Independent Author Pete Morgan BA, MA, MA & CQSW

1. Introduction

This is a summary of a Safeguarding Adults Review commissioned by Portsmouth Safeguarding Adults Board (PSAB) to review the circumstances that led to Mr D's emergency admission to hospital in September 2017 with a grade 4 pressure sore and osteomyelitis. The Safeguarding Adults Review sub-group recommended to PSAB's Chair that the case met the threshold for a Safeguarding Adults Review because of concerns about the effectiveness of agency involvement with Mr D and his family. Safeguarding Adults Boards are required by the Care Act 2014 to carry out a Safeguarding Adult Review when an adult at risk in their area has been seriously harmed or has died, and abuse or neglect is suspected, and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future.

A Review Panel was established, and an Independent Author appointed. Terms of Reference for the review were agreed and Individual Management Review reports were requested from all the organisations that had been involved with Mr D. The Panel worked from a chronology of the activities of the agencies involved, the reports they provided and further information sought for clarification. A workshop was also held with practitioners who had worked with Mr D to identify learning and to understand the challenges faced by practitioners at the time. Mr D and his mother also spoke to the Independent Author to contribute their views to the review. This report is an executive summary produced by the Panel, based on the full report produced by the Independent Author. The Board decided not to publish the full report to protect Mr D's anonymity.

The Panel carried out its work between August 2018 and March 2019.

2. Background to the Review

Mr D has a learning disability and was 21 at the time of his emergency admission to hospital in September 2017. The circumstances leading up to this incident were complex, and Mr D had a long history of involvement with health and care services since childhood.

At the age of 11 he was removed from the family home as a child due to neglect and his parents' inability to support his nutritional needs. At this time he weighed 16 stone 7 lbs and required oxygen at night as a result of his obesity. Mr D appears to have experienced stability of placement through his seven years in care, with just two placements, and the second placement being with respite carers from the first. He successfully lost weight through a maintenance eating plan and at the age of 16 he was discharged from Paediatric Outpatient Services as he no longer required oxygen at night. He also started attending college. There is limited evidence of any work being undertaken with Mr D's parents during this period to understand and enhance their parenting capacity to ensure they could meet his needs once he left foster care. As Mr D approached the age of 18, there were instances of unplanned

contact with his mother. Mr D showed signs of becoming anxious and distressed and there were instances where he self harmed and went missing. Mr D remained in foster care until the age of 18 when he was deemed to have the capacity to choose to return to the family home.

On leaving care he weighed 15 stone 4 lbs and was no longer obese. Foster carers and professionals expressed concerns about his mother's behaviour and her capacity to change. Over the next three years, Mr D's weight increased to 29 stone. During this period Mr D had a significant number of contacts with ED and 111 services due to 'accidents', and his college attendance declined. Health and social care professionals found it difficult to engage with Mr D and his family, with appointments frequently being missed or cancelled by his mother. In June 2017 Mr D was admitted to hospital with back pain. Pressure areas were noted and Mr D was not complying with advice on eating, drinking and mobilising. His mother continued to provide unsuitable food and drinks. Following Mr D's discharge professionals expressed concerns about the home environment, including the impact of family pets on the treatment of his pressure sore. On some occasions dressings were unavailable and suitable pressure relieving equipment could not be sourced. The Adult Multi-Agency Safeguarding Hub had a number of safeguarding concerns raised to them regarding Mr D.

In September 2017 Mr D was admitted to hospital on an emergency basis, with a grade 4 pressure sore and osteomyelitis. He required surgery for debridement of the wound. It was deemed by all professionals that it was not safe for Mr D to return home. Mr D was judged to lack capacity to make informed decisions regarding his health needs. Mr D was discharged to a residential placement.

3. The Panel's discussion and analysis

The focus of the review's analysis was on welfare of Mr D and the lessons to be learnt to improve experiences for adults with learning disability and leaving care in similar circumstances in the future. This included the degree to which decisions were personal, focussed, and the effectiveness of working arrangements particularly around transition across agencies and services.

4. Findings

The Independent Author identified 27 separate findings during the review:

4.1 That there was no evidence of any remedial work being undertaken with Mr D’s parents to prevent the need for his being accommodated by the local authority or to establish whether or not planning for his future should include returning home to live when he left care.

4.2 That there was no evidence of any consideration to the mental capacity of either of Mr D's parents as part of the procedure for the assessment and meeting of Mr D's social care needs as a child or as he became an adult.

4.3 That the legal advice given to Children's Social Care at the time of the Care Proceedings was inadequate, as was the legal advice given to Children's Social Care for future consideration of the implications of the Mental Capacity Act 2005 for young people leaving care.

4.4 That while Mr D was in foster care Mr D's mother demonstrated a consistent inability to cooperate with the agreed care plan for Mr D if not a deliberate intent to undermine it and thereby put his health at risk.

4.5 That while Mr D was in foster care, Mr D's mother was not challenged about her disruptive behaviour and inability to cooperate with Mr D's Care Plan and was granted a level of power and control in the relationship between the family and the statutory authorities.

4.6 That her behaviour during this period did not lead to any professional questioning Mr D's mother's capacity to make decisions relating to her son's health and welfare.

4.7 That the professionals working with the family did not develop a 'professional relationship' with, in particular, Mr D's mother and that this was not identified and addressed within Supervision.

4.8 That Children's Social Care staff showed a lack of awareness of the Care Act 2014 as it relates to safeguarding adults and the Mental Capacity Act 2005 as it relates to Powers of Attorney.

4.9 That Transition Planning for Mr D was instigated later than it should have been and that his Care Plan prior to its instigation did not reflect the need to be planning and preparing him or his family for when he left Care.

4.10 That Adult Social Care staff demonstrated a lack of understanding of the Mental Capacity Act 2005 and its implementation with regard to planning Mr D's Transition into Adult Social Care that left him at risk of exploitation and coercion.

4.11 That Mr D was not supported properly during the Looked After Child Review process and was not therefore enabled to contribute to it effectively and the process itself therefore failed to safeguard Mr D effectively.

4.12 That no health agency recognised the change in Mr D's behaviour, resulting in his having frequent and minor 'accidents', after he left foster care.

4.13 That, despite his known learning disability, no consideration was given to his mental capacity as a result of this sequence of 'accidents'.

4.14 That Mr D was not offered an assessment of his care and support needs either at the time of his transition from Children's to Adult Social Care or under the Care Act 2014 until July 2017.

4.15 That Mr D's mother was not offered an assessment of her needs as a carer either at the time of Mr D's transition from Children's to Adult Social Care or under the Care Act 2014.

4.16 That Adult Social Care did not consider the family history in allowing Mr D's mother to act as Mr D's advocate.

4.17 That during the period after Mr D returned home, Mr D's mother was not challenged about her inability or unwillingness to cooperate with Mr D's Care Plan and was granted a level of power and control in the relationship between the family and the statutory authorities.

4.18 That Mr D's mother's behaviour during this period did not lead to any professional questioning her capacity to make decisions relating to her son's health and welfare or whether she was intentionally depriving him of necessary medical treatment.

4.19 Despite Mr D's Care Plan not being properly implemented and his mother appearing to take decisions on his behalf, no consideration was given to assessing his mental capacity to make decisions about his care and medical treatment and therefore whether any offence was being committed under s44 of the Mental Capacity Act 2005.

4.20 That despite there being evidence in the past of Mr D's health needs being neglected by his family, in particular his mother, professionals did not identify or escalate concerns about how his care needs were not being met.

4.21 That there was a lack of an available scanner that could accommodate someone of Mr D's size and weight.

4.22 That despite the risks of an unplanned discharge being made evident to clinical staff at the Queen Alexandra Hospital, Mr D was discharged home without the appropriate discharge planning taking place.

4.23 That Mr D's capacity to make decisions relating to his health care needs or his personal safety was not appropriately questioned when he was an in-patient at Queen Alexandra Hospital or when he presented at ED.

4.24 The attempt by the Adult Learning Disability team to contact Mr D using a standard letter is not good practice; given his assessed learning disability and difficulties assessing risk, a standard letter was unlikely to be an effective form of communication with him and a more direct means, such as a telephone call or home visit should have been made.

4.25 That Adult Social Care did not meet its statutory duties in failing to offer Mr D an annual review of his care and support needs.

4.26 That all the agencies involved with Mr D failed to identify the need to raise a safeguarding concern with the local authority at an early enough stage.

4.27 That the Adult Multi-Agency Safeguarding Hub did not initiate a s42 Enquiry as required by the Care Act 2014 when it received a safeguarding concern relating to Mr D.

5. Conclusions

The Independent Author concluded that although there was no single incident or failing which directly caused Mr D's hospital admission, it was concluded that the whole series of events, beginning when Mr D became a looked after child, led to the outcomes he experienced. From the findings a number of key themes were drawn out:

5.1 Agencies focussed on referring on, but not on addressing the causes of the concerns.

5.2 Agencies did not help Mr D to express what his desired outcomes were from the support he was offered. There is no record of a s9 assessment being undertaken or reviewed since October 2015, when Mr D was not present.

5.3 Mr D was not empowered to participate in assessments, to make decisions, or to safeguard himself. He was not supported by an advocate at transition or at other times.

5.4 There was a culture of ‘Professional Optimism’ that assumes the best of service users and their families. This led to a lack of challenge to the service user and families, but also to the professionals involved. This meant practitioners were not being challenged within their professional supervision and line-management processes, but also across professional boundaries.

5.5 There was a lack of ‘Professional Curiosity’ to look beyond the presenting issues other than to refer on to another agency. Although individual practitioners had concerns about the care and support Mr D was receiving and his mother's ability to meet his needs appropriately, there was no evidence of any attempt to look beyond the presenting issue to address the question of ‘Why?’

5.6 There was a failure to consider the whole family, and recognise that Mr D's mother and father may well have had care and support needs of their own. Mr D's mother was not offered a carer's assessment, nor was her own mental capacity or capacity to change her behaviour considered.

5.7 There was an apparent lack of recognition of the long-term impact of abuse and neglect on the survivor’s physical and mental health and their social functioning. There was no evidence of work being done with Mr D either as a child, during the Transition Process or as an adult to enable him to understand

his early experiences of neglect and to be aware of their implications for his future in order to empower him to minimise their impact.

5.8 As has often been identified in national reviews, there were obstacles to people with learning disabilities experiencing good health outcomes - the circumstances that led to Mr D's removal from his family as a child did not lead to any substantial action when he became an adult, despite a range of agencies being aware of them.

6. Recommendations

The Independent Author made the following recommendations to the Portsmouth Safeguarding Adults Board, which were accepted by the Board on 7th March 2019.

6.1 That the Board, together with the Portsmouth Safeguarding Children's Board (PSCB), seek assurance from Adult Social Care and Children's Social Care that they have reviewed and revised as appropriate the Transition Process from Children's to Adult Services, with a particular focus on Looked After Children and Care Leavers, including ensuring their staff have a proportionate knowledge of the relevant social care legislation and practice.

6.2 That the Board seek assurance from the PSCB that it monitors its partner agencies' implementation of the Mental Capacity Act 2005 in their involvement with parents and carers.

6.3 That the Board seek assurance that the local authority's Legal Services have reviewed and revised as appropriate its procedures and practice for advising both Children's and Adult Services on the implications of the Mental Capacity Act 2005 for their young people transitioning from Children's to Adults' Services.

6.4 That the Board seek assurance from the PSCB that its member agencies are ensuring parents and carers are challenged appropriately if they do not cooperate with agreed Care Plans, with a particular focus on children in transition to Adults' Services.

6.5 That the Board seek assurance from PSCB and its own member agencies that they monitor Supervision Procedures and Practice to ensure that staff are supported to develop professional working relationships and encouraged to show 'professional curiosity'.

6.6 That the Board seek assurance from partner agencies that they and the services they commission, have appropriate systems and processes in place to ensure the effective implementation of the Mental Capacity Act 2005 and its supporting Code of Practice, in particular in respect of Unwise Decisions.

6.7 That the Board seek assurance from Children's Social Care that it has reviewed and revised the Looked After Children Review process to ensure it is

fit for purpose and that independent Advocates are used to ensure that those children who may have difficulty participating in the Reviews are enabled to do so effectively.

6.8 That the Board seek assurance from partner agencies that they, and the services they commission, have appropriate process and systems in place to monitor adults with care and support needs who make frequent use of their emergency and out-of-hours services.

6.9 That the Board seek assurance from Adult Social Care that it has reviewed and revised as appropriate its policies and procedures for the provision of assessments and implementation of Care Plans to ensure that they are compliant with the Care Act 2014 and its supporting Statutory Guidance, with particular reference to the provision of Independent Advocates and those who do not engage with services.

6.10 That the Board seek assurance from partner agencies that they and those services they commission have reviewed and revised as appropriate, their 'did not attend' (DNA) policies and procedures.

6.11 That the Board seek assurance from partner agencies that they have reviewed the processes by which consideration is given as to whether there are grounds for a formal investigation into whether any offences have been committed under s44 of the Mental Capacity Act 2005.

6.12 That the Board seek assurance from partner members that they, and the services they commission, ensure that assessments are holistic and multi-agency and that staff are encouraged to demonstrate ‘professional curiosity’ to look beyond the ‘presenting issue’.

6.13 That the Board seek assurance from the Health and Wellbeing Board that services are being developed to ensure that they are accessible to all, including those who are obese.

6.14 That the Board seek assurance from the Queen Alexandra Hospital that they have reviewed and revised as appropriate their Discharge policies and procedures to ensure that adults with additional care and support needs are discharged safely into the community.

6.15 That the Board seek assurance from partner members but from Adult Social Care in particular that they have reviewed and revised as appropriate their policies and practice re communicating with adults with learning disabilities and/or communication difficulties.

6.16 That the Board seek assurance from partner agencies that they and the services they commission have in place effective staff development and monitoring processes to ensure that staff know when and how to raise safeguarding concerns with the local authority.

6.17 That the Board seek assurance that the Adult Multi-Agency Safeguarding Hub has reviewed and revised as appropriate its Policies and Procedures for triaging safeguarding concerns to ensure proportionate responses in accordance with the principles of Making Safeguarding Personal.

6.18 That the Board seek assurance from the Health and Wellbeing Board that the lessons identified in recent research into the health outcomes for adults with a learning disability have been recognised and addressed locally by both health and social care agencies, including the development and implementation of Health Action Plans.