

Safeguarding Adults Review

Executive Summary

**Tower Hamlets Safeguarding Adults Board**

**Title**: Mr B

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# Safeguarding Adults Review concerning Mr B for Tower Hamlets Safeguarding Adults Board

#  Executive summary

1.1 This Safeguarding Adults Review has considered the care and support Mr B received from the London Borough of Tower Hamlet’s (LBTH) adult social care service and Tower Hamlets Clinical Commissioning Group (THCCG) and their partners, commissioned both directly and indirectly.

1.2 The review primarily focuses on the care and support Mr B received for the two years prior to his death (January 2015 to December 2016) but does include relevant information from before that time, to assist in giving a wider context to the events.

1.3 Mr B was described by his family as an angel in the family. While he couldn’t hear, couldn’t see and couldn’t speak he was ‘a very happy person’.

1.4 Mr. B was a British born man of Bangladeshi origin. He had had severe complex disabilities since birth. Mr. B had always accessed specialist services due to the complexity of his disability. Mr. B lived at home with his family and received a range of support to assist them in caring for him.

1.5 Mr B had a large number of health and care needs and was supported by the Tower Hamlets Community Learning Disability Service (CLDS)[[1]](#footnote-1), his GP and other NHS services. He also attended a day centre and had respite and outreach support.

1.6 All Mr B’s nutrition, fluid and medication was via percutaneous endoscopic gastrostomy (PEG)[[2]](#footnote-2). His hospital passport dated 07/08/2015 noted he had a PEG inserted in 2004.

1.7 Mr B died in December 2016 in The Royal London Hospital. The cause of death was pneumonia.

1.8 It is unclear what caused Mr B’s pneumonia, but in the months leading to his death there were safeguarding concerns about his PEG feeding and how this was delivered and managed. The Safeguarding Adults Review (SAR) report evidences:

* a lack of integrated and coordinated services across social care and health;
* a lack of published PEG feeding standards and guidance;
* coordination in commissioning and contract monitoring; and
* care providers who failed to provide appropriate and consistent support.

1.9 The report makes recommendations for health and social care partners on:

* developing good practice guidelines for adults that are tube fed and supported in the community;
* reviewing how PEG feeding support and training is commissioned;
* ensuring that there are clear lines of accountability between health and social care when commissioning support services;
* ensuring there are understood and robust systems in place where statutory responsibilities are delegated between organisations;
* for CLDS working with partners to review the opportunities for enhancing integrated working at a practical and operational level;
* enhancing integrated support planning for people with complex health and social needs;
* reviewing the support available to family carers when they are caring for someone with complex needs;
* reviewing the local processes around CHC funding; and
* auditing care records.

2.0 Mr B’s family were involved in the creation of this report and the author would like to thank them for their invaluable contribution and insights. The final report was shared and discussed with Mr B’s family by the author prior to publication.

1. CLDS is a multi-agency multi-disciplinary team made up of health staff and social workers. The service has been managed by different providers. At the time of the safeguarding referrals the service was managed by Barts Health NHS Trust but is now managed by the East London Foundation Trust. [↑](#footnote-ref-1)
2. A percutaneous endoscopic gastrostomy (PEG) is a procedure to place a feeding tube through the skin and into the stomach to give the person the nutrients and fluids they need [↑](#footnote-ref-2)