Safeguarding Adults Review on the Adult known as 'Stuart'

What is a Safeguarding Adults Review?

A Safeguarding Adult Board, as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

***(1)** A SAB **must** arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:*
(a)** there is **reasonable cause** for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, **And
***(b)** condition 1 **or** 2 is met (see below)*

(2) Condition 1 is met if: -
***(a)** the adult has died, **and (b)** the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)*

(3) Condition 2 is met if: -
***(a)** the adult is still alive, **and (b)** the SAB knows or suspects that the adult has experienced serious abuse or neglect.*

SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.

About this briefing – A Safeguarding Adults Review (SAR) has been undertaken by the Bexley Safeguarding Adults Board (BSAB) in respect of an adult known as Stuart. This briefing aims to summarise key learning from the review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners so that learning can be embedded.

Please take time to reflect on the findings and consider how you can learn, develop, and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

Care Act 2014

Care and support needs are identified in the Care Act 2014 as the following –

Stuart was known to services prior to his unexpected death in March 2023. Stuart had complex health and social care needs as an adult with a learning disability as well as medical conditions that required professionals to understand and meet his needs. There was conflicting information shared in the review regarding whether or not Stuart had someone to 'legally' represent him as he did not have Mental Capacity to make decisions for himself.

Pen Picture of Stuart is summarised below –

Stuart was an adult with a moderate to severe learning disabilities living in Bexley with his elderly father, until his father was unable to care for him due to Dementia. After his father became unable to care for him, Stuart was cared for by Right Support to live in supported-living accommodation in Bexley and remained there for 8 years before he died in 2023.

Stuart had attended the Learning and Enterprise College Bexley for many years enjoying artwork, pottery, and socialising with others.
One of the teachers at College stated, '***Stuart presented with a slow and quiet demeanour. Stuart was non-verbal but would let you know when he needed the toilet during lessons, which could be often if he was feeling anxious with a new carer. Stuart did not engage in projects unless supported 1-2-1 and required constant support to stay focussed. Stuart worked hand over hand but not independently. He will put his hand on the arm of a carer whilst they touch the materials. Stuart will often leave his desk to point out light switches and exit signs during lessons. Stuart engaged in his sessions as much as he was able and liked to take his work home at the end of each project.***'

Stuart's health had deteriorated in the Winter of 2022, and he had a short stay in hospital where an undiagnosed 'bleed' was never determined, and he went back to his home. In March 2023, Stuart's health worsened, and his care provider rang 999 for emergency services. However, on this day, there was a reduction of services due to a national strike across the country. The London Ambulance Service (LAS) has provided their learning included in this briefing. Stuart was 67 years old when he died.

This is the learning brief on what was found and how you can make a difference to protecting other adults like Stuart from experiencing abuse or neglect.

About the review process – Stuart came to the attention of the Bexley SAB in October 2023 and went to Bexley SAB SAR Subgroup in October 2023 to make recommendations to then Independent Chair, Andy Rabey, to agree the criteria had been met and oversee the final learning and recommendations of the review process. Bexley SAB commissioned a SAR to follow the Rapid Review methodology with Anita Eader, to Chair and lead the SAR to coordinate the engage with Bexley services in order to provide evidence as to who worked with Stuart and how they safeguarded him. The time period for this review was from November 2022 – March 2023.

Summary of Findings –

Key Finding as identified by LAS – *'There were various NHS services contacted on the day Stuart died. This was due to ambulance service strike/shortage of staff/resources across LAS so 999 calls were sent to Wales then to UCAS and other services which caused delays and confusion within the Categories issued to Stuart's case.'*

1. The LAS Quality Assurance (QA) report revealed that Stuart's case was not handled in line with LAS policy. There was opportunity to re-triage the call based on the fact that the Patient's condition had worsened. Worsening instructions were also not provided.
2. The LAS highlighted that there was more scope to establish any red flags that might have led the clinician to call an ambulance. The risks taken by not enquiring about sufficient red flags were mitigated by the fact that the call back from his GP was due within 2-3hrs.
3. The LAS identified there was a lack of probing in a lot of areas of the call which made the pathway chosen questionable. The outcome was not safe and appropriate.
4. The LAS reported that Stuart's call was passed between the 999 service and 111 service multiple times and there were potential opportunities to obtain a more detailed assessment of the Patient to explore the issues.
5. No agency identified health and/or social care concerns for a safeguarding process to be initiated.
6. Agencies did not challenge Stuart's Hospital Discharge although there was an existing 'bleed' from an 'unknown' source.
7. The hospital reported that Stuart's notes for discharge were not uploaded onto the system for other health services to see.
8. Agencies were not able to evidence that they worked with Stuart to Make Safeguarding Personal.
9. The lack of engagement with acute health professionals is a key feature in Stuart's case. Particularly around Cardiovascular follow up and identifying who was responsible for Stuart to attend appointments and respond to invited to appointments is unclear.
10. Agencies were unable to provide evidence for who had 'legal' power for decision-making for Stuart's health and social care planning.
11. Stuart's health and social care information was not up to date, including risks not being shared even though his health was deteriorating.

Identified Good Practice –

1. There was Good Practice highlighted by Right Support as they persevered and followed-up with 999 and rang early in the day to seek help for Stuart.

Overarching Themes –

1. Sharing Information in a timely and accurate manner
2. Making Safeguarding Personal
3. Safeguarding Process
4. Lack of clarity of roles & responsibilities

Recommendations for Partners to consider –

LAS provided the following Safety Actions and Recommendations.

1. All Learning Disability/Autism patients should have an urgent care plan (UCP). These UCP's should be embedded into the CAD system. This would allow clinicians involved at all stages of care to view and understand the Patients individual needs.
2. LAS Health Advisors and Clinicians could benefit from LD focused training as they currently do not receive this training as part of their induction. This impacts on staff ability to have awareness and the experience to understand a person's potential needs relating to their learning disability, moderate their own communication and understand someone else's.
3. The LAS could provide support for the objectives identified within the 'Learning from lives and deaths – People with a learning disability and autistic people' (LeDeR) report in their service delivery by educating formal and informal carers on useful information to communicate and be observing when accessing urgent and emergency care. This will support the service in better understanding the presenting patient's needs and most appropriate response to achieve the best health outcome. Ensuring the right service and response is being provided.
4. The LAS to consider embedding learning disability / Autism into the Medical Priority Dispatch System (MPDS) and Pathways systems to capture soft signs of deterioration that this group of patients may present with.
5. The LAS Patients that are identified to have learning difficulties and assessed as a category 5 response should be reviewed by the CHUB prior to be transferred to the Urgent Care Assessment Service (UCAS).
6. The LAS Patient Safety Incident Investigations identified new opportunities for learning and development. Given that, this incident and the associated report should be considered in conjunction with any similarly themed incidents and reports and subsequently combined into a thematic review to identify, where appropriate, wider system changes that will enable quality improvement.
7. Greater Quality Assurance from the Local Authority and Commissioners with supported living accommodation; including a multi-agency review process to seek Stuart's views, his voice was not captured.
8. There is a need for professionals to understand that emergencies / safeguarding doesn't require permission/consent. This is not isolated to Stuart's case and other recent Bexley Reviews: Noah; and the Adult with Learning Disabilities Systems Review identified this as a key finding.

Questions for you to consider –

1. Whose role is it to review an Adult when they are deteriorating slowly? According to the Care Act 2014, it is the Commissioner and the Local Authority's duty, but this is not clear in Stuart's case.
2. An adult with complex health care needs were quite significant in Stuart's case – where was the acute health input? For example, where was the cardiovascular services involvement? Was there consideration for a more appropriate service considered?
3. What training was provided to supported living for oversight when the 'plan' to support adults when emergency services may take longer than desired?
4. Do Supported Living Providers have their own Provider's Forum in Bexley? This is something that may be required due to the number of SARs linked to ALD in Supported Living in the last 2 years.
5. What is the role of the Commissioner with cases like Stuart's? Stuart does not have mental capacity and was living in supported living as part of a Package of Care, commissioned by the Local Authority.
6. How well / confident are you with applying the Mental Capacity Act?

Resources to assist you further –

SAR Noah Executive Summary / Report

SAR Adults with Learning Disabilities Systems Report

National LeDeR Findings for Adults with Disabilities Report

Bexley Safeguarding Adults Board website

SAR Themed Learning & Development Programme 2024-2025
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