Executive summary and action plan

for Serious Case Review

in respect of A1

(26.07.1975 – 28.08.2009)

Executive Summary

1.0 Introduction

1.1 This report will describe the care and interventions in A1's treatment between 2006-9. Following the admission to hospital in June 2009 an adult safeguarding alert was initiated by the West Midlands Ambulance Trust. Following admission to hospital and extensive emergency surgery A1 died a few weeks after admission.

1.2 The purpose of the complete serious case review (SCR) report (confidential to the Board) is to:

- Summarize the circumstances that lead to a review being undertaken
- State terms of reference for the review
- List contributors to the review and nature of their contribution
- List review Panel members and author of overview report
- Present the facts
- Compile an integrated chronology of involvement with the adult, family, carer on the part of all the relevant organisations, professionals and others who have contributed to the process
- Prepare an overview that summaries what relevant information was know to the agencies and professionals involved about the carers, any perpetrator and the home circumstances of the adult.
- Analyse how and why the events occurred, decisions that were made and actions taken or not taken
- Review in hindsight and make recommendations
- Define what lessons are to be learnt and translated into action plans if lessons for local as well as national practice issues these should be highlighted.
  (ref BSAB Policy sub appendix 8 pages 1 and 2, June 2009)

2.0 The SCR context and this executive summary:

It is considered to be a good practice response to the death or serious harm of a vulnerable adult when abuse or neglect is known or suspected to be a factor in their death, or where the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.

2.1 A SCR will assess and review the case and will make recommendations for changes in single and/or multi-agency procedures and practice.

2.2 Serious case reviews are not enquiries into why an adult dies or who is culpable. Those are matters for Coroner's Courts, Criminal Courts and Employment Procedures as appropriate.

2.3 In the production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. Birmingham Safeguarding Adults Board (BSAB) has to balance privacy for the individual subject of this review and those who knew him well with the need of the agencies to learn the lessons in relation to improving practice.

2.4 The board recommends that the findings of this review should be brought in to the public domain and any recommendations to be identified for safeguarding practice and implemented and monitored closely.

3.0 The Review Process

3.1 The vulnerable adult will be referred to as A1 throughout this report, he died in July 2009.

3.2 The serious case review panel was initially set up in July 09 following A1's admission to hospital and the strategy meeting held in July 09. The SCR was established in March 10 following an eight month delay because of lack of systematic processes for referral and communication between the Safeguarding adult's team office and the Chair of BSAB and the SCR Subgroup Chair. At times insufficient detail was given to trigger the SCR. The Coroners office requested reports that renewed the SCR process identifying its delay.

3.3 The composition of the serious Case Review panel established by the Board was chosen carefully to ensure those involved were experienced adult social care professionals who had no prior involvement with deceased or any line management responsibility of the staff who had worked with him.

3.4 In December 2010 an independent author was appointed for the executive summary due to staffing issues within the safeguarding office and the previous author having left the authority.

3.5 The Serious Case Review panel members were:

- South Birmingham Primary Care NHS Trust – Associate Director of Nursing (South Birmingham Community Health)
- Birmingham and Solihull Mental Health Foundation Trust - Safeguarding Lead for Children & Young People
- University Hospital Birmingham NHS Foundation Trust – Lead Nurse Safeguarding
- West Midlands Police – Detective Superintendent - Public Protection (Adults)
- Adults & Communities Directorate – Head of Service Safeguarding Adults (Chair)

3.6 The most important issues to understand in lessons learnt were identified in the terms of reference as:

- Establishing the facts about events leading up to and following A1's death on the 28 July 2009.

- Examining the roles of the agencies involved in his care and wellbeing, the extent to which he was dependent on those agencies, and the appropriateness of single agency and inter-agency responses to his needs.

- Establishing whether there are lessons to be learnt from this case about the way in which local professionals and agencies carried out their responsibilities to care for A1 and to safeguard his wellbeing as a vulnerable adult.

- Identifying clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

- Identifying whether, as a result, there is a need for changes in single agency or inter-agency policy, procedures or practice in Birmingham in order to improve single agency and inter-agency working and better safeguard vulnerable adults.

4.0 Outline of Findings

4.1 A1 was a 34 year old man, with mental health issues and learning difficulties living at home with his parents and three siblings. There was no history of A1 being known to adult social care but he had been in receipt of care and treatment in primary care, community nursing services, secondary mental health services and acute hospital care in the last few months of his life.

4.2 A1 was the youngest of seven children and lived at home with his parents and three of his siblings. The family had lived in Birmingham for his lifetime. Although, it is suggested that he had a learning difficulty and that he had attended a special school, A1 and his family were not known to local Adult Social Care services.

4.3 Over 10 years ago in July 1995, A1 was referred by his General Practitioner (GP) for a psychiatric assessment as a result of concerns about his lack of sleep, visual and auditory hallucinations and his uncommunicative behaviour. He was discharged from the psychiatrist's outpatient care in January 1996 but continued to be monitored via local (secondary mental health services) Community Psychiatric Nursing Service (CPNS) until April 1997.

4.5 However, it appears there were no other contacts made with secondary mental health services for a further nine years. In late March 2006, A1's GP undertook a home visit – as A1 was having difficulty walking due to

an injured toe that was not healing. In late April 2006, the GP referred him to the District Nursing Service (DNs) to dress the toe and to Vascular Services (in the local Acute General Hospital) but A1 did not attend the appointments scheduled for him. The hospital followed their DNA policy on writing to A1's GP following non attendance at the vascular clinic. The GP also re-referred A1 to the local secondary mental health services for a further psychiatric assessment as a result of concerns about his withdrawal from social interaction.

4.6 For a period of 3 years from April 2006 through to June 2009, A1 was treated at home by the GP and the DNs with regard to his foot, his other foot also developed gangrene and there were other health problems in that period. There was intermittent contact by staff from the Birmingham and Solihull Mental Health Foundation NHS Trust who reviewed his mental health needs and his psychiatric medication over the same period.

4.7 Throughout this period, A1 and his family did not always cooperate with the treatment prescribed by both the DNS and the Mental Health Services. In this time A1 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. However they were visited by various members of health care teams including G.P and District Nurses (DNs), Psychiatrists and Community Psychiatric Nurses (CPN). There had been mention of a referral to adult social care but there is no record of this being received in Adult Social Care.

4.8 There was a gradual but significant deterioration in his condition to the point where, on 19 June 2009, the family asked the DNs for additional assistance with his care after his mother, who had been his prime carer, suffered a stroke. There had been previous attempts to admit A1 into hospital and the main carer did not comply due to her severe phobia about hospitals as her father had died in hospital and she did not trust them. A1 had also been adamant that he did not want to be admitted to hospital during this time. Some other family members had different opinions but it was assumed that A1 had capacity to agree to this decision with no admissions to hospital. At no point was the main carer, A1's mother offered a carer's assessment.

4.9 There are references of concern over A1's self neglect in the Individual Management Reports (IMRs) but no referrals made to safeguarding or social care.

4.10 After discussion with A1's GP, and with A1's agreement, it was decided to seek his admission to hospital in June 2009. He was transported to Selly Oak Hospital, University Hospital Birmingham NHS Foundation Trust, by ambulance and admitted to the hospital via the Accident and Emergency Department. On admission A1 was extremely ill and was

semi-conscious. It appeared the blood circulation to both of this legs was compromised.

4.11 In the early hours of 20th June 2009, A1 was operated on after a Best Interest Decision was made in order to attempt to save life. This emergency surgery resulted in a double amputation. A1 was treated in hospital for the following 5 weeks but died on 28th July 2009. 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. A1's death was reported to HM Coroner.

4.12 Concerns were expressed at the quality of care his own self neglect and carer's interventions. A Strategy Meeting was held on 8th July 2009 under the Safeguarding Adults Procedures. This referral followed his death as neglect was suspected to be a factor in his death.

4.13 The agencies to be involved in the care of A1 or his family prior to his admission to hospital in June 2009 were his GP, the DNS and the BSMHFT.

4.14 There was a history of A1's mother as main carer being unwilling for him to be hospitalised at the time of his initial referral to secondary mental health services in July 1995 and of not being fully compliant with recommended treatments in the periods 2006 to 2009. In September 2007, there was a change in the mental health diagnosis recorded in A1's GP records that does not seem to have a basis in any reassessment by a specialist mental health practitioner.

4.15 There is evidence of disagreements within A1's family as to his treatment and care, but the wishes of his mother appear to have been accepted. There is no evidence of a formal assessment being undertaken of A1's capacity with regard to decision-making about his care and the treatment of his feet prior to his hospital admission.

4.16 He had been visited by a Psychiatrist who felt he had capacity to make these decisions but this assessment was done with interviews with the mother and not through contact with A1 who was asleep at the time of the Psychiatrist's visit.

4.17 There are no references to the Mental Capacity Act (2005) when it was in place in 2007 and no-one referred him for a MCA assessment. It is acknowledged that MCA had not been enacted when the first referral for his toe was instigated.

4.18 There was no systematic process for information sharing between the professionals and agencies involved in A1's care about his capacity, his lack of cooperation with or refusal of treatment, the attitude of his Mother as main carer or his prognosis.

4.19 There is little evidence that A1 was directly approached by or advised by the professionals involved in his treatment about the impact of his wishes on his treatment.

4.20 There is little reference to the issue of self-neglect or unintentional neglect in case notes by A1's Mother in the manner she 'managed' his care or whether this could be deemed to have been 'in his Best Interests' in the IMRs but the SBPCT IMR does identify this as one of the factors in this case.

4.21 Referrals were made to specialist services within the BSMHFT, but the assessments did not consider A1's needs once there was non compliance in attending hospital appointments and treatment regimes. It may be they were not informed about his non compliance.

4.22 Although A1's Mother was his prime carer and his needs were not being appropriately met, at no time was a referral to A&C for a Carer's Assessment made or discussed with her or the family.

4.23 There is evidence that there were periods of time when professionals involved in his care did not have direct access to A1 and based assessments of his physical and mental health on information provided by his family.

4.24 There is evidence that professionals and agencies operated in isolation, within their own professional roles.

4.25 There is evidence that all appropriate care and support was provided to A1 in hospital. There is also evidence that the hospital followed its internal procedures correctly when A1 did not attend the outpatient appointments with the specialist vascular services he was referred to by his GP. A letter was sent to the GP saying A1 had not attended two offered appointments and no contact had been made with the Booking Centre. The standard letter says that the service would be happy to see A1 as the GP thought fit to make a re-referral. This does not appear to have been followed up by the GP.

4.26 Birmingham City Council Adults and Communities had no previous knowledge of or contact with A1 or his family. It is thought that siblings in the family were described as having a learning difficulty and having attended special schools. It can only be assumed by this SCR that, on the basis of his learning disability/difficulty that A1's resulting educational needs did not make him eligible for adult social care services.

5. Findings

5.1 There is no evidence of intentional neglect of A1, either by the professionals and agencies involved in his assessment, care and support or by his family. This was supported by the Coroner in his report dated 23rd March 2011.

5.2 There is evidence that professionals both in the mental health services and the community health services did not provide a coordinated service to A1 and his family and so failed to work together in an effective way.

5.3 There appears to be little knowledge of the systems in place to support carers and possible referrals to adult social care for A1 and his mother.

5.4 It appears that his views and wishes about his treatment regime were not sought on an individual basis by staff visiting him and that his mother's decision was sought and followed which meant that A1, de facto was assumed to be lacking the capacity to make that decision himself and that his mother was acting in his best interests.

5.4 If A1 had been assessed as lacking the capacity to make that decision, a Best Interest decision could have been made under the Mental Capacity Act as to the most appropriate treatment regime and as a result, A1's capacity would have been reviewed on a regular basis.

6.0 Conclusion

6.1 There is no evidence of any deliberate neglect or abuse of A1 by any of the professionals involved in the care and support provided to A1 and his family. Equally, there is no evidence of any deliberate neglect or abuse of A1 by his family.

6.2 This conclusion is consistent with the Coroner's findings following the inquest in 2010-11. His verdict was that A1 died of natural causes of which neglect contributed. No single action by any one agency was responsible for the overall neglect although there was a failure by ALL care professionals to provide basic care.

6.3 However, the evidence indicates a lack of multi-agency working and liaison to inform the care and support provided to A1 and his family. This was underpinned by what appears to be have been a lack of awareness of relevant legislation and guidance, in particular the MCA and the Safeguarding Adults Procedures.

6.4 The professionals and agencies involved did have sufficient knowledge of A1's family and its dynamics to have instigated a case conference and referral to a safeguarding process in order to understand the potential for self neglect or the capacity for A1 to make the best decision for his care.

6.5 Had the legislation and guidance that were available been known and understood, the treatment regime proposed for A1 by the GP and the DNS would either have been facilitated or A1 would have been admitted to hospital to receive treatment.

7.0 Recommendations

7.1 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.

7.2 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.

7.3 That the BSAB require its member agencies to demonstrate multi-disciplinary 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.

7.4 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.

7.5 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.

7.6 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.

7.7 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.

7.8 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.

7.9 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.

Action Plan

Rec	Actions	Who	When
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 build into the training and development programmes for staff in their agency	BSAB	July 2011
2	Individual agencies (BSMHFT and BCHT) to report to the SCR Sub Group of the BSAB on a quarterly basis on progress from their IMRs.	BSMHFT BCHT	Quarterly Quarterly
3	BSAB reviews multi-disciplinary team working for complex cases with all member agencies.	BCC/ BCHT	September 2011 BSAB
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.		April 2012
5	All member agencies to demonstrate to BSAB that their staff receive training appropriate to their role re the Mental Capacity Act.	All	Quarterly agency reports to BSAB
6	That the BSAB requires all member agencies to demonstrate that their staff receive training in the multi-agency processes regarding safeguarding adults.	All	Quarterly agency reports to BSAB
7	That the BSAB require all member agencies to demonstrate that all relevant staff receive training in referrals to A&C for a Carer's Assessment.	All	By December 2011
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.	Secondary Health Care and Primary Care Trusts	September 2011
9	That the BSAB review the SCR Procedures and timescales and training including how IMRs are undertaken.	BSAB	Jan-June 2011