

SCENARIO CASE STUDY FOR DISCUSSION BASED ON THE A1 SERIOUS CASE REVIEW

Brian is a 34 year old man with learning difficulties, living at home with his parents and 3 siblings. He is the youngest of 7 children. His mother is his main carer

Brian attended special school as a child but has had no contact with social services as an adult. There is no record of any contact with LD services as an adult

Brian does have a psychiatric history. When he was in his early twenties, his family became concerned that he was uncommunicative, not sleeping well, and appeared to be experiencing auditory and visual hallucinations. Brian was referred by his GP for psychiatric assessment. Brian's mother did not want him to be admitted to hospital. He was seen by a psychiatrist, diagnosed with Schizophrenia and monitored via local Community Mental Health team. Brian was subsequently discharged from their care after 18 months.

For the next 10 years Brian continued to live with his family and had no further contact with mental health services. He then injured his toe at home. The injury was not healing well and the GP was called in. The GP referred Brian to district nurse service, and to the local hospital for vascular services. Brian did not attend the hospital appointments offered to him. Around this time the GP also re-referred Brian to mental health services .

Over the next three years various professionals were involved in Brian's care: He was seen by 6 different district nurses, 4 different GP's, 2 psychiatrists, staff from the Home Treatment Team, Tissue Viability nurses and the Podiatry team. During the course of these interventions, Brian was never seen alone, his mother was always present.

Throughout this period, Brian and his family did not always fully cooperate with the treatment offered by health professionals, access was sometimes denied and the family were making decisions on Brian's behalf. Brian developed gangrene in both feet, leading to serious complications and reduced mobility. His general health became poor, with the family struggling at times to manage care of his physical health needs. There was a gradual, but significant decline in Brian's condition, however his mother was absolutely adamant that he should not go to hospital. She had a morbid fear of hospitals because her father had died in hospital and she did not trust them. Brian himself said he did not want to go to hospital. Some family members thought that Brian 'knew his own mind' on this matter. Others did not.

Eventually Brian's mother, who had been his prime carer, suffered a stroke. The family then asked the district nurses for additional assistance with his care.

Brian became very ill and was eventually admitted, with his consent, to hospital. He was semi-conscious upon admission and emergency surgery was undertaken. Brian had a double amputation but died 5 weeks later. The death certificate recorded death had been due to:

septicaemia; gangrene and wound infections associated with critical ischemia; poor nutrition, previous urinary sepsis and hospital acquired pneumonia

Some questions for facilitated discussion

If Brian does not want to co-operate with his care package do we have the right to force it on him? If so by what authority?

Who makes decisions and takes the lead in a case like this?

What rights does Brian's mother have as his main carer?

Is Brian making an informed choice?

Is this simply a case of self neglect?

Does Brian's diagnosis of schizophrenia and learning difficulties impact on the actions and decision making of the health care professionals visiting him?

Should a Mental Capacity assessment have been made? If so, by whom?

Should a referral to social services have been made? Why?

Should a carer's assessment have been offered?

Should a safeguarding referral have been made? Is abuse or neglect by others occurring in this situation?

What approaches might have been used to get better engagement with the family?

What approaches might have been used to get better engagement with Brian?

Where many professionals are involved in a case over a period of years, what are some of the challenges?

How do we maintain perspective and an informed overview?

What are the barriers to professionals sharing information and communicating?

When several agencies are involved in a case, who assess the level of risk, and how?

What kind of information would you expect to see in the professional records of this case?

Is prescribing the most appropriate medical treatment necessarily always the same thing as acting in someone's best interests?

A1SCR Recommendations

1 A case study to be developed from this case to highlight shortfalls in practise and to illustrate the lessons to be learnt. This case study to be circulated by the BSAB Chair to Chief Executive Officers in each organisation to be incorporated into the training and development programmes for staff in their agency.

2 Progress on the Individual Management Reports (IMRs) that contain recommendations for some agencies to be reported back to the SCR Sub Group of the BSAB on a quarterly basis.

3 That the BSAB require its member agencies to demonstrate multidisciplinary team working in complex cases to ensure up-to-date information is shared to enable appropriate decision-making.

This to be appropriately monitored on an on-going basis.

4 That the BSAB commission multi-agency guidance/checklists for staff in situations where treatment is refused and there are serious implications for the health and well-being of the service user/patient by April 2011.

5 That the BSAB requires all member agencies to demonstrate that their staff receive training appropriate to their role regarding the Mental Capacity Act and that this and its implementation is appropriately monitored on an on-going basis.

6 That the BSAB requires member agencies to demonstrate that their staff receive training appropriate to their role in the multi-agency processes including raising awareness to safeguarding adults and raising Safeguarding alerts.

7 That the BSAB require member agencies to demonstrate that relevant staff receive training appropriate to their role to enable them to consider referrals to A&C for a Carer's Assessment in all situations where it may be to the benefit of the service user/patient or the carer.

8 That the BSAB requires Secondary Health Care and Primary Care Trusts to provide reassurance that non-attendance of vulnerable adults at outpatient appointments is followed up.

9 That the BSAB require its SCR Sub Group to review the SCR Procedures and documentation and ensure that a process is incorporated to ensure referrals are tracked and responded to within a timeframe that is sufficient for the completion of effective IMRs and that training is undertaken on SCR and IMR completion.

Link to A1 Serious case Review:

<http://www.bsab.org/media/Serious-case-review-executive-summary-and-action-plan-A1.pdf>

The Birmingham Safeguarding Adults Board (BSAB) website for information about the Board, how to report abuse, policy/procedures/guidance and safeguarding materials (leaflets /posters /fact sheets /reports) is accessed via:

www.bsab.org