Safeguarding Adults Review - Josanne

A life of a person with learning disabilities is a life like any other...

Josanne
Josanne enjoyed arts and crafts and being out and about. She had severe learning disabilities and epilepsy, used some words and Makaton to communicate. Josanne was admitted to hospital for a routine procedure. Unfortunately, this procedure never took place and Josanne died after 16 days. The coroner concluded that Josanne died from natural causes contributed by neglect.

Josanne was known to a number of agencies in Hertfordshire. The review considers how well these agencies worked together prior to and leading up to, her final hospital admission in January 2017. The review also looks at Josanne’s time in hospital, multi-agency working, and support offered to Josanne and her family.

Key learning:

- Effective communication and coordination reduce the risk of delays and gaps in care
- Knowledge is power and lead professional/care coordinator can promote good practice and challenge gaps in care
- The person’s voice even when they don’t use words to communicate should be at the centre of their care
- Josanne was admitted to hospital multiple times – a local system recognising “frequent attendees” can promote multi-agency working and holistic care
- Whilst in hospital, Josanne became very unwell – robust process for multi-disciplinary and departmental working could have flagged her deterioration and prompted action
- My Purple Folder – the review identified poor perception and understanding of this source of information about the person’s care and treatment. Greater recognition of My Purple Folder as an aid in clinical practice needs to happen
- Understanding of MCA and acting in the person’s best interests as well as application of DoLS needs to be demonstrated more consistently
- All staff interacting with people with learning disabilities need LD specific training proportionate to their role and involvement
- “Stepping into someone’s shoes” and seeing the person as a whole, not just through the lens of their needs or disability can help to understand them better
Wider picture

Josanne’s case is not an isolated one and too often people with learning disabilities are overlooked or assumptions are made about their quality of life with adverse impact on their health. The LeDeR report highlighted many issues related to the quality of care of people with learning disabilities, including delays in identifying that a person was ill, recognising further deterioration, and accessing appropriate medical care. Failure to recognise or act on signs of deterioration can result in missed opportunities to provide the necessary care to give the best possible chance of survival.

Good Practice

We believe that every practitioner strives to make a difference. That’s why, when we undertake a SAR, we look for good practice too. Here we found examples of strong advocacy for Josanne from those who knew her well. There are also examples of joint working were professionals used their expertise to manage Josanne’s symptoms. Person centred, caring and compassionate practice is evidenced too.

Overcoming barriers and finding solutions

SARs frequently highlight failures between safeguarding partners to work jointly. Such failures can lead to serious abuse and harm and in some cases death.

As part of our work, we strive to improve links between safeguarding partners, develop joint approaches to safeguarding practice and encourage information sharing.

Our joint training and policy development help to:

- Increase knowledge and understanding of multi-agency procedures
- Agree common language, terms and definitions
- Bring together people from different organisations to develop shared perceptions of risk
- Improve understanding of the different roles and responsibilities of safeguarding partners
- Ensure all staff understand the basic principles of confidentiality, data protection, human rights and mental capacity in relation to information-sharing

The full SAR report is available on our website [www.hertfordshire.gov.uk/hsab](http://www.hertfordshire.gov.uk/hsab) where you will also find updates on the Board activity, practice guidance, training opportunities and more...