Trafford Strategic Safeguarding Board

SAFEGUARDING ADULT REVIEW

In respect of Ryan

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Greater Manchester Police

NHS Trafford Clinical Commissioning Group

Trafford Council

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Acknowledgements

I should like to thank all those who contributed to this Safeguarding Adults Review (SAR). Ryan's parents were asked if they would like to meet to contribute to the review but they declined a meeting but did refer to some written observations, they had sent to the Trafford Safeguarding Board manager.

The management of SARs places significant responsibilities on what is often a small and very busy group of Safeguarding Board staff. I should like to thank those staff for their work and support throughout this Review.

1. Introduction and reason for this Safeguarding Adults Review (SAR)

1.1 Ryan was 30 years old when on the 26th February 2016 he was found dead by a care support worker in the bathroom of his rented (own tenancy) apartment. The post mortem conducted on 23rd March 2017 concluded that "This man suffered from epilepsy and may have died during an epileptic seizure". The coroner adjourned the inquest until the SAR had been completed and a report made available.

1. 2 Ryan was a white British man, born with a rare genetic disorder, Johanson Blizzard Syndrome.[1] This disorder can affect multiple organ systems of the body, though there is variation in presentation and degree of disability.

1.3 Ryan had a mild learning disability; showed symptoms of epilepsy (absence seizures –petit mal[2]) aged 2, though for most of his life this was well controlled by medication; had knee operations aged 10 and had some mobility issues as one leg was shorter than the other; was diagnosed with type 1 diabetes at age 11 and was insulin dependent. He had eyesight problems, losing sight in his right eye aged 12. His parents described hospital as becoming his 'second home'.

1.4 In the last year of his life Ryan lost most of his sight in his left eye. He also displayed symptoms of depression and high anxiety and reported 'hearing voices'. Although Ryan had experienced epilepsy since being a toddler, towards the end of 2016 he had what was believed to be his first serious tonic clonic (formerly referred to as grand mal) seizure on 4th October 2016, and a further 4 seizures prior to what was also thought to be a 6th seizure early in the morning of his death.

1.5 Although the term 'autism' appears in some agencies early case recording he was not formally diagnosed with 'atypical autism'[3] until 2016.This took place during a psychiatric hospital admission following concerns over his mental health and reluctance/refusal to take some medication, including insulin for his diabetes.

1.6 Ryan was an only child and lived at home with his parents until he was 25 years old. He had special needs support in primary school and attended a Trafford secondary school for pupils with special needs/moderate learning disability and

[1] https://rarediseases.org/rare-diseases/johanson-blizzard-syndrome/
The severity of the symptoms in Johanson-Blizzard syndrome (JBS), estimated to affect 1 in 250000 births, varies. While some patients may develop life-threatening complications during infancy, others have a less severe disease. Although intellectual disability does occur, in some cases, intelligence is normal.

[2] www.epilepsysociety.org.uk

[3] www.betterhelp.com/advice/autism/atypical-autism-traits-and-symptomsthese traits can include [1]: A delay in social and communication skills and language use 'An inability or difficulty in relating to others/Challenges to adapting to new routines or environments/Repetitive behaviours and movements.

then went on to a local further education college. Neither Trafford nor Warrington Councils (where the family home address was) have any record that Ryan had any services from children's social services.

1.7 Ryan's mother held Power of Attorney (PoA) in relation to Ryan's finances and health and care decisions[4].

1.8 In the 5 years prior to his death Ryan received a range of accommodation and care support services commissioned by Trafford Council Adult Social Care (ASC) and Trafford Clinical Commissioning Group (CCG). Other support and services included: psychiatry and other mental health services from Cheshire and Wirral Partnership (CWP), neurology from Salford Royal NHS Foundation Trust hospital, cataract surgery at Manchester Royal Infirmary, diabetic nurse support from Trafford General hospital and epilepsy advice from Cheshire and Wirral Partnership.

1.9 At the time of his death he was receiving care and support services from staff employed by the registered charity, Imagine, Act and Succeed (IAS). IAS had been his care provider for nearly 4 years and managers and some members of his support team had supported him over that whole period.

1.10 In October 2018 Trafford Strategic Safeguarding Board received information that at an Inquest Hearing into Ryan's death the Coroner suggested that a SAR should be considered. Trafford Strategic Safeguarding Board subgroup reviewed some documentation in order to give informed consideration of whether the circumstances of Ryan's death met the criteria for a Safeguarding Adults Review (SAR).

1.11 Ryan's health conditions and increasingly risky refusal/inability to accept health interventions confirmed his status as an adult at risk with health and support needs, and the circumstances of his death and the range of agencies involved indicated that there may have been good reason to suspect his death might have been contributed to by neglect, if not abuse, from others.

1.12 On 12th October 2018 a recommendation from the Safeguarding Adults Review Sub Group (SARSG), of the Trafford Strategic Safeguarding Board (TSSB), was made to the Chair of the TSSB who agreed there was evidence to explore potential learning across agencies and a SAR was authorised.

[4] www.gov.uk/government/publications/make-a-lasting-power-of-attorney

2. Purpose of and Methodology for this Serious Adults Review (SAR)

2.1 The Statutory Guidance to the Care Act 2014 Act states that Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of abuse or neglect[5], whether known or suspected, ***and*** there is concern that partner agencies could have worked more effectively to protect the adult.

2.2 The purpose of a SAR, as described very clearly in the Statutory Guidance is so "lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[6].

2.3 There is no single prescribed method to conduct a SAR. The Statutory Guidance places emphasis on local decisions with a focus on "what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected".

2.4 Trafford Strategic Safeguarding Board decided to adopt an approach similar to what is described as the 'Welsh Model'. The key features of this methodology are:

- There is recognition of the complexities of safeguarding;
- Reviews should concentrate on a short-ish time frame;
- Whilst looking at who did what, it was more important as to why things happened; the context of events and what could have been done differently/better by people and organisations;
- To understand practice from the viewpoint of the individuals and organisations at the time rather than with hindsight;
- To be transparent about data;
- To make use of case evidence and research

2.5 I was appointed as an independent person[7], with substantial experience of safeguarding adults work and conducting similar reviews, to chair the Review Panel and provide a report after the review process was completed.

2.6 A Panel of senior staff to guide and support the review was established from agencies that had some contact with Ryan.

Name and role	**Organisation**
Shirley Williams-Chair and Author	Independent self employed
Jed Pidd - Trafford Safeguarding Board Officer-Adult Lead	Trafford Strategic Safeguarding Board (TSSB)
Sophie Triantafillou – Trafford Safeguarding Board Manager	Trafford Strategic Safeguarding Board (TSSB)

[5] Neglect does not need to be intentional to considered for a SAR
[6] Care and Support Statutory Guidance to Care Act 2014 published 24th March 2016 https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding
[7] I author) have never been an employee of any organisation in Trafford or of those providing services to Ryan or his family.

Jacqui Coulton –Designated Nurse Safeguarding Adults	Trafford Clinical Commissioning Group (CCG)
Emma Brown Service Manager Complex Needs Adults	Trafford Metropolitan Borough (TMBC)
Jill Pilkington - Head of Operations	Imagine, Act and Succeed (IAS)
Helene Fiendley -Deputy	Imagine, Act and Succeed (IAS)
Zylla Graham- Detective Inspector	Greater Manchester Police (GMP)
Satwinder Lotay -	Cheshire & Wirral Partnership Hospital Foundation Trust(CWP)
Neil Humphreys-DoLS Quality Assurance Manager	TMBC
Julie Burroughs-Specialist Commissioner	TMBC
Morgan Adams - Safeguarding Support Officer	Trafford Strategic Safeguarding Board (TSSB)

2.7 The SAR Panel met on 7th December 2018. Based on some information contained within the Coroner's bundle of evidence (witness statements) shared from the adjourned Inquest it was agreed that the SAR would look at Ryan's care and support provision from 1.3.2016 to his death on 26.2.2017. Particularly significant information prior to March 2016 was also requested from agencies.

2.8 The terms of reference (TOR) and areas to be explored were agreed by the Panel to provide focus for the review, based on initial information.

Terms of Reference

1. Was the Mental Capacity Act (including Deprivation of Liberty Safeguards) used appropriately? If not, why not, and what could have been done differently that might have led to better outcomes?
2. Did decisions about accommodation and support arrangements place Ryan's views and wishes at the centre of all discussions, and were all other views, including those of his parents/advocates taken appropriately into consideration, given the risks posed by his disabilities, and potential fluctuating mental capacity to make decisions? If not, why not, and what might have been done differently that might have led to better outcomes?
3. Did agencies recognise and respond appropriately to Ryan's needs arising from his fluctuating mental health? If not, why not, and what could have been done differently that might have led to better outcomes?
4. Were the risks associated with Ryan's physical and mental ill health recognised and were they recorded? Was there a regularly updated,

effective, and personalised risk management/safety plan in place? If not, why not, and what could have been done differently that might have led to better outcomes?

5. Was information pertinent to Ryan's changing mental and physical health, particularly his epilepsy, communicated to relevant professionals and family members appropriately? If not, why not, and what could have been done differently that might have led to better outcomes?
6. Did professionals consider the risks related to the use of technology as a management solution for Ryan's changing mental and physical health needs? If not, why not, and what could have been done differently that might have led to better outcomes?

Family involvement

2.8.1 The purpose of meeting family members during the SAR process was to enable them to share information they believed relevant to the Review; have their views and any concerns taken into account; and identify any recommendations for improvements in systems and practice they would like to come out of the Review.

2.8.2 Ryan's parents were contacted to arrange a meeting with the Chair/Report author but understandably they said that they would find a meeting upsetting and had already identified their concerns in an email to the TSSB manager in November 2018.

2.8.3 Ryan's parents had been very actively involved with him as had his grandmother until she died in June 2016.

2.8.4 IAS described their relationship with Ryan's family as generally good. His mother in particular had very regular contact with Ryan and staff and attended a number of multi-agency meetings and was always eager to do what she could for her son.

2.8.5 Ryan's parents had voiced concerns, particularly in the last year of his life, about the appropriateness of risk assessments, particularly after Ryan had his first seizure for a long time in October 2016.

2.8.6 They described him as being happy when at Greenways Assessment and Treatment Unit and they questioned whether his single occupancy apartment was still the right place for him as they felt he needed 24 hour care worker presence in his home.

2.8.7 They also expressed concern over what they experienced as a "lack of *consideration for their feelings* in being asked by Trafford via IAS to clear his belongings within 48 hours of his death"[8].

2.9 Practitioners' meeting

2.9.1 The Statutory Guidance to the Care Act 2014 states, "professionals should be *involved fully* in reviews and invited to contribute their perspectives *without fear of being blamed for actions they took in good faith".*

2.9.2 TSSB adopted the good, (now becoming more standard practice and being

[8] It is reported that it was the Housing provider who asked for this to be done.

seen as a sign of a quality SAR by the Social Care Institute for Excellence {SCIE}[9]) practice of bringing together practitioners who had contact with the person who has died or experienced serious harm and/or those with some responsibility for quality and development in organisations. The purpose is for staff to share their experience and consider what might have been done differently that could have provided better outcomes.

2.9.3 8 staff from GMP, TMBC adult care services, IAS, CWP, and Trafford CCG attended a practitioner event on 8th March 2019. Unfortunately not all those invited were able to attend and only Ryan's consultant psychiatrist and 2 managers from IAS who attended had known him well. Arrangements were made for me (SAR author) to talk to his TMBC social worker on 14th May 2019. His social worker had only been allocated as the case worker for Ryan in November 2016, and his CWP community learning disability nurse, who had known him since April 2016, was on long-term leave. The views of those practitioners are included later in this report.

2.10 Additional Review/Investigation/Inspection Reports

2.10.1 As the inquest into Ryan's death had already gathered information from relevant parties prior to the beginning of the SAR process, a significant number of witness statements, described as the Coroner's 'bundle', were made available to me as SAR author. I also viewed the standard SAR combined chronology brought together by officers of the TSSB, containing analysis/commentary from some agencies.

2.10.2 I viewed the IAS Case Review Report dated 1st August 2018. This was an internal review that had been commissioned by the Board of Trustees of IAS, into Ryan's care and the circumstances of his death.

2.10.3 Whilst conducting this Review I (the author) searched for Care Quality Commission (CQC) Inspection Reports for the 3 registered providers; IAS; Cheshire and Wirral Partnership NHS Foundation Trust of which Greenways is a part; and Urmston GP practice[10].

2.10.4 An inspection of IAS by CQC dated 10th November 2017 (a few months after Ryan died in February 2017 but which included the inspection team visiting the apartment complex where Ryan had been living) found IAS overall to be providing Good services in all 5 domains. A previous CQC report in May 2015 also rated the provider as Good.

2.10.5 It is relevant to note one of the comments made by CQC as it illustrates the value base of IAS in action. "*One care plan stated 'I am very independent and capable; please remember this and don't try to do too much for me.' This meant that people were encouraged to maintain their skills and independence. IAS's philosophy of providing 'just enough support' meant that people had the support they required, but also had time on their own where this was assessed as being safe. Assistive technology was used to enable people to have more*

[9] www.scie.org.uk/safeguarding/adults/reviews/library/project - in order to access the Quality Markers you may need to register (free) with SCIE

[10] All CQC reports can be viewed at: www.cqc.org.uk/what-we-do/how-we-do-our-job/inspection-reports

independence. For example, sensors were used to alert staff if people had left their homes and fall sensors informed staff if someone had had a fall. This meant that people did not need to have staff with them at all times and provided them with their own space and independence".

2.10.6 Greenways[11], as part of CWP, last inspection was in April 2014 was rated as Good overall. Whist this is not a recent inspection there is no publicly available regulatory information to suggest any issues with this provider.

2.10.7 CWP Adult Community Services in 2017 were also rated as Good overall. As will be seen later in this Report, Ryan received a number of support services and interventions from staff employed in that part of CWP services.

2.10.8 CQC carried out an announced comprehensive inspection at Urmston Group Practice (Ryan's GP practice) on 21 January 2015. Overall the practice was rated as Good.

2.10.9 Trafford Clinical commissioning Group (CCG) confirmed that a Learning Disability Review (LeDeR[12]) will be conducted following completion of this SAR.

[11] Greenways is an inpatient Assessment and Treatment Centre run by Cheshire and Wirral Partnership NHS Foundation Trust for patients with a learning disability.

[12] http://www.bristol.ac.uk/sps/leder
"A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities aged 4 years and over, irrespective of whether the death was expected or not, the cause of death or the place of death. This will enable them to identify good practice and what has worked well, as well as where improvements to the provision of care could be made".

3. Case summary: key events and interventions.

3.1 Ryan lived at home with his parents until he was 25 years old. They described him as a 'loving boy' and it is clear from staff in agencies involved in this Review that his parents loved him dearly. Staff who provided him with support from 2013 onwards described him as a very likeable person.

3.2 He enjoyed music (rock and heavy metal), supported Manchester United, liked to try out unusual food and enjoyed making his meals, and was very interested in falconry. He had a good sense of humour and was very attached to his grandmother, who provided some care for him as a child and whom he visited regularly at weekends until her death in June 2016.

3.3 Ryan had a long standing interest in falconry. In his grandmother's garden he had a shed, which he knew as 'The Centre', where he liked to spend time with his large treasured collection of replica birds of prey.

3.4 In 2011, Ryan's sometimes challenging and difficult to manage behaviour became more of a problem and on occasion his family needed to seek support from the police. This behavioural change was believed to be for a variety of reasons, including his father's ill health, and the breakdown of a relationship with a girl friend from school.

3.5 He was referred to a neurologist at Salford Royal Foundation Trust because of his aggressive episodes, including self harm when frustrated, and also concerns about his short term memory. However, following a number of tests and a CT scan, no specific diagnosis was made.

3.5 In 2011 he moved to stay in respite accommodation commissioned by Trafford Council and provided by staff from a registered charity, Creative Support. He went back to the family home for short periods but in April 2013 it was agreed that he needed a permanent home and he moved to live in a shared property in Trafford, supported by another registered charity, Imagine, Act and Succeed (IAS).

3.6 Initially Ryan settled well but the relationship between Ryan and his fellow tenant became a problem involving aggressive behaviour. Ryan displayed his unhappiness by isolating himself, refusing to leave the house, and being aggressive towards staff and on occasion to his mum when she visited.

3.7 When working with IAS staff, Ryan had expressed 'hopes and wishes' to have a 'bachelor pad'. Following discussions with Ryan and his family, he moved on 21st March 2016 to a single tenancy property in Flixton. His apartment was one of twelve of which six were let to people who had care and support needs. One apartment is where the IAS 'sleep in' staff member stayed overnight. IAS continued to support Ryan, mostly by staff he had known for some time.

3.8 Ryan's family were understandably anxious about this move as it meant there would not be a staff member with Ryan in his apartment at all times. Initially a high package of support hours was allocated to him during the day and regular

risk assessments taking into account his wishes were recorded. A member of staff was always available in an apartment a few door from his own.

3.9 After some reluctance to make the planned move when the date arrived, Ryan settled well in the first few weeks but by May 2016 he was becoming unsettled and said he was hearing voices. He was also becoming anxious at the prospect of a planned cataract operation required because the sight in his remaining functioning eye had deteriorated.

3.10 In June 2016, very sadly and significantly for Ryan, his grandmother died. Even when Ryan was reluctant to leave his apartment he visited her and 'The Centre' most weekends. It was unclear initially (and subsequently) what Ryan understood about her death but he became increasingly upset and would not accept that she wasn't alive and he couldn't visit 'The Centre'.

3.11 Plans, including the reasonable adjustments the hospital were required to provide to accommodate his disability, were in place for Ryan to have his eye operation at Manchester Royal Infirmary on 27th June. However, on the day he refused to go to hospital and another appointment was made.

3.12 Ryan did attend hospital on the evening of 17th July accompanied by his IAS support worker in preparation for the operation on 18th. Unfortunately none of the planned and agreed 'reasonable adjustments' were adhered to and Ryan displayed his fears by becoming uncooperative and aggressive.

3.13 He did finally settle and the operation was performed but it was a very traumatic experience for both Ryan and his support worker.
Afterwards a formal complaint was raised by the Trafford Community Learning Disability Team (CLDT) worker on Ryan's behalf and on 14th August 2016 a safeguarding alert was submitted, initially to Manchester where the hospital is located. However, following discussion with Manchester social services it was agreed that the incident would be followed up by CLDT.

3.14 Trafford commissioners agreed to fund extra night support for him for several days on return to his apartment.

3.15 Between 18th July and 4th August 2016 Ryan's anxiety and bouts of non-compliant behaviour and aggression increased. On occasion he refused to allow staff to take his blood sugar readings and/or agree to take his diabetes medication, which if not done regularly would have life threatening consequences.

3.16 Ryan was also referred back to a consultant psychiatrist specialising in learning disability, employed by Cheshire and Wirral Partnership Hospital Foundation Trust. He had seen her on several occasions since 2014.

3.17 On three occasions during this period police officers were called to support IAS care staff and Trafford ambulance service staff to manage Ryan's behaviour and enable his medication to be given as he seemed to be more compliant with uniformed staff.

3.18 One example of the need for police officers to be called was on 24th July. Ryan

required hand-cuffing and the use of leg restraints for a short period of time for everyone's safety due to his kicking out and writhing. He remained calm whilst paramedics from the ambulance service were able to undertake their observations. They did not identify any medical concerns, but suggested he went to hospital for a mental health assessment which he agreed to do.

3.19 He was taken to Salford Royal Foundation Trust (SRFT) hospital. His mum and an IAS staff member attended with him.
An assessment was undertaken and although he was mildly dehydrated it concluded that there was no chest or urinary infection and the deterioration in his behaviour was as a result of psycho-social stressors, primarily the loss of his grandmother, his move to a new apartment, and his recent cataract surgery. He was discharged home with a view to follow up by the CWP Community Learning Disabilities Team (CLDT).

3.20 Hospital records noted that he had recently been prescribed sertraline[13] for his anxiety by his psychiatrist and his GP had done blood tests and nothing abnormal was detected. It was noted that he did not live in accommodation providing 24 hour 1:1 support but his mother had said that extra staff could be negotiated with the manager as this was a crisis for Ryan.

3.21 On 1st August 2016, following refusal by Ryan for a second day to take his diabetic medication, a decision was made that a mental health assessment was needed. The on-call GP attended to Ryan and due to everyone's concerns about his mental health and well-being the GP began the process to detain him under a Section 2 Mental Health Act 1983[14].

3.22 On 2nd August Ryan's CLDT nurse attended with his consultant psychiatrist and an Approved Mental health Practitioner (AMPH) and agreed he needed to be admitted under section 2 of MHA. Records indicate that his mother and aunt were also present.

3.23 As a place in a local psychiatric unit couldn't be located until 4th August and Ryan continued to display risky and challenging behaviours, Trafford commissioners agreed to fund IAS to put extra night staff in place for the interim period.

3.24 During this period Ryan had two changes of social worker and his CLDT worker asked for urgent consideration for a new social worker to be allocated to him.

[13] **Sertraline** is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).
www.nhs.uk/medicines/sertraline

[14] The grounds for a Section 2 (maximum holding power is 28days) is that a person (a) is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and (b) the person ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

www.legislation.gov.uk/ukpga/1983/20/section/2

3.25 On 4th August Ryan was admitted under section 2 of the Mental Health Act 1983[15] to Greenways in Macclesfield, a Learning Disabilities Unit accommodating patients with Mental Health Issues, provided by Cheshire and Wirral Partnership (CWP).

3.26 On the first day of admission Ryan was described as "fluctuating in presentation throughout the day; at times showing signs of aggression, at other times compassion, humour and pleasant banter. He refused physical health observations; however allowed for his blood sugar to be monitored".

3.27 Observation and assessment of Ryan in the first few days noted some behaviours that indicated his disturbed mental state. Staff also concluded that an assessment for autism would be helpful.

3.28 One example of this behaviour was when on his second day of his admission it was recorded that "he attempted to get onto his bedroom fixed shelf but fell off onto his bottom (he would not allow staff to check to see if he had any bruising to the area), he stood up and then appeared to have a conversation with himself about the rationale for taking his medication, then asked for his medication".

3.29 A discussion took place with Ryan's mother (who also held Power of Attorney (PoA) about the need for Ryan to have an autism assessment. It is recorded that she agreed he did display some autism traits, though she was unsure what a positive diagnosis would achieve for her son.

3.30 Over the next few weeks a wide range of specialist staff carried out assessments with Ryan and identified that, whilst a Positive Behavioural Support Plan (PBSP)) was being developed, Ryan's challenging behaviour would need to be managed "in a reasonable and proportionate manner adopting least restrictive principles".

3.31 Ryan also attended Manchester Eye Hospital during this period following some concerns. He initially found it difficult to comprehend that he no longer needed to wear his old glasses but no further treatment was needed.

3.32 There was evidence of good personalised care whilst he was in hospital: he was given choices about attending meetings and having copies of reports; he met with an Independent Mental Health Advocate (IMHA); he got involved in some social activities and ate his meals with others; his parents were involved in discussions about triggers affecting his mood. By the third week of his stay there had been a general improvement in Ryan's behaviour and mood: he no longer reported hallucinations and was generally compliant with medication, though again this seemed to be related to his acceptance of the authority of staff in uniforms.

3.33 On 24th August Ryan's legal status under S2 of the MHA was considered as it was assessed that he did not have capacity to understand information about

staying in hospital and accessing treatment on an informal basis. The Section 2 MHA 1983 was no longer appropriate and a Deprivation of Liberty Safeguard (Dolls)[16] was completed on 26th August.

3.34 A discharge plan began to be developed with agreement from Trafford commissioners initially for extra IAS support staff time, deploying a smaller team of carers to ensure greater consistency of care for Ryan.

3.35 On 1st September 2016 Ryan's CLDT nurse had a long discussion with Ryan's mother regarding a transitional period/ graded approach for Ryan to return to his apartment and potential alternatives: for example, supported accommodation and residential care. His mother was of the view that Ryan required social interactions and access to staff more frequently.

3.36 IAS staff attended meetings every week at Greenways and a member of Ryan's core care team visited him on an almost daily basis. His PBSP was completed and his IAS Care Plan was updated and arrangements made for all IAS staff to attend training on autism. Greenways staff gave advice about appropriate lighting and advised staff not to try to make Ryan be more sociable.

3.37 A vacancy in a 3-person staffed house in Streford was identified but staff from IAS said he needed his own space and social services said Ryan expressed his dislike of sharing with others: he wanted to live independently

3.38 On 7th September a Care Programme Approach (CPA)/Best Interests meeting was held at Greenways with attendance from a range of staff from Greenways, Trafford CLDT, and Trafford Commissioners. Ryan's parents also attended.
It was recorded that Ryan had been "mainly settled on the ward, compliant with his medication, was socialising with others and having meals in the communal area and he had also accessed the bath and changed his clothes with prompts".

3.39 Options for discharge were explored and it is recorded that all agreed it was in Ryan's best interests to return to his apartment with an increased package of care.

3.40 It was agreed that there was a need to develop a contingency plan, possibly residential care as his parents were unsure that continuing to live at his apartment would meet Ryan's needs long term.

3.41 It was also agreed to check out whether Ryan met the criteria to have access to a Motability car, which was something he wanted and it was hoped this might encourage him to go out.

3.42 Further work was to be done before discharge on Social Stories[17]/ Sensory integration work, particularly focused on the death of his grandmother and returning to his apartment.

[16] The **Deprivation of Liberty Safeguards** are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.
www.scie.org.uk/mca/dols/at-a-glance

[17] **Social stories** and comic strip conversations are ways to help people with **autism** develop greater social understanding. www.autism.org.uk/about/strategies/social-stories-comic-strips.aspx

3.43 Discharge from Greenways was planned for the end of September as Ryan was due to have his cataract check up on 14th September followed by new glasses, which would require a stable period for him to adjust to them.

3.44 Following a Mental Capacity Assessment, a Best Interests Decision was made that Ryan would return to his apartment with an additional four hours support per day for a limited period. This funding was provided by Trafford CCG in anticipation that it would avoid further deterioration in Ryan's behaviour/mental state and prevent a further hospital admission.

3.45 On 26th September staff from an alternative service provider, visited and completed a gate-keeping assessment for Ryan's potential contingency plan in the event of placement breakdown at his apartment. This followed a referral from his Community Learning Disability Nurse.

3.46 On 3rd October Ryan was discharged from Greenways back to his apartment. It is reported that he had a settled first day and night. However on 4th October he had a brief epileptic seizure, the first observed by IAS staff. He was taken to Wythenshawe hospital for a check up but did not need any treatment. The next day he attended his GP surgery but was not assessed as needing a change in his epilepsy medication.

3.47 IAS staff, in discussion with his CLDT nurse quickly arranged for him to have a Falls Pendant and a Bed Sensor that could notify them quickly if another seizure occurred.

3.48 Ryan had a follow up discharge visit with his psychiatrist. She advised that, if he had further seizures, his medication might need to be reviewed as Sertraline, his antidepressant medication and/or Risperidone, his antipsychotic medication, might affect the efficacy of his epilepsy medication.

3.49 On the 15th October, 11 days after his first seizure, Ryan had a second tonic clonic seizure in the evening when preparing his meal. He had a brief 'absence' and didn't require medical attention.
An appointment was made with his GP to review his epilepsy medication, and the dosage was increased on 18th October.

3.50 At a Care Programme Approach (CPA) meeting on 16th October it was agreed that the equipment in place to ensure Ryan's safety helped to manage the risk of unobserved epileptic seizures. Ryan's epilepsy care plan had been updated and this was shared with his GP.

3.51 On 27th October at 2.30am, 12 days after the second seizure, Ryan's bed sensor alerted night staff to his third seizure in a month. Although staff called an ambulance, Ryan was not injured and had recovered quickly, so he was not taken to hospital.

3.52 Ryan's GP referred him for assessment to the neurologist at Salford Royal Hospital. The referral letter from the GP noted that Ryan had never experienced a tonic clonic seizure until 'about a month ago'.

3.53 The neurologist responded on 10th November that he already knew Ryan's case. He had a clinic appointment in January 2015. Ryan hadn't attended but he saw Ryan's mother who "gave a really helpful description of symptoms".

He wrote, “I don't think I need to see him at this stage. I think the increased dose of levetiracetam[18] (this increase had been prescribed by the GP) is entirely reasonable for the convenience of Ryan and his family. Perhaps we should await his progress on the higher dose of levetiracetam and then decide what to do.” He asked to be kept informed if there were further seizures.

3.54 On 17th November a multi-disciplinary professionals’ meeting was arranged to review Ryan’s situation. There was concern about the increased frequency of seizures but also concerns that he was very fixated on seeing his mum and going to ‘The Centre’. He was not accepting ‘the Social Story work’ that tried to demonstrate that ‘The Centre’ had gone. His parents were moving into a new house and planned to create a new ‘Centre’ there but that would take time.

3.55 His psychiatrist felt Ryan needed some psychological support to deal with his grandmother’s death; a referral was made but there was a waiting list.

3.56 There was discussion that Ryan might benefit from a Medical Alert Dog[19] to help him to manage his diabetes, for which he was required to take insulin 4 times per day. An application was made but Ryan was not seen as eligible.

3.57 There was regular contact throughout November and December 2016 between Ryan’s CLDT nurse and IAS and other staff involved with him. This included:
26th November; a Blue Light Care and Treatment Review (CTR) with the CCG, which concluded that whilst Ryan was not at risk of being admitted to hospital, there was a risk of placement breakdown.
7th December: attendance by CLDT nurse at IAS staff meeting to discuss difficulties in supporting and motivating Ryan as he would only agree to specific staff working with him
12th December his CLDT nurse arranged for the speech and language therapist to have a consultation with IAS staff team, particularly as Ryan had difficulties in processing information.

3.58 In December there was also a consideration as to whether a DoLS in a Domestic Setting[20] application should be made to the Court of Protection. The social worker did not make the application because after meeting with/gathering information from Ryan, his mother, his psychiatrist, and CLDT nurse and utilising the 1st of the 5 Principles of the Mental Capacity Act[21]: ‘capacity should be assumed unless it is proved otherwise’ he concluded, “I do not feel that Ryan is being placed under continuous supervision and control. He clearly loves his independence and likes residing in his apartment. The fact that he has Assisted Technology within his apartment, promotes the 'least restrictive option' and ensures that Ryan is able to maintain a level of independence without being under continuous supervision and control. Ryan is also aware that he is unable to leave his apartment without support due to his visual impairment and will not attempt to leave his apartment without staff support, therefore indicating that he has good levels of capacity and is making a supported decision about

[18] Levetiracetam antiepileptic medicine (a medicine used to treat seizures in epilepsy). https://bnf.nice.org.uk/drug/levetiracetam.html
[19] www.medicaldetectiondogs.org.uk

[20] www.scie.org.uk/mca/dols/at-a-glance

[21] www.legislation.gov.uk/ukpga/2005/9/contents

his care and treatment".

3.59 On 23rd December Ryan experienced a fourth seizure, 58 days after the 3rd seizure. It was observed by his support worker at 12pm and lasted 4 minutes, which was the longest time of all the seizures, and he took 10 minutes to fully recover. He was incontinent of urine and hurt his arm as he fell. He was taken to Salford Royal Hospital and diagnosed with a 'soft tissue injury'. An outpatient appointment was made for him.

3.60 IAS staff became more concerned about Ryan in January as he was refusing to go shopping or get his medication. His mother was also concerned, and contacted the CLDT nurse by email on 9th January as Ryan was not engaging with staff and was fixated on her and 'The Centre'.

3.61 On 15th January 2017 IAS staff called the Police in the early hours of the morning as a door sensor alerted the 'sleep in' staff member. Ryan had taken his pendant off and was walking the corridors outside his apartment confused and shouting. He had a visible head injury and his trousers were around his ankles. Staff took him back to his room and discovered a cupboard door on the floor in his kitchen. It looked as if the door had come off and hit Ryan in the head causing the injury. When the police arrived Ryan was locked in the bathroom and was talking to himself.

3.62 Ryan did not want to go to hospital and as he presented well and seemed quite cheerful it was considered the least restrictive practice not to take him to hospital. He was cleaned by the carers and appropriate dressing applied to the head wound. Ryan refused to go to the GP surgery for a check up but his GP speculated that Ryan had had another seizure (22 days after the 4th seizure).

3.6 On 19th January a professionals' meeting took place to consider Ryan's deteriorating mental health and the increasing number of seizures. The meeting was attended by his social worker, his psychiatrist, his CLDT worker and an assistant psychologist.
The issues discussed were that:

- Ryan wasn't wearing his pendant to alert staff if he had a seizure, as he considered he didn't need it, maintaining on some occasions that he didn't have epilepsy.
- Some staff felt uncomfortable supporting him in his apartment without the right equipment whilst his epilepsy was unstable.
- Ryan was talking to himself a lot and rationalising information in his head, which could lead to agitation and him disengaging from staff or refusing medication
- Discussion with his mother about the 'new Centre' which would not be ready until March 2017 was causing him to become anxious
- Ryan was refusing to provide a urine sample

3.64 Ryan's capacity to make decisions about his care and whether his apartment without 24 hour staffed cover was a safe place for him were discussed. His psychiatrist, and social worker, felt another move would be to detrimental to his mental health. All agreed that Ryan was at risk of serious injury due to his unstable epilepsy and to manage the risk he would require night staff until additional Telecare equipment had been arranged.

3.65 Actions were agreed to:

- Seek advice about additional technology to monitor his epilepsy
- Explore putting 'Just Checking'[22] in his apartment to see if he was up in the night and was sleeping more in the day.
  His psychiatrist to review Sertraline (antidepressant medication) and Risperidone (antipsychotic medication)
- IAS staff to contact his GP regarding a bed pan to collect urine sample and arrange another GP appointment.
- IAS staff to chase up his neurology appointment at Salford Royal hospital
- IAS to introduce new staff who could work with Ryan over longer periods

3.66 Ryan consented to having the 'Just Checking' system in his apartment and on 23rd January 2017 it was installed. It allowed staff to understand Ryan's movements from the previous day / night without being with him. It would also provide information on his sleep. It was agreed it should be reviewed after 2 weeks.

3.67 IAS sourced an 'epilepsy watch' from Trust Call[23]. The watch, which was a relatively new development in assistive technology, connected to an 'iPod' device located within Ryan's apartment via a wireless connection. If the watch started to detect a seizure it would send an alert to the iPod which would then automatically ring the IAS sleep-in member of staff. Ryan continued to have waking night staff until the watch was delivered on 9th February.

3.68 The watch was believed to be a good solution for Ryan as he liked to wear watches, sometimes as many as five at a time. He was reluctant to wear this one at first but staff worked with him and he learnt to charge it himself. IAS staff were all shown how to use the equipment.

3.69 The IAS manager began the process of completing a capacity assessment in relation to Ryan's understanding of the rationale for using the watch and identifying any associated risks. She was advised by CLDT staff to use pictures as Ryan wasn't currently retaining the information given to him. There had been previous reports that Ryan was experiencing short term memory loss.

3.70 During this period Ryan was agreeing to go shopping, but refusing to take his diabetes medication. The CLDT nurse had been meeting fortnightly with IAS staff in what were called formulation meetings to discuss how to respond to Ryan's changing needs. He was very unhappy and distressed but did not express suicidal thoughts.

3.71 A professionals' meeting was planned for 27th February to decide whether it was in Ryan's best interests to continue using the watch or have a staff member present in his apartment during the night.

[22] The 'Just Checking' system uses "discreet door and movement sensors around an individual's home, Just Checking shows an overview of daily activity that helps professionals make proportionate care decisions. Using the system, professionals can gain a better understanding of where support is needed, helping to maximise independence and improve efficiency without compromising on quality of care". https://justchecking.co.uk/

[23] **'A medical wearable which uses advanced machine learning to detect generalized tonic-clonic seizures and immediately notify caregivers. It also provides rest and physical activity analysis to better understand lifestyle ... fast charging and a 48+ hour battery life, it gives more freedom ... Embrace requires a designated smartphone'https://www.empatica.com/en-gb/embrace2/**

3.72 On the evening of the 25th February 2017 the sleep-in support worker observed Ryan through the baby monitor. At 11pm she observed that he was singing and dancing in his room.

3.73 On 26th February 2017 Ryan was found unresponsive on his bathroom floor after his support worker who arrived at 8am called for assistance from the sleep-in member of staff who had observed Ryan the previous evening. They called the ambulance service but they were unable to resuscitate Ryan. The police and Ryan's parents were informed and came to the apartment. This event took place 42 days after his fifth seizure.

3.74 No suspicious circumstances were found, though a police officer who attended began a Special Procedure Investigation due to the fact Ryan had been found on the bathroom floor and had a history of depression/anxiety and had on occasion made threats to take more insulin.

3.75 Following Ryan's death, it was established that he had been wearing his watch when he was found but it had no battery power. The watch and charger were manufactured by Empatica and purchased by Trustcall (Trafford Housing Trust). The watch was then rented from Trustcall for Ryan. The iPod was purchased by Ryan's parents and this was set up with the watch.

3.76 Examination of the watch and iPod by Empatica following Ryan's death indicated that the iPod had lost charge on 8.30pm on 25th February 2017 and the watch at 12.30am on the 26th February 2017. The Just Checking system which monitors movement showed that Ryan's last known movement was approximately 4am on the 26th February 2017 in his bathroom.

3.77 There is some lack of clarity about the reasons for the equipment not having a charge, but there were also concerns that the watch was not as reliable as IAS staff were led to believe as it 'fell out' of Bluetooth signal with the iPod when in Ryan's bathroom.

4. Findings and Analysis

The Practice Guidance developed by the Social Care Institute for Excellence (SCIE) to assist agencies carrying out Safeguarding Adult Reviews (SARS) as required by the Care Act 2014, suggested that a SAR needed to achieve understanding of the following:

1 What happened?

2. Were there any errors or problematic practice and/or what could have been done differently? Why did those errors or problematic practice occur and/or why were things not done differently?

3. What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases?

4.1 Section 3 of this Report sets out some of the key events and interventions in Ryan's life, whilst section 4 looks at the professional practice and context in which some of that practice took place, and whether things could have been done differently and potentially lead to better outcomes.

4.2 In my (SAR report author) experience, having worked in a variety of roles in social services including as a senior manager with responsibility for service provision and development for people with learning disabilities, safeguarding, undertaking whole service reviews, and authoring a number of SARs, it is evident that most of the social and health care and support Ryan received would be regarded as good professional practice. This view was shared by SAR Panel members and by staff who attended the practitioners' meeting.

4.3 Ryan had a number of serious health issues, that when combined with his refusal on occasion to accept medication and staff support, put him at high risk of serious illness. He also needed careful, person-centred, non-intrusive interventions and support to meet his needs related to his autism and mental health difficulties. His psychiatrist described him, in the meeting with practitioners, as one of her most complex patients, and his social worker made a similar statement.

4.4 Examples of Good Practice

4.4.1 Ryan was well loved and cared for by his parents and his grandmother. When his father became ill and Ryan was exhibiting increasingly aggressive behaviour he was accommodated in a respite care placement. After a period in a house shared with another person with difficulties his wishes for a 'bachelor pad' were met by allocation of a tenancy in appropriate community-based accommodation that enabled his independence, met his wish for privacy, and had 24 hour on-site staff support.

4.4.2 Whilst there were some difficulties of access to a consistent individual to provide social work support until November 2016, Ryan had access to his CLDT nurse/care coordinator and there is evidence that the multi-disciplinary team including his IAS staff met together on a number of occasions to problem-solve and to carry out statutory and progress reviews.

4.4.3 When Ryan became mentally unwell his needs were identified and risks

assessed and an appropriate, legally compliant admission to a local specialist mental health treatment unit, Greenways, was achieved and, after a range of specialist professional assessments and interventions, a sensitive planned discharge took place.

4.4.4 His mother and staff from his community care provider, IAS, visited him regularly and were involved with assessments and interventions so that there could be continuity following his discharge.

4.4.5 Although there were issues over his delayed Manchester Eye Hospital admission for an eye operation whilst resident at Greenways, good planning for the admission had taken place to identify what 'reasonable adjustments'[24] needed to be made.

4.4.6 During most of the period after leaving his family home Ryan was supported by the same registered Charity provider (IAS), who recognised his wishes and right to have a life like any other person. He received support from a consistent staff group, who also continued to work with him and take him out during his hospital stay.

4.4.7 Police officers who attended the practitioners meeting commented on the compassionate care they witnessed when they were called to Ryan's apartment to support IAS staff and on occasion North West ambulance staff who were experiencing difficulties with him, particularly around taking his diabetes medication. IAS staff also spoke in similar terms about the care shown by police and ambulance staff.

4.4.8 Whilst discussion about the level and costs of Ryan's care, particularly costs arising from additional staffing, was evident in reports, there is no evidence that funding issues posed an unreasonable obstacle to Ryan receiving appropriate support that recognised his needs and wishes balancing risks with opportunities, to live a life that allowed him to have some control over how he lived.

4.4.9 There were timely multi-professional risk assessments following his first seizure in October 2016 and IAS moved quickly to source advice and assistive equipment. The IAS organisation had experience of supporting people with epilepsy and had access to specialist technological as well as care advice within their organisation.

4.4.10 The use of technology to monitor his activity in his apartment, provision of bed and door sensors, falls pendant, and the visual monitor was sound. He was asked his permission for use of these evidencing a personalised respectful response to a man who demonstrated regularly that he needed his own space and choice about when he wanted to engage with others.

4.4.11 Following the seizure on 15th January, when Ryan had removed his pendant alarm and it was only the door sensor that alerted the sleep-in staff member to check on him, a professionals' meeting was held on 19th January to consider next steps in managing his risks. It was agreed at that meeting to investigate new technological solutions but in the interim he needed a member of staff in his apartment during the night. The funding for this was agreed. A change of

[24] www.gov.uk/government/collections/reasonable-adjustments-for-people-with-a-learning-disability

accommodation was considered but on balance it was agreed a move would be seriously detrimental to his mental health.

4.4.12 Using a person-centred, least-restrictive practice framework, in the knowledge of how autism and the importance of quiet and alone time was for Ryan, the search for innovative technological solutions to try to keep him safe was good practice. There had also been efforts to get him an 'alert' dog, though these were not successful.

4.4.13 There is some evidence that Ryan was offered choices even when he was not deemed to have capacity, but appropriately it seems any decisions were made using the principle of using the least-restrictive option, to manage identified risks.

4.4.14 Whilst there were some discussions about the number of social workers Ryan had in his last year, there is no evidence that this impacted negatively on the support Ryan received as all professionals agreed that his CLDT nurse/care coordinator was regularly and effectively involved with him and his parents. As I did not meet with Ryan's parents, I am not able to comment on how they experienced the changes in social worker.

4.5 Areas of practice where there were errors or where practice might have been done differently and lead to better outcomes.

4.5.1 The most significant area where different practice might have led to a better outcome for Ryan was in the depth of the risk assessment process for use of the epilepsy alert watch and associated technology. Much of the practice in relation to the use of supportive technology prior to use of the epilepsy alert watch was good.

4.5.2 Ryan was well known to IAS staff and there had been good practice prior to his first tonic clonic seizure in investigating and making a range of standard technology available to reduce predictable risks, for example falling or leaving his apartment.

4.5.3 The epilepsy alert watch and iPod link were new technology but their introduction was agreed after professional discussion and conversations with Ryan and his parents. The watch was technology the staff believed Ryan would agree to wear as he liked wearing watches. The 'standard' technology was not adequately reducing the risks posed by an increasing number of seizures.

4.5.4 There was some delay in getting the right iPod technology to support the watch alarm but it was eventually in place on 9th February. IAS staff were shown how to use it and there is evidence that the importance of charging the watch and the iPod was communicated to staff. There were some initial issues with Ryan denying that he needed to wear the watch but he became more compliant as the alternative was having staff in his apartment, which he did not want. The night staff presence was withdrawn.

4.5.5 With that universally elusive gift of hindsight it is acknowledged by agencies that a more detailed risk assessment might have provided a more balanced evaluation of the benefits and residual risk associated with this equipment and less optimism about a technological solution. Such an approach, taking account of Ryan's compliance/cognition issues, informed by Ryan's past behaviours and the views of family, might have led to a longer trial period with night staff

remaining in his apartment.

4.5.6 Whilst a number of Mental Capacity Assessments of Ryan were evidenced and some Best Interest Assessments were undertaken, it is unclear that these were recorded and consistently communicated with all those working with him. Ryan's social worker from November 2016 to his death acknowledged that in his contact with Ryan, that whilst he was correct in working to the first principle of the MCA in assuming capacity unless there was evidence to doubt it, that it would have been more transparent to others if that had been recorded in full.

4.5.7 Whilst there seemed to be some misunderstanding and delay in an appointment being arranged with the neurologist at Salford Royal hospital following the professionals' meeting on 15th January, it is difficult to conclude that this materially affected the outcome from the seizure that is believed to have preceded his death on 26th February. The frequency of the 5 identified seizures after his initial one almost immediately following his discharge from Greenways was erratic with gaps of: 11 days; 12 days; 58 days; 22 days; and then 42 days.

4.5.8 However, given the rising level of concerns about the increasing length of the seizures and slower recovery time there may have been a missed opportunity to consider changes in his medication.

4.5.9 There is evidence that Ryan's parents, particularly his mother, were actively involved with him and agencies, including presence in a number of meetings with professionals. Whilst it is very clear that his family wanted the very best life possible for Ryan they, very understandably, wanted him to be safe. They expressed their views that they believed Ryan needed 24 hour staff presence on a number of occasions following his discharge from Greenways. This view was based on their experience, in that he seemed to recover well there and was generally compliant with the support he received.

4.5.10 In my experience it would have been very difficult to find accommodation and support that would meet his needs and importantly his wishes better than that which was provided at his apartment.

5. Conclusions

5.1 The key challenge for professionals, and to some extent his family, was what they had to do *and* regularly review, to establish an appropriate and justifiable balance between helping Ryan to stay safe, whilst respecting his wishes for privacy and control over how he lived his life. This balance became more challenging as his already extremely complex physical and mental health needs, became more complicated as his serious epileptic seizures increased in the 4 months before his death.

5.2 The ethical and legal position in relation to risk for adults who have a range of physical, mental health and cognitive difficulties is complex, particularly when individuals present practitioners and families with fluctuating and/or uncertain capacity to make decisions that may be judged by others as exposing themselves to life threatening events.

5.3 There was a speech, entitled 'What price dignity' made in July 2010 to the Association of Directors of Social Services, by the now retired Lord Justice, Sir James Munby[25]. It is often quoted by professionals involved in safeguarding adults work. It is relevant to the dilemmas identified in this SAR.

"Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?"

5.4 As set out in finding 4.5.9 it is acknowledged that a more balanced evaluation of the benefits and untested risks associated with the alert watch technology might have led to a decision that night staff presence should have run alongside the technology for an agreed period of time, to assess the reliability of the technology in all the rooms of Ryan's apartment, and the potential for human error in the battery charging of the technology.

[25] The direct link is no longer available but some information can be found at: https://thesmallplaces.wordpress.com/2014/11/14/what-good-is-it-making-someone-safer-if-it-merely-makes-them-miserable/

6. Recommendations[26]

1. Trafford Strategic Safeguarding Board (TSSB) should provide guidance on workforce development for partner agencies who work with adults who are potentially vulnerable, to consider the findings and learning from this SAR, particularly in relation to risks associated with epilepsy and technological solutions to support people in need of health and social care services.

2. All partners within the TSSB should provide assurance to the TSSB that they have a programme of staff training that includes practice based workshops on use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards DoLS), including Deprivation of Liberty in a Domestic setting (DIDs).

3. All partners within the TSSB should provide assurance to the TSSB that mental capacity considerations and assessments of life threatening risks arising from physical health, mental health, cognitive and social difficulties are carried out, recorded, and appropriately shared by well-informed staff. Consideration should be given to joint assessments for people with complex needs and high risks.

4. TSSB to request that NHS England should consider commissioning a research project to bring together information and evidence based practice in relation to assistive technology for people who are at risk of serious harm as a result of their disabilities.

5. TSSB to request that Trafford health and care commissioners explore with the expert local provider of technological equipment, Trust Care, whether a loan service can be set up to prevent delay in issuing appropriately risk assessed equipment to individuals and provider organisations.

6. All partners within the TSSB should provide assurance to the TSSB that safeguarding case file audits show evidence of open, regular, and recorded discussions with the person at risk and their families (subject to service user consent and/or compliance with data sharing protocols) about how safety risks are balanced with the potential unhappiness and risks to mental health associated with a restriction of lifestyle to manage risks.

7. TSSB should provide guidance on workforce development for partner agencies for all staff with responsibilities for care of people who may be vulnerable and who need to be aware of changes in presentation and impact of epileptic seizures, which are noted for their unpredictability (though some people are able to ‘sense’ warning signs). Seizures can be life changing and sometimes lead to loss of life so speed in identifying new and increasing life threatening seizures that appear without any obvious trigger should quickly receive specialist attention.

8. TSSB should provide guidance on workforce development (using evidence from CQC inspections, NHS Quality and Surveillance Group information, LeDeR reviews, safeguarding notifications and complaints information) for local health providers, including hospitals, in relation to the requirement for ‘reasonable adjustments’ to be made in the delivery of care

[26] Recommendations are for TSSB consideration and action and recommendations for individual organisations are not included in this SAR report.