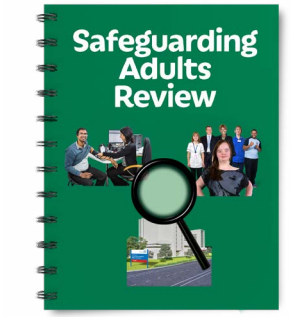
Systems Findings Report Easy Read

About this report

This is a report following the death of a man we will call Nigel. This is not his real name.



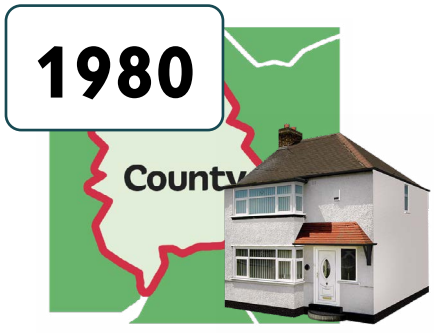
After Nigel died we looked at what happened. We looked at what made it harder or easier to help Nigel and his sisters.
This is called a **Safeguarding Adult Review** or **SAR**.

This is so we can learn how to help people better in the future. We will share what we have learnt.

The review looked at what happened between 11th January until 23rd February 2021 . This was during the Covid -19 Pandemic and the UK was in lockdown.

This was a time when a lot of people working for different services were not at work because they were ill. Also patients who became ill with Covid-19 needed to be checked a lot.

More about Nigel



Nigel moved to Suffolk with his family in the 1980s.

He went to a special school for children with extra needs.

He had never had a paid job. He had not lived away from home or had a relationship.

After his Dad and Mum died he carried on living in the same house. He lived there with his two sisters.

Nigel's mum died 3 years before he died. She had been very important to Nigel and his sisters. They may have had strong feelings about her dying.

More about Nigel

Nigel and his sisters found it hard to do everything around the house.

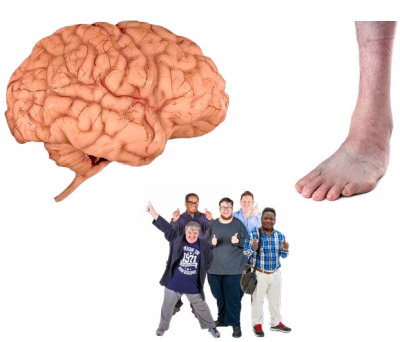
Nigel liked watching TV. He liked watching sport such as football. He supported Liverpool football club. His favourite player was Mo Salah.

He did not seem to have any other interests or hobbies. He did not seem to have any friends.

He could move around using a walking stick.

We do not know how well he could look after himself.

More about Nigel



Nigel had a disease in his brain. This made walking difficult. He had a **club foot**. This means his foot was turned in. He also had a learning disability.

He was **morbidly obese**. This means he was very overweight and this was bad for his health.

About two months before he went to hospital Nigel started to sleep downstairs in his chair because he could not climb the stairs.

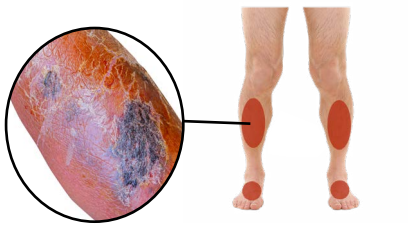
He used the kitchen sink as the toilet.

He did not wash himself and he looked dirty.

More about Nigel

When their mother died Nigel's sisters became in charge of his money and house. They should have done the shopping and jobs around the house.

They did not ask for help from health or social care services. Nigel did not see his **GP** much for many years. A **GP** is a doctor.



By the time Nigel went to hospital he had sores on his legs and feet.

Nigel could not tell the hospital doctor why he did not get help with his legs from his GP.

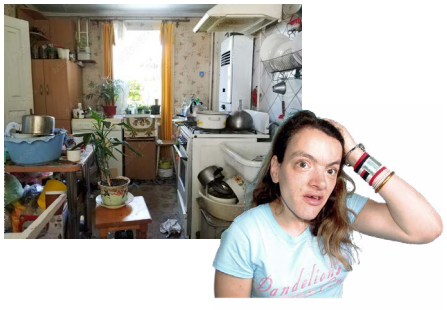
The doctor felt that Nigel had a learning disability. He said that Nigel did not have **capacity** to look after himself. This means he was not able to look after himself.

More about Nigel

Nigel told the doctor that at times he felt low and angry.

Nigel also seemed upset and angry in hospital. This may have been because he was in hospital.

Services were able to go into Nigel's house before he went home. It was very cluttered and unclean.

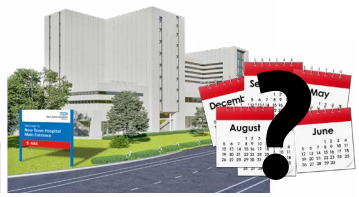


His sisters did not know what changes to make so that Nigel could go back home.

Nigel's sisters were very polite but did not want the services to help. This may be because it seemed like too much.

More about Nigel

The social worker who was helping the sisters did try to help us speak with them. She found that one of the sisters was ill and got her in to hospital.



When we wrote this report the sister was still in hospital and had no date for leaving.

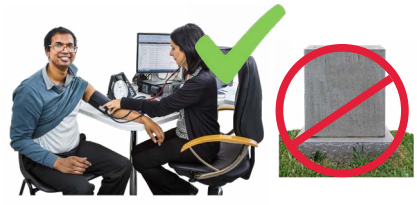
We would like to speak with the sisters more. This could help us to get a true idea of what life was like for Nigel.

We have been looking at the best ways of finding out about people's lives for the review.

What we found

1. GP practices may not know about all of their patients with a learning disability.

Those patients would not be getting their annual health check. An annual health check is a free check of your health every year.



Having an annual health check can stop people with learning disabilities from dying sooner than other people.

What we think should happen next:

The learning disability steering group should use what we have found to make sure GPs know who has a learning disability.

The NHS that buys services from GPs in Ipswich, East and West Suffolk should check that GPs are contacting people with learning disabilities in the best way for each person.

More about what we found

2. Some patients need us to check if it safe for them to go home. They need the right group of people to meet together to make a going home plan. These meeting are not always happening.

The rules about sending people home were changed during the pandemic. This was to free up beds in hospital once people were well.

The new rules say that professionals will look at what the person needs. This should happen at home once the person has gone home.

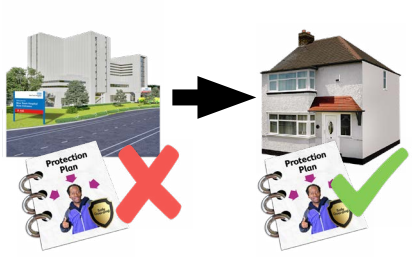
What we think should happen next:

If there is a worry that it is not safe for someone to go home there should be a meeting to look at what to do.

The rules should be changed to say this meeting should happen before the person is sent home.

More about what we found

3. There was no check to see if people may need a **protection plan** when they move from one place to another. A protection plan says what is needed to help keep someone safe.



Nigel did not need a protection plan in Hospital. He **did** need one at home.

Even if Nigel had a protection plan the ambulance service would not have known about it.

What we think should happen next:

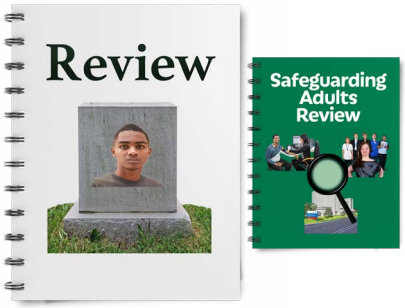
If we are not sure if a person is safe there should be a rule to see if they need a protection plan when they move to a different place.

There should be a way of sharing protection plans with all the professionals who might be helping a person.

More about what we found

4. The services that were trying to help Nigel were doing a **Safeguarding Enquiry**. The **Safeguarding Enquiry** was looking at how to keep him safe. When Nigel died the enquiry stopped.

After the enquiry stopped there was no check to see if there should be a Safeguarding Adults Review



4 months after Nigel died a **LeDeR review** looked at his death and said a Safeguarding Adults Review should have been done.

A **LeDeR review** is a look at the death of someone with a learning disability

What we think should happen next:

After a safeguarding enquiry there should be a question asking if there should be a Safeguarding Adults Review.

Other things we have learnt

How the Safeguarding Enquiry went

The safeguarding enquiry meeting made a list of things to be done. These things were not done.

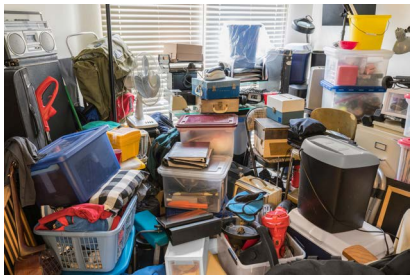
Social workers could not meet with Nigel to ask what he would like to happen. This was because they could not go into the hospital.

No-one was asked to help Nigel speak up for himself.

There was no check to see what help Nigel's sisters might need.

Self-Neglect

Hospital staff did not think about **neglect** for a while. **Neglect** means that he may not be looking after himself well or his carers may not be looking after him.



When professionals began to work with Nigel's sisters to get ready for him to go home they found there was a problem with **hoarding**. **Hoarding** means keeping too many things in the house so that it is no longer safe.

More about other things we have learnt

Understanding of the law

Professionals were confused by the law around **capacity** for a long time. **Capacity** means what someone can do.

Some professionals did not know the difference between two different laws.

Learning Disability

There was a lot of talking for a long time about whether Nigel had a learning disability. This carried on even after the doctor said Nigel did have a learning disability.

Getting help for Nigel

The district nurse was very worried that Nigel may have Covid-19 symptoms and that his sisters were ill in bed.

The nurse spoke to person on a phone line called Customer First. Following this phone call Nigel did not get the help he needed.

More about other things we have learnt

Mental Capacity Act 2005 Assessments

In hospital Nigel could make choices for himself if staff used easy words.

When Nigel was due to go home a check said he did not have capacity to make choices about going home.

There should have been a **best interests** meeting. A **best interests** meeting looks at what is best for a person if they cannot decide for themselves.

Talking to Nigel's sisters

When Home First and the District Nurses were visiting the family regularly this seemed to build trust with them. This could have been a way to find out more about their lives.

Help for families where adult children may struggle when their parents die

When Nigel's mother died this could have been an important change. This could have made services check what help Nigel and his sisters needed.