GLOUCESTERSHIRE COUNTY COUNCIL

ADULT SAFEGUARDING BOARD

Gloucestershire
Safeguarding Adults
Board

SIGNIFICANT INCIDENT LEARNING PROCESS (SILP)

silp™
Significant Incident Learning Process

RE: Mr.O.O

Born 22.5.67

Died 8.1.13

EXECUTIVE SUMMARY

P Tudor

January 2014

1. INTRODUCTION

1.1. In January 2013, Mr O.O, a 45-year old man died alone and in distressing circumstances. Mr O.O. had been known to a number of services and agencies in the last few years before his death.

1.2. At the present time, Adult Safeguarding Boards conduct Serious Case Reviews on a discretionary basis; but the forthcoming Care Bill will outline the statutory requirements of Adult Safeguarding Boards, and these are likely to include conducting Serious Case Reviews on a formal and statutory basis.

1.3. Gloucestershire Adult Safeguarding Board commissioned a Serious Case Review on the circumstances surrounding the death of this man, in order to determine whether there are lessons to be learned about the way in which agencies and services worked together. The Board chose to utilise a recognised systems methodology called SILP (Significant Incident Learning Process).

1.4. The key features of a SILP include:

- a focus on systems
- proportionality
- full practitioner participation
- learning from good practice

2 TERMS OF REFERENCE OF THE REVIEW

- To establish the facts about events leading up to Mr O.O's death on 7th/8th January 2013.
- To examine the roles of the agencies involved in his care and wellbeing, the extent to which he was dependent on those agencies, and the appropriateness of single agency and inter-agency responses to his needs.
- To establish whether there are lessons to be learned from this case, to identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

- To identify whether, as a result, there is a need for changes in single agency or inter-agency policy, procedures or practice in Gloucestershire in order to improve single agency and inter-agency working and better safeguard vulnerable adults.

Specific Scoping Instructions/Terms of Reference

- Any reports of critical incident debriefs, complaints investigations or internal case reviews already undertaken should be included in agency reports

Timetable

- Authors Meeting Friday 17th May
- Commission Agency Reports by letter during Authors Meeting
- Deadline for submissions of Agency Reports Monday 10th June
- Distribute all material to all Learning Event participants by Monday 24th June
- Learning Event Monday 1st July
- Recall Day 13th September

3 **PROCESS**

3.1. Reports from the involved agencies and services were produced, based on the agreed Terms of Reference. Then a significant number of staff and managers attended a Learning Event, to debate and analyse those reports. They subsequently returned to analyse and debate a first draft of the Overview Report, which was received by the Serious Case Subgroup, and finally signed off by the Gloucestershire Adult Safeguarding Board on 28 November 2013.

4 Mr O. O.

4.1. Mr O.O was of Black African heritage and originated from Kenya; but came to the UK as a teenager.

4.2. After suffering a serious road traffic accident, he was left with a number of physical, emotional and mental health problems.

4.3. Mr O.O was assessed medically and socially on a number of occasions and was in receipt of a range of Health and domiciliary services. He also had a strong source of support within the local community.

5 FINDINGS AND CONCLUSIONS

5.1. In the few weeks prior to his death, the Police were called on several occasions, as Mr O.O was allegedly the victim of burglaries, thefts and assaults. He also received services from two domiciliary care agencies, one focusing on practical tasks such as food and hygiene, and the other on support and advocacy such as benefits, passport, TV licence, etc. Nevertheless, on one occasion he chose to cancel services. Additionally, he saw a GP twice (on successive days).

5.2. A significant event was that Mr O.O presented to the Emergency Department at hospital in the early hours one morning; and upon examination by doctors he was considered to be very poorly. Nevertheless, he discharged himself overnight (i.e. he was not admitted to a ward). The key decision was that at that point in time he had capacity to make that – albeit poor – decision.

5.3. The Review has highlighted inter-agency working and has identified many areas of good practice, eg. communication between the two provider agencies, the good support and coordination demonstrated by the GP and the provider agencies; and the frequent Police rapid responses. The Review has also highlighted some very important

communication systems issues from the Hospital into the community (see Implications and Recommendations below).

5.4. Whilst Mr O.O was clearly vulnerable in the broad sense of that term, he was never considered to be in need of a safeguarding referral until the day before he died.

5.5. At that stage, i.e. within the last 24 hours, Adult Social Care made a significant number of enquiries and checks; and additionally, Mr O.O was due to have another GP appointment on the day that he was found dead.

5.6. The Review has concluded that greater attempts should have been made for someone to try to see Mr O.O during the hours leading up to his death.

6 IMPLICATIONS AND RECOMMENDATIONS

6.1. Some recommendations are directed towards the Adult Safeguarding Board:

- An Escalation Policy (Resolution of professional disagreements in work relating to the safety of vulnerable adults) procedure to be adopted.
- The dissemination of the lessons from this Review, and lessons from it to be incorporated into multi-agency training.
- An expanded role and remit for the Gloucestershire County Council Emergency Duty Team, to act as a coordinator of information, eg. between Police/Hospital/Adult Social Care.
- The inter-compatibility of electronic communication systems.
- A protocol for missing vulnerable adults
- The notion of keyworker, case-coordinator, team around the service-user.

6.2. Other recommendations are directed to particular agencies and services:

- Gloucestershire Hospitals NHS Foundation Trust have already adapted their admissions assessments, their self-discharge processes and their communication with GPs as a result of this Review. Other Health Trusts should also adopt this similar process

- Gloucestershire County Council Adult Social Care are to ensure that the Annual Reviews are robust in addressing medication compliance and dental care.

- Gloucestershire County Council Adult Social Care are to report on a review of their Assessment systems.

- Gloucestershire County Council Adult Social Care are to ensure that there is an effective process of feedback to referrers.

- The Gloucestershire Constabulary will adapt their Vulnerable Adults training.

6.3. Other recommendations are directed to all agencies:

- The importance of capitalising and coordinating support within the community.

- Challenge and escalation must be used by professionals who have concerns, eg. regarding thresholds.