Executive Summary

Serious Case Review

Case D -- 2003

Introduction to the Serious Case Review (SCR)

This case concerned a young man (D) who had profound physical and learning disabilities. He died in hospital, aged 27, from uncontrolled fitting exacerbated by other serious conditions. He had lived with his parents in impoverished and squalid surroundings. For much of the period reviewed, failure to act within a Child Protection framework was a significant factor in his ongoing experiences of inadequate care and serious neglect. It has raised questions about the way in which protection issues are managed within a transition planning process as Social Services did not interpret diffuse actions or failures to act as indications of continuing neglect and deprivation, which would have warranted definitive action. Health care professionals were confused about where the responsibility for decision-making lay and did not challenge actions which ran counter to D's best interests.

It is unclear whether the failure of his parents to seek out or comply with medical treatment contributed to his early death.

The Purpose

The purpose of this SCR was primarily to inform child and adult protection procedures and practice to better safeguard vulnerable adults as well as to review the management of protections issues within a transition planning process.

Outline of Review Process

The terms of reference for the review was drawn up by the SCR panel chaired by Professor Hilary Brown. It focussed on the history of decision-making within the child protection framework and the difficulties in responding under the various legislative mechanisms relating to vulnerable adults. Specific questions were asked in relation to the consideration of legal challenges by social services, and how consent issues were dealt with within primary and acute health services when faced with refusal by the family to seek, accept or follow medical advice. To address these questions, the following services were asked to submit management reports to the SCR Panel, chaired by Professor Hilary Brown, in 2003:

- Kent Social Services
- West Kent Community Learning Disability Services
- Primary and Acute NHS

Subsequently legal advice was sought from an independent expert on legal remedies that may have assisted services to protect D at a time prior to the implementation of mental capacity legislation.

Circumstances that led to the SCR

This serious case review was commissioned by the Kent and Medway Adult Protection Committee as the circumstances surrounding the case met the criteria for a SCR. The SCR procedures aim to audit serious cases that have been

managed under vulnerable adult procedures. It was clear that failure to act within a child protection framework meant that D had received inequitable treatment as a child and young person. Symptoms or behaviour changes were discounted based on assumptions made about his disability (diagnostic overshadowing). The various legislative mechanisms relating to vulnerable adults made it difficult for a clear decision-making process to be followed with regards to D's best interests. It has raised questions about the way consent issues and care decisions were made about D's health in relation to discharge planning from the hospital and the difficulties community health staff faced in dealing with D's carers failing or refusing to administer prescribed medication. Care management staff did not feel able to intervene appropriately when faced with the threat by the family to remove D from much-needed day services.

Key Issues from Management Reports

- Social Services' legal department were unable to trace records regarding the background issues which led to care proceedings under the Children's Act being rejected when D was a child.
- Guardianship under Sect 7 of Mental Health Act 1983 was ruled out as his impairment was not associated with abnormally aggressive or seriously irresponsible conduct.
- A 'place of safety' was discounted as inappropriate because his situation was seen as chronic and not acute.
- Prosecution under Sect 127 of the Mental Health Act 1983 was considered but not followed through because it necessitated a high degree of proof of wilful neglect, requiring police investigation and referral to the CPS.
- The application to the local district council under Section 48 of the National Assistance Act 1948 to remove D for a (renewable) period of 3 months failed because the District Community Physician did not support it.
- None of the routes under consideration were revisited in the light of this failed application; instead there was an abandonment of the commitment to legally challenge the family's neglect of D.
- Issues of consent to, and responsibility for, treatment decisions by D's parents were not challenged by health professionals.
- There was little evidence that liaison processes with the CLDT had been in place despite D's severe learning disability when he was in hospital.

Recommendations

- Adult protection concerns must be taken into consideration in discharge planning including discharge from A&E departments.
- GPs should be informed of child and adult protection concerns and ensure that this information is made available to hospital doctors to inform diagnostic and treatment decisions.
- Disabled children should be treated with the same care and alertness to protection as any other child.
- Child protection concerns should be central to the transition planning process.

- Protocols must be in place to ensure that people with learning and or physical disabilities receive adequate nursing and personal assistance when receiving treatment in acute health settings.
- Clarity about the principles and process of decision making in cases involving adults who lack capacity must be made an urgent requirement of medical and nursing staff training within acute and primary care trusts. The limit of the family's decision-making role must be clear. All decisions must be taken in the best interests of the vulnerable adult.
- The interests of the child or vulnerable adult must be at the heart of the protection process and their interests must govern the willingness to take legal action.
- Police officers, social workers, health staff and legal advisors must be fully aware of their powers and duties under a raft of different areas of legislation and open to using different avenues to achieve a safe outcome.
- Key staff should be given training in managing difficult personal interactions and in dealing with confrontation.
- In extreme cases, there should be a contingency fund available to seek additional legal or professional advice to support decision-making and to advise on further action.
- Representation from the legal department at planning meetings is essential in cases that have the potential to be damaging to the vulnerable adult.
- Keeping a multi-agency chronology of events where there are ongoing concerns about abuse or neglect as several isolated incidents if considered together would warrant definitive action.

Action Plans

Social Services

- Previous history of any Adult Protection concerns must be passed to the adult's GP to assist in diagnosis, treatment and discharge.
- Child Protection or Child in Need concerns should be central to the transition planning process.
- A vulnerable adult is the primary client who should be at the heart of the protection process; legal action should actively uphold the vulnerable person's human rights.

Social Services/NHS Trust

- Clarity regarding the principles and process of decision making in cases where lack of capacity is an issue. Medical and nursing and care management staff must be aware of best interest decision making and about the role of families and the formal decision maker.
- Staff should be fully apprised of the relevant parts of the Mental Health Act and Mental Capacity Legislation. In individual cases they should be fully briefed through the multi-agency arrangements to assist in professional decision making.

NHS Trust

- Adult Protection concerns must be taken into account in discharge planning from hospital settings.
- The GP should make information about any previous safeguarding history available to hospital staff as appropriate.

Police

- *Need to be clear about responsibilities to use common, civil or criminal law to achieve safe outcomes for adults and children.*

Police/Social Services/Legal

- Staff must be fully cognisant of their powers and duties under a raft of legislation and avenues to achieve a safe outcome.

All

- Staff should receive training in managing difficult personal interactions and in dealing with confrontation and conflict.
- In extreme cases there should be contingency funds available so it is possible to seek additional legal or professional advice to support the adult protection process.

Conclusion

This case was characterised by a background of indecision and confusion on the part of the agencies involved. Staff from social services, health and the police were unclear as to what could be legally challenged in terms of D's best interest because of a fragmentary understanding of the legal process. A collective decision to take legal action under the National Assistance Act was overturned putting the best interest of D secondary to the family's. Manipulation and intimidation on the part of the family was not dealt with appropriately by staff who feared D would be removed from day services if they confronted the family. Despite an accumulation of concerns, and a history of deprivation and neglect, the adult protection alert was raised only months before D's death. It is expected that the implementation of the Mental Capacity Act 2005 and the role of an independent mental capacity advocate will assist in addressing such serious adult protection concerns in future.

The Panel expects the agencies involved to accept the recommendations and to agree with the Chair of the Panel arrangements for scrutiny and follow up of the recommendations.