

Learning from the Safeguarding Adult review to improve practice: Themes – inter-agency communication, record keeping, lead practitioner, timeliness of progress of enquiries

John was a 66 year old male at the time of his death in 2016. He had a learning disability and a long diagnosed mental health condition together with other medical conditions which included difficulties with swallowing food. He was placed by one local authority into a care home situated in a neighbouring local authority where he lived for many years. John's health deteriorated, and he was observed to start unusual eating habits, including taking and eating frozen food during the night.

A Section 42 (Care Act) enquiry was commenced in autumn 2015 in response to concerns about the risks of choking. A Care Plan was agreed. At a multi-disciplinary team meeting held in March 2016 it was agreed that he required a 'waking' night staff rather than the current 'sleep in' arrangements to monitor his nocturnal activity due to the heightened concerns of him taking food.

Before the staffing arrangements were put into place John took food which was not fork mashable from the kitchen during the night and was found deceased the following morning by care home staff. A post mortem examination recorded the cause of death as 'choking' with a secondary cause of cerebral vascular disease

Areas for improvement:

- There was poor verbal and written communication which needs addressing for person centred care to be effective. Better record keeping would have improved everyone's knowledge about John's care and support needs. The Care Home staff were in the best position to monitor John's well-being and information sharing with others engaged in meeting his needs could have been improved.
- There was a lack of a holistic and coordinated approach to the complex needs of adults with care and support needs. This doesn't necessarily need to be the NHS or Local Authority, the care home staff could have co-ordinated activity.
- There is a potential disconnect between the information from quality inspections of care homes, individual safeguarding enquiries and wellbeing assessments meaning that all information needed to address the circumstances of adults with care and support needs is not available and not addressed.
- The confusion about roles and responsibilities undermined care planning and safeguarding planning. Where there are cross boundary matters it would be beneficial to clarify roles and responsibilities early on in any enquiry.
- The Lack of clarity regarding who should carry out a mental capacity assessment with John regarding food choices and actions left him at risk.