

SAR Danny Executive Summary

A Safeguarding Adult Review (SAR) was commissioned by Gloucestershire Safeguarding Adults Board in March 2017 to consider the circumstances leading up to the death of Danny on 3 November 2016. Concerns had arisen regarding the way in which organisations worked together to ensure his safety and wellbeing, especially around hospital admissions and discharges, with areas for learning and improvement to be identified.

The work was led by an Independent Reviewer and supported by a Panel comprising all organisations involved with Danny's care and support over the period from September 2015 until Danny died. The principles set out in the Care Act 2014 were followed throughout. The process, in which Danny's next of kin participated, was based on a systems methodology intended to understand from practitioners what happened at the time and on what information decisions were made.

Danny was a white British man, aged 64 when he died. Throughout his life he had significant mental health and learning disabilities, with diabetes diagnosed in 2001. His physical health was exacerbated by lifestyle choices he made regarding his diet. He lived in Supported Accommodation with an extensive care package aimed at supporting his independence whilst ensuring personal and home care needs were met. His support worker team was consistent over many years and the service was effective, despite several hospital admissions, until his final few months when his needs became complex and challenging in this setting.

The Review has sought to understand Danny's capacity to make informed decisions about his finance, accommodation and food choices, the last of which contributed to his deteriorating health, and to decisions to be in the town by himself. The application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was considered to be effective overall but with some points for consideration around Danny's fluctuating ability to make decisions and the 'unwise decisions' which impacted on his health.

Danny had complex and changing needs throughout his lifetime. Significant input was made by the Community Mental Health Service, who were the lead agency, and by Primary Care, which provided universal services appropriate to his age and diabetic care. From May 2016, Danny attended the Emergency Department seven times due to a combination of physical and mental health related matters, leading to six inpatient admissions. The acute hospital setting was not ideal for Danny as his condition improved and the Review concluded that he would benefit from support from familiar staff, which was not arranged in time.

Danny's discharges from hospital were planned in advance but delays and failure to communicate effectively and in a timely way led to rapid readmissions. Funding the different components of his care was not straightforward and needs improvement.

The Review has concluded that good practice was evident in this case. It has also highlighted a number of areas where improvements are needed to avoid this situation occurring again. These are reflected in the recommendations made to the Safeguarding Adult Board.

- 1. The Board should request a review of the Multi-Agency Hospital Discharge Policy to ensure that it sets out best practice in making safe and effective arrangements for people with complex needs. This should include:**
 - **The role of the Hospital Discharge Social Worker**
 - **Guidance on essential information requirements to ensure continuity of care and treatment and who will be involved in delivering each component of the Care Plan.**
 - **Arrangements for monitoring**
 - **Expectations on communication and timeliness**

- 2. The Board should be assured that multi-agency care planning, including advocacy, is in place for people with complex and deteriorating co-morbidities and that it takes account the views of the Care Provider and family. Funding responsibilities need to be clear in order to avoid delays in services in compliance with the Care Act 2014.**

- 3. The Board will request that the Local Authority, Clinical Commissioning Group and Gloucestershire Royal Hospital will explore providing additional support in hospital for people with substantial difficulties from support workers with whom the person is familiar. This will provide continuity of care and contribute towards their wellbeing.**

- 4. The Board should be assured that all agencies continue to work towards improving understanding the Mental Capacity Act and Deprivation of Liberty Safeguards and that they are implemented fully. Practitioners need the confidence and support to challenge appropriately to establish capacity when it is unclear or fluctuating, and where 'unwise choices' lead to ongoing harm to the individual.**