7 Minute Briefing

1 Who was Adult G?

Adult G was an adult male in his late 40s at the time of his death

He had complex health needs - He was deprived of oxygen at birth, resulting in paralysis. He was diagnosed with congenital cerebral palsy and scoliosis for which he underwent corrective surgery at a young age.

Adult G lost his ability to communicate verbally in his early teens and required wheelchair use throughout his life.

He lived with his family until his late 20s, at which point he then moved into a care home, where he resided for more than 20 years.

2 What happened?

Over time Adult G lost full ability to communicate. His needs escalated and the care home struggled to meet them.

At the time of his death, concerns were raised about the level of care he received leading up to his death.

Brent Safeguarding Adults Review to examine the multi-agency response in attempting to meet Adult G's escalating needs.

Safeguarding Children in Brent

Brent Safeguarding Adults Review (SAR)

Adult G

Safeguarding Adults in Brent

3 Finding

Cross-borough interagency working

Safeguarding concerns raised were largely managed by another borough due to the location of the care home.
Five Section 42 Safeguarding Enquiries were progressed in relation to neglect at the care home.

Safeguarding concerns were also raised about the standard of care provided whilst in hospital.

Enquiries regarding hospital concerns were undertaken by a different safeguarding team to the care home concerns.

The outcome of the LeDer report and the SAR were that the communication between the boroughs and agencies was insufficient and led to delay and silo working. It also led to agencies making decisions based on only partial information.

4

Learning point: Clear structured and systemic working by all partner agencies

Adult G was not assessed for a learning disability until late in life. The family provided feedback that were not aware that a meeting they had attended was a meeting to assess his disability. A theme in relation to the case of Adult G was that professionals did not always make clear their role or the purpose of a meeting to Adult G or his family. This led to decisions being made in isolation by agencies based on meetings whereby the family and Adult G may not have been aware of the decision being taken at that point in time.

5

Learning point: Working within complex systems

The following agencies were involved:

Two hospital trusts, two care home providers, two safeguarding teams, two learning disability teams, hospital discharge team, two CCG's (pre restructure), Continuing Healthcare assessment team, a district nursing provider, two social care review teams, the regulator for health and care, a mental health provider and London Ambulance Service. The involvement of such a large number of services resulted in a complex system that appeared unable to respond effectively to Adult G's needs.

6

Learning point: Multi-agency monitoring of standard of care provided across locations

Adult G had complex needs. He developed pressure ulcers that were very serious and extremely difficult to manage. Concerns were raised about pressure ulcer management in all locations where Adult G had received care. Pressure relieving/management equipment was not always provided. Due to an administration error, district nurse care was not provided in the care home for an extended period but this was not escalated. The care home became unable to meet his needs in terms of pressure ulcer care. The monitoring systems in place did recognise that his needs were not being met at his home and he returned there following discharge from hospital.

7 Finding:

A personalised approach

Adult G had severe difficulties in communication, professionals could have made more consistent and sustained efforts to ascertain his views about important decisions.

As Adult G's wishes were largely not obtained, his capacity to make decisions was not fully explored.

Where there are concerns a person may not be able to communicate a decision, professionals have a duty to try and obtain a person's views in relation to decisions about their life.

Professionals should record:

- **the detail of how they attempted to do this**
- **the person's response**

assess the person's capacity to make that decision.

The full SAR report can be found here: LINK