



Safeguarding Adult Review Executive Summary – Stacey

Death of an adult with learning disability, contributed to by neglect

Learning

Consistent application of legal frameworks; independent scrutiny through safeguarding; making safeguarding personal; reflection and enquiry around care user's triggers and feelings; insufficiency of community-based provision to meet complex needs and challenging behaviours; access to advocacy; communication between professionals and family members.

Summary recommendations

Seeking assurance that agencies address legal literacy within training, embedding reflective practice; positive risk taking; implementation of transforming care agenda; independent scrutiny of high volume, high severity self-harm incidents; advocacy during MHA detention.

Keywords

Legal literacy, learning disability, reflective practice, advocacy, MHA detention, self-harm.

Introduction

This is the summary published report made by Warrington Safeguarding Adult Board (WSAB) following a Safeguarding Adults Review (SAR). The full report can be made upon application to WSAB.

The full report was ratified in December 2019 by WSAB.

In accordance with her family's wishes, Stacey's real name has been used throughout this report.

Summary of the case

Stacey was born with bulbar palsy and a type of cerebral palsy called Worster Drought Syndrome, and was later diagnosed with a learning disability with challenging behaviours. Stacey faced challenges throughout her life, having lifelong difficulties with swallowing, feeding, mobility and speaking. Stacey had severe difficulties in understanding and communicating with others, difficulty evaluating situations and interpreting the intent of others. Stacey was cared for at home until she was 20, at which point she moved into supported living accommodation. This led on to a range of living arrangements that included stays in respite placements and periods of detention in psychiatric wards. Stacey's difficulties with decision-making increasingly put her in harm's way over time, and it eventually became necessary for the local authority in which Stacey was ordinarily resident to apply to the Court of Protection so that Stacey's freedom could be restricted in order to limit her risk of exploitation. The difficulties increased yet further, necessitating mental health act detention. A nine month stay in a psychiatric hospital near where she and her family lived gave way to a longer stay of three years at a hospital in a new area about 20 miles away from home.

The environment in psychiatric wards was considered to be unsettling for Stacey, and it had been found that Stacey did not require low secure services, but commissioners found it difficult to secure a suitable community placement. Stacey increasingly found it hard to live on the ward and the environment exacerbated her behaviour, to the extent that there was increased risk to Stacey and others, and it frequently became necessary to have police involvement on the ward as a result of Stacey's behaviour. Linked to Stacey's difficulties with swallowing due to her congenital conditions,

Stacey increasingly exhibited ingestive behaviours that were dangerous for her. Her high risk of swallowing non-food items was established, and Stacey was moved to a different low secure unit at the same out of borough placement whilst a search for a suitable placement for Stacey continued. One such ingestion event led to serious physical harm and a need for intensive care treatment, concluding in a safeguarding referral, in turn leading to recommendations to improve Stacey's safety, generally managed by the use of 2-1 observations.

Stacey's risk of ingesting objects remained high over the subsequent period. Despite the 2:1 observation arrangements, and after a weekend during which her level of distress had been particularly pronounced, Stacey ingested paper hand towels, which caused her to suffocate. After resuscitation attempts Stacey was placed into an induced coma and died three weeks later, after it had been established that the harm she sustained through hypoxia was too severe for her to survive.

The inquest into Stacey's death concluded in November 2019 that Stacey died as the result of misadventure, contributed to by neglect.

Findings and recommendations

Finding 1

The application of legal frameworks was not always as consistent or robust as it should have been and agencies could have explored the use of less restrictive frameworks to manage Stacey's challenging behaviour.

Recommendation 1

Professionals need to robustly and consistently apply the legal frameworks within which they work to enable clarity for the individual, their families and other professionals. The WSAB should seek assurances that agencies are addressing legal literacy within their safeguarding training and agencies should monitor the impact of this on practice. Alongside this local practice guidance should be established to support professionals and families to navigate and challenge appropriate use of frameworks.

Finding 2

Stacey's behaviour and incidents were recorded but there was a lack of reflection and enquiry regarding the triggers and feelings that underpinned them. This was not consistently reviewed and explored in terms of its indication of her response to care plans and decisions being made.

Recommendation 2

In line with NICE guidance professionals should seek to record not just events and behaviours but also share reflection on these with the service user and their families/representatives to reach a mutual understanding of their underlying meaning for the service user. Agencies working with service users with communication challenges should ensure they are using reflective supervision approaches that facilitate professionals exploring underlying meaning of presenting behaviours.

Finding 3

Stacey experienced a prolonged period of detention within an environment where she was unable to develop and exercise some controls other than through negative behaviours. That this continued was partly due to attitudes to risk and a lack of joined up formal reflection and planning by agencies on what could be done differently to create an environment where transition to a more positive adulthood might be more likely such as PBS or an intermediate placement.

Recommendation 3

The WSAB should explore options for promoting "Positive risk taking" within

practice across the partnership that builds upon the evidence based models of practice such as strengths based and making safeguarding personal approaches.

Finding 4

There is insufficient community based accommodation with skilled staff support to meet the needs of people who are complex and have risky and challenging behaviours, to live a good life safely.

Recommendation 4

The WSAB should seek assurances from commissioners around the implementation of the Transforming Care agenda locally and escalate issues beyond the local areas control to central government via the national SAB Chairs network.

Finding 5

There were multiple incidents of ingestion and harm that did not receive independent scrutiny from a safeguarding process.

Recommendation 5

The WSAB should clarify local safeguarding referral expectations around self-harm incidents in terms of thresholds for reporting due to volume or severity of an incident.

Finding 6

Stacey did not receive independent advocacy whilst detained under the Mental Health Act. This impacted on her rights to appeal the detention and ensure her wishes and views were promoted.

Recommendation 6

Warrington Borough Council should assure WSAB that it has developed a clear protocol for advocacy provision in cases of detention either under the DoLS or MHA to ensure advocates are in place at the earliest opportunity. The WSAB should communicate this protocol and identify mechanisms to monitor its use and impact.

Finding 7

Despite regular meetings and multi-disciplinary case discussions there were evident communication issues. This was between professionals and with Stacey and her family. The professional communication issues in this case created a sense of no shared plan across the agencies involved guiding interventions and transition activity. Recommendation 1 will aim to support effective communication where disagreements are apparent. However, agencies will need to explore how they

receive, record and process information to ensure that their own internal practice is not impacting on the quality of their communication with others.

Recommendation 7

All professionals have a responsibility to effectively share information in relation to safeguarding and providing care and support. The WSAB, in partnership with TSAB, should develop and deliver a lessons learnt workshop for SAR H that promotes multi-agency roles and responsibilities in relation to sharing, recording, receiving and clarifying information and decision making.

Finding 8

Northwest Boroughs have identified single agency care quality issues within their practice in this case in relation to the quality of care that Stacey experienced. This related to aspects such as staffing levels and adherence to internal policies and procedures. (attached)

Recommendation 8

The WSAB should seek assurances that NHS England and CQC are satisfied that NWB have adequately addressed their action points from the Serious Incident Report to effectively respond to any care quality concerns for adults with Learning Disabilities within their inpatient areas.

Recommendation 9

WSAB should seek assurance from NWBH Trust and Knowsley CCG (as lead commissioner of NWBH Trust) that Serious Incident processes comply with the NHS framework and that there is an effective system in place to ensure that they inform learning and future developments.

Recommendation 10

WSAB should seek assurance from NWBH Trust and Knowsley CCG that staff undertaking serious investigations are adequately train.