



Person I

Safeguarding Adult Review

Executive Summary

Nicki Walker-Hall

June 2022

THIS REPORT IS STRICTLY CONFIDENTIAL AND MUST NOT BE DISCLOSED TO THIRD PARTIES WITHOUT DISCUSSION AND AGREEMENT WITH THE TSSP PRIOR TO PUBLICATION. THE DISCLOSURE OF INFORMATION BEYOND THAT WHICH IS AGREED, WILL BE CONSIDERED AS A BREACH OF CONFIDENTIALITY FOR THE SUBJECT AND A BREACH OF CONFIDENTIALITY OF ALL THE AGENCIES INVOLVED.

EXECUTIVE SUMMARY

Initiation of the review

This review was commissioned by Sheffield Adult Safeguarding Partnership (SASP). PI, the subject of the review was 22 years old when he was admitted to the Intensive Care Unit close to death. PI is White British and was the eldest child in a family of 5. PI and sibling 1 (then aged 17) both had learning disabilities (LD) and were the children of father. PI was also diagnosed with autism, irritable bowel syndrome (IBS) and arthritis. PI had no known contact with father. Sibling 2 was born during the review period and was the child of mother and step-father. PI had been taken by ambulance to the Emergency Department in a malnourished and neglected state weighing approximately 39kg. It was believed PI had experienced serious abuse and neglect over a period of months and was close to death. PI was well known to a number of services across Sheffield. PI had not been seen by any professional for a number of months.

Succinct summary of the case

Prior to the review period PI had been attending college, and the Day Centre regularly. From March 2018 PI became less visible as at this time PI stopped regular attendance at the day centre. Although PI was still having annual reviews by the continence advisory service, these were being completed via telephone. All face to face appointments, arranged with step-father, were missed resulting in consultations being completed over the telephone.

Mother was pregnant with sibling 2 and was attending the majority of her antenatal appointments. As sibling 2's birth became imminent, arrangements were made for PI to go into respite care. PI went into respite 2 days before sibling 2 was born for a fortnight.

Following sibling 2's birth in November 2018 midwifery completed a Family Common Assessment Framework (FCAF) due to mother having 2 children with LD. Mother was noted to be loving towards sibling 1 & 2; PI was in respite care at that time. Mother attended all but 1 of her post-natal appointments, and was discharged to the care of the Health Visitor (HV) when sibling 2 was eighteen days old. PI did not return to college. The HV made two visits to review sibling 2's growth, during which she conducted a routine domestic violence check and assessed mothers emotional health. As there were no concerns it was arranged that a nursery nurse would complete sibling 2's 8-12 month check.

In February 2019 parents emailed the college to say PI would not be returning as they had decided, in conjunction with PI's support worker, that college was not the best environment. Alternate arrangements were being made. Burton Street offered PI a new service and parents were to call and make arrangements; this didn't happen.

In March 2019 the PAT care manager sent an email to Abbey Care with documents to arrange care for PI; the family never responded to this or further efforts to establish contact. At the same time there was a change of PAT worker. When the new PAT worker contacted the family, they indicated that everything was in place and there were no issues. Based on this information the PAT worker made a decision that PI's case was for tabletop reviews going forward.

PI attended respite care in March 2019, enjoying his stay and trips out; he had further weeks in respite care in May and August 2019; all was well.

In November 2019 PI went into respite care. PI appeared to staff to have lost weight so they weighed him (53kg). They had no baseline weight to compare with but sought, and were given permission by mother, to weigh PI each time he went into respite care. A discussion was had with mother who indicated PI 'ate like a horse' but was thin due to his IBS. Mother was advised to speak to the GP for advice.

In January 2020 the GP invited PI for his annual health check; there was no response. PI was booked to go into respite care in March 2020 and September 2020 however on the 11th March the family cancelled respite care citing Covid-19. They reported PI was 'eating like a horse' but they were not sleeping well due to sibling 2. The family cancelled a further booking for respite care in May 2020 again citing Covid-19.

In June 2020 an ambulance was called for PI after he had allegedly been found collapsed by his mother. Mother alleged PI had been living upstairs in an attic room and hadn't been eating or drinking for a number of weeks. Mother alleged she had been trying to give him Complan and that she had heard him moving around upstairs. This was disputed by medical staff who thought it unlikely that PI had been able to mobilise for some time. Marks on PI's body suggested that he may have been crawling. PI also has bruising across his body. Sibling 1 told police officers that PI was locked in his bedroom to stop him from getting food. PI was found to be in a very malnourished and neglected state, covered in faecal vomit and with faeces under his nails. PI had oral thrush and rotten teeth. PI weighed approximately 39kg (6 stone 1 lb). PI was transferred to critical care in a life-threatening condition.

Summary of Learning

1. There was no identified way of communicating with PI directly unless he attended a service. The majority of contact between services and mother and step-father was initiated by services; the exception being respite care where mother or step-father made requests directly. There was a mixed response to PI not being brought, with some agencies contacting the couple, and others sending further appointments. At the point PI was withdrawn from college and day care services, no one from those services sought to assess PI's mental capacity or seek his opinion. It is not clear whether step-father or mother were spoken to by care manager 2 but PI was certainly not seen by care manager 2 prior to the decision to move his case to desktop review. The reviewer learned there was an over reliance on information from parents who were caring for adults with learning disabilities and lots of assumptions that they were acting in their child's best interests. There was a lack of focus on whether there may be domestic abuse in the parents/carers relationship and whether the client might be subject to domestic abuse themselves.
2. Current systems for gathering and sharing information across and between services for people with LD are awkward. Ways of working are not supporting a multi-agency approach to working with adults who have LD. The rich information gathered throughout childhood is not transferring to adult services during the transition period. Agencies are not routinely sharing or collating basic information regarding family demographics, health issues or other involved services at start of involvement and are not alerting other services when their involvement ceases. If a person does not have a PAT allocated care manager there is no identified lead professionals and no reliable system for coordinating, communicating and information sharing between services. The process for ending an EHC plan is not robust. The LeDeR review¹ made the following recommendation which is mirrored within this review: Guidance continues to be needed

¹ <https://www.hqip.org.uk/wp-content/uploads/2019/05/LeDeR-Annual-Report-Final-21-May-2019.pdf>

on care-coordination and information sharing in relation to people with learning disabilities, at individual and strategic levels.

3. In this case none of the practitioners involved had any suspicions that PI's mother and step-father were not acting in his best interests. However, neither did they have any sense that PI was not happy attending college or the day care centre. Currently there is no requirement for services to directly ascertain a person with reduced mental capacity' wishes, prior to accepting they no longer wish to attend a care facility or college, although this would be best practice. Had each establishment been in a position to speak with PI directly, they may have been able to establish his wishes and enquire as to whether he was experiencing domestic abuse. Prior to acceptance of a family members withdrawal of a person with reduced mental capacity from a service, that service must first have contact with their client to establish whether their wishes and feelings are being taken into full account or whether they are experiencing domestic abuse; consideration of the use of an advocate in these circumstances should become standard practice.
4. Agencies are missing subtle signs that all is not well. Lack of confidence to initiate open dialogues with clients that they don't know well, is inhibiting professional curiosity. Families not bringing their dependents to medical appointments, education and day care services, in line with plans, should be considered as indicators that abuse may be occurring, and require further exploration. Services need to adopt the same requirements for baseline information for those in temporary care as for those who are permanent residents.
5. The LED DES provides an opportunity for GP's to know their patients better, review existing conditions, discuss any new and emerging problems and consider any non-attendance with the GP and other health disciplines. The reviewer learned that across Sheffield different GP practices are adopting different ways of promoting attendance. The current lack of requirement to complete these reviews is leading to missed opportunities to identify additional health and social care needs.
6. Current processes and systems within the PAT team are not leading to a clear picture of a client's daily lived experience and there is no assessment of their living quarters within the family home. There is no statutory requirement to do this and no legislation to dictate frequency of visiting which is limiting assessments. The current manager of the PAT team has introduced practice standards to try and improve standards and streamline practice.
7. Currently the FCAF assessment form makes no reference to domestic abuse between other members in a household other than between a couple however the associated guidance does.
8. During periods where those with learning disabilities are self-isolating or not attending services for health reasons, can easily become invisible and at increased risk of harm through neglect. Direct checks should be made with the individual to ensure they are receiving appropriate care and support.

Recommendations:

1. All services providing a service for a client with learning disabilities, to ensure they have established lines of communication with the client and their family/carer. Services must, wherever possible, communicate with the client and assess their mental capacity to make decisions regarding their care provision. Whether the client is assessed to be competent or not, the service must have direct contact with the client to seek their thoughts and explore issues such as coercive control and neglect before accepting they no longer wish to attend a service.
2. SASP to review its current systems, processes and guidance on care co-ordination, recording and information sharing. SASP to consider its approach to working with

adults with learning disabilities and ensure there is both clear identification of a lead professional and a clear, cohesive multi-agency approach.

3. SASP to seek assurance that all services Was Not Brought Policies consider the impact of not accessing their service on clients who may lack capacity, and include the requirement to consider domestic abuse, explore the issues and share information re non-attendance and concerns with other partner agencies involved in the client's care.
4. The CCG to work with GP's to increase understanding of the importance of LD DES reviews and consider how best to ensure these are completed.
5. SASP to seek assurance that the PAT teams practice standards are driving improved outcomes for adults with learning disabilities and include the need to request to review a client's living quarters, including their bedroom, and explore their daily lived experiences.
6. SASP to inform and seek advice from the Department of Health and Social Care.

Examples of Good Practice:

1. Care Manager 1 followed standard procedure and completed some good face to face assessments with PI assessing his needs and his capacity; she documented his wishes/feelings and what PI has said.
2. The Continence Advisory Service has made yearly contact with PI's family, to confirm that his continence products continue to meet his needs. The Continence Advisory Service ensured cancelled appointments were re-booked.
3. Maternity Services completed an in-depth handover for the Health Visiting Service. The FCAF was shared with appropriate agencies, including Health Visiting.
4. Community Midwives visited a number of times to support mother. Consistency was provided with respect of the same staff member supporting mother throughout the process and attending most visits.
5. Frequent reference is made to PI and sibling 1 in the Maternity notes, which demonstrates professional curiosity and consideration of their well-being.
6. Maternity staff always enquired about PI and sibling 1's whereabouts at home and clinic visits. Maternity staff were professionally curious and displayed an active concern for mother's ability to care for two children with learning disabilities, leading to the Family Common Assessment Framework being completed. The completion of the FCAF can be seen as being good practice in supporting not just mother, but the wider family.
7. The respite care service took time to get to know PI and tailored excursions to what PI liked. e.g. an excursion to a farm.
8. The day care service were alert and always knew when PI was missing from the service; they kept good attendance and communication records. This information is now entered and stored electronically into Lamplight.
9. Mother PI and sibling 1 were discussed in two meetings between the Community Midwives and the Health Visitors. These meetings are held to discuss expectant mothers and to explore any concerns or complex health and social needs.
10. There is evidence of improved record keeping within the Health Visiting records since 2018. Clear and contemporaneous records were kept.
11. The Community Midwife provided antenatal and postnatal written information to the Health Visiting team about mother and her family's circumstances. These are included in mother's health record and information received in the post-natal period was included in sibling 2's health record following birth.
12. The completed FCAF assessment was shared by the Community Midwife with the Health Visiting team and this was included in mother's health record.
13. There is reference made to PI and sibling 1's diagnosis in mother and sibling 2's health records.

14. Home visits were undertaken by the Health Visiting team according to the National Healthy Child Programme; relevant formal assessment tools were used appropriately and all assessments were documented (i.e postnatal depression screening and assessment, 'Ages and Stages' assessment tool for BPI at 8-12 month developmental and health review, Safe Sleep Questionnaire, family health assessment based the assessment framework).
15. An assessment of mother's emotional health and routine Domestic Abuse enquiry were carried out at the 6-8 week visit when SFPI was not present (recommended practice in respect of DA enquiry according to the Department of Health, Responding to Domestic Abuse 2017).

What will Sheffield Adult Safeguarding Partnership do in response to this?

The SASP have prepared SMART action plans describing the actions that are planned to strengthen practice in response to the learning from this Safeguarding Adult Review.