Northamptonshire
SAFEGUARDING ADULTS

Serious Case Review

Executive Summary

Mr and Mrs Randall

Independent Author: Sallyanne Johnson

Independent Chair Serious Case Review: Chris Moore

June 2010

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Note:

The Northamptonshire Safeguarding of Vulnerable Adults Board is committed to the principles of openness and honesty whilst recognising the importance of respecting individuals and family members. It is normal practice is for executive summaries of serious case reviews to be anonymised.

This Review did not arise from allegations of neglect or abuse. For this reason, and due to the level of public and press interest and current information in the public domain, in this case, the Board has taken the decision to name Mr and Mrs Randall in this Executive Summary.

Serious Case Review – Mr and Mrs Randall

Executive Summary

1Introduction

1.1 Reasons for the multiagency serious case review

1.1 This serious case review (SCR) was initiated by the Northamptonshire Safeguarding Vulnerable Adults Board (NSOVA) following the death of Mr and Mrs Randall. The coroner has determined that Mr and Mrs Randall both died of natural causes. The primary cause of Mrs Randall's death was congestive cardiac failure, and the secondary cause was chronic obstructive pulmonary disorder. She was also found to have had acute erosive gastritis, high blood pressure and abdominal adhesions. The primary cause of death of Mr Randall was pneumonia and the secondary cause was lung cancer. The coroner was satisfied in both cases that an inquest was not needed.

1.1.2 At the time of their deaths, Mrs Randall had ongoing health input regarding eye problems and her heart condition, receiving home based phlebotomy visits related to setting medication levels. Mr Randall was not receiving any treatment, having not consulted anyone about his health; the only reference to his own wellbeing came in December 2009, when he reported feeling tired. There was no other ongoing agency input to the couple during 2008 or 2009.

1.1.3 The couple had been referred for assistance to health and social care agencies in December 2009, initiated by Mr Randall contacting their GP. There was no referral or suspicion expressed of an abusive situation. To that extent, this case falls outside the usual range of situations that would normally prompt a serious case review. Nevertheless, the case prompted much media attention, with speculation that the agencies could have acted differently, and the implication that they could have prevented both deaths. The Independent Chair of the NSOVA Board therefore decided, in the interests of learning and transparency, to review the circumstances and actions of the agencies concerned to identify what, if any, lessons could be learned from this situation. The key agencies are:-

- Northampton General Hospital NHS Trust
- Northamptonshire NHS Provider Services
- Local GP/Primary Care practice
- Age Concern
- Northamptonshire County Council, Adult Social Care

1.2 Terms of Reference

The terms of reference for the SCR are as follows

Relating to:

Mr Derrick Randall - born January 1933

Mrs Jean Randall - born March 1931

Of: Northampton

Chair : Mr Chris Moore, Dean of Social Sciences, The University of Northampton

The Serious Case Review will review the circumstances leading to the deaths of Mr and Mrs Randall in January 2010. The review will look specifically at all the agencies involvement in / or between.

Timeframe: October 2007 to 7 January 2010

Specifically: Actions and behaviours of Northampton General Hospital in relation to the admission of Mrs Randall in October 2007 and discharge arrangements from Northampton General Hospital to her home in January 2008.

Agency Roles:

The role of all agencies involved with / or working with Mr and Mrs Randall between October 2007 to 7 January 2010 including any involvement with family, friends and neighbours.

Specifically: The role of all agencies in any and all processes of referral(s) by anyone of concern regarding Mr and Mrs Randall in particular:

How said referral and concerns were acted upon by agencies.

The Serious Case Review will consider and make any recommendations relating to individuals, services, systems including inter agency working as identified by the investigation.

1.3 Methodology

The NSOVA Board appointed an independent Chair, Mr Christopher Moore, and an independent author, Mrs Sallyanne Johnson, to support the Chair (Mr Moore) in preparing for the NSOVA Board the executive summary and overview report on their behalf. Mr Moore is Dean of Social Sciences at the University of Northampton. He is a qualified social worker, with more than 26 years' experience in both front line social work practice and social work and social care education. He is the Chair of the East-midlands Higher Education and Social Care Employers Group working with Skills for Care and Social Care employers on the modernisation of the social care workforce.

Mrs Johnson has 9 years' experience in the statutory posts of Director of Social Services and Director of Adult Social Services, across two local authorities, and has 34 years' experience in social care, working extensively at the interface of health and social care services. This includes a period of 6 years in the, then, national inspectorate of Department of Health – the Social Services Inspectorate. She has direct operational and strategic experience of both children's and adult safeguarding.

In line with the agreed procedure of the Northamptonshire Safeguarding Vulnerable Adults Board, each contributing agency undertook an Independent Management Review of the agency's involvement with Mr and Mrs Randall, during the period defined by the review. These individual agency reports were prepared by an individual who had no direct involvement in, or responsibility for, the case. These reports were then submitted to the Serious Case Review Panel. This panel was formed for the purposes of conducting the multiagency serious case review and was chaired by Mr Chris Moore as above. The authors presented their reports individually to the panel and the panel members raised their questions with the authors. The panel then considered the information presented and determined that there was sufficient to permit the independent author of the overview report to draft the panel's report on their behalf. Points of clarification and query raised during the drafting stage were discussed at the panel and resolved to the panel's satisfaction to inform the findings. The panel agreed the final report for submission to the NSOVA Board.

1.4 Contributors

The agencies contributing Independent Management Reviews to the panel are as listed above in paragraph 1.1.3 above. Family, Neighbour A and the local MP were also offered the opportunity to contribute to the Review.

1.5 Review Panel Members

Independent Chair: Mr Chris Moore, Dean of the School of Social Sciences, University of Northampton

Panel Member: Sylvia Manson, Associate Director, Safeguarding, NHS Northamptonshire, until 29 March 2010

Panel Member: Peter Boylan, Interim Associate Director, NHS Northamptonshire, from 29 March 2010

Panel Member: Natalie Green, Acting Deputy Director of Nursing – Governance, Northampton General Hospital

Panel Member: Liam Condron, Chief Officer, Age Concern Northamptonshire

Panel Member: Charlie MacNally, Corporate Director of Health and Adult Social Services, Northamptonshire County Council

2 Summary background

2.1 In October 2007 Mrs Randall fell and broke her hip. She was admitted to hospital and made slow progress, never fully recovering her previous level of mobility. She was discharged home in January 2008, and her husband took sole responsibility for her care and support. The couple refused offers of equipment to aid her care and mobility at home and also declined a referral to the County Council's social care service to consider other forms of home based support.

2.2 There were no further admissions to hospital, or urgent health care needs raised, between the discharge from hospital in 2008 and the contact made with the GP by Mr Randall in December 2009. Apart from ongoing health contacts related to Mrs Randall's medication and eye problems, the couple had no contact with any of the local care and support agencies in this period.

2.3 In December 2009 Mr Randall contacted the couple's GP to say that his wife's condition had deteriorated and he was having difficulty coping with her care. As a result of this call, the District Nurse and GP visited the couple at home on 8 and 10 December 2009 respectively. The District Nurse made a referral to the County Council's adult social care services on 8 December 2009, to consider what support could be offered to the couple. In the couple's contact with each of these agencies, offers were made of support at home and residential respite care, but these offers were refused. The couple had decided that they wanted Mrs Randall to move into a care home permanently and did not wish to take up any alternative or interim forms of support.

2.4 The couple had sufficient funds to pay for the costs of residential care themselves and they were therefore ineligible for the County Council to fund the care. Mr Randall asked for advice and information regarding him affecting the move into residential care and, with Mr Randall's agreement, the County Council's Principal Care Manager referred the couple to Age Concern, who provided this kind of support. The referral to Age Concern was made on 15 December 2009. The Principal Care Manager understood that part of Age Concern's service offer would be to escort Mr and Mrs Randall to view potentially suitable residential homes, thereby supporting an informed choice of home. However, the Principal Care Manager learned on 22 December 2009 that this was not a service offered by Age Concern at the time. On 24 December 2009 the Principal Care Manager telephoned Mr Randall to advise him that the accompanied visit service was not available. Mr Randall had, by then, been in contact with Age Concern and accepted their telephone advice and also information sheets, which were posted out to him. At this point he declined any further assistance from the County Council.

2.5 A neighbour (who this Review refers to as Neighbour A) began, at Mr Randall's request, providing meals and shopping for the couple from late November 2009.

She delivered both shopping and meals personally to Mr Randall at the front door, or left them on the doorstep, depending on Mr Randall's wishes at the time. She did not enter the house. She became very concerned for the couple's welfare and telephoned the County Council on 15 and 17 December 2009 to ask for assistance for them. The contact with the County Council was appropriately recorded onto 'Goldmine', the County Council's record system for people in touch with the Customer Service Centre. A separate recording system is in place for the specialist social care requirements called 'CareFirst', however her contacts were not recorded onto the case records on CareFirst. The Principal Care Manager did not, therefore, have access to this additional information about the couple's welfare at the time that he was in discussion with Mr Randall about support that could be offered by the County Council.

2.6 Neighbour A also contacted Age Concern, having learned that the referral had been made to them to support Mr and Mrs Randall to secure a place in residential care, and similarly tried to seek support for the couple. After contacting what she was told was the national telephone number, she telephoned the local service on 21 December 2009. Neighbour A was not registered with Age Concern as an emergency contact for Mr and Mrs Randall and so the person that she spoke to could not share any information about the actions of Age Concern in respect of the couple. This was a frustration for the neighbour; however her information was recorded and available for the agency to consider.

2.7 The last contact with Mr Randall from any of the agencies was the telephone call from the Principal Care Manager on 24 December 2009. Neighbour A continued to have contact through the Christmas period, providing meals and shopping as she had been doing since late November, and her last contact with the couple was on 3 January 2010. Neighbour B called the emergency services on 7 January 2010, having seen that Mr Randall was lying behind the front door. The Ambulance Service forced entry to the house and discovered that both Mr and Mrs Randall had died.

2.8 A letter dated 22 December 2009 from the local MP arrived in the County Council on 31 December 2009, addressed to the Corporate Director responsible for Adult Social Services. This letter relayed Mr Randall's concern about his wife's condition and that they were seeking residential care. The MP requested that the couple's situation be assessed urgently. On 4 January 2010 (i.e. the next working day) an acknowledgment reply was sent to the MP, confirming that an assessment would be undertaken. The letter was passed through to the relevant team and on 7 January the Principal Care Manager telephoned the couple. However, the telephone was answered by the paramedic who was, by then, attendant at the house and he informed the caller that the couple had died.

3 Summary findings

3.1 We now know that both Mr and Mrs Randall were suffering from serious health conditions, however Mr Randall did not present to his GP with any adverse health symptoms of his own, focusing always on his wife's condition. Mr Randall's health condition was only discovered at the post mortem examination and, whilst Mrs Randall was known to have a degenerative heart condition, the full extent of her condition was also not known until post mortem examination. In both cases their decline was inevitable and probably rapid. The Coroner has determined that both died of natural causes and no inquest was necessary.

3.2 This was not a situation which was referred or otherwise triggered as one of abuse or neglect. This Review has confirmed that there is no evidence of an abusive situation and the circumstances did not meet the criteria to be considered as one of 'safeguarding vulnerable adults'. The couple's vulnerability increased as their health deteriorated and there were some points in the situation where that increasing vulnerability might have been more clearly identified. This may, in turn, have led to more robust efforts on the part of the agencies to persuade Mr and Mrs Randall to accept interim or longer term support – whether residential care or otherwise. However, this does not emerge as a situation that would have met the criteria for intervention at the level of 'safeguarding vulnerable adults'.

3.3 Mr Randall was a committed carer for his wife and he cared for her successfully despite her mobility and personal care needs. The couple rarely sought outside assistance and consistently refused support both at, and following, Mrs Randall's discharge from hospital in 2008. In December 2009 their capacity to provide for themselves deteriorated rapidly, but they also refused various forms of support that could have eased Mr Randall's burden of care and provided relief for both of them.

3.4 Both Mr and Mrs Randall were judged by the professionals who had contact with the couple between October 2007 and December 2009 to be fully able to make decisions about their own circumstances and support options. The decisions they made did not always accord with professional advice, but this does not mean that they did not have the ability to make those choices for themselves, nor that their choices could be overridden.

3.5 In January 2008, at the point of Mrs Randall's discharge from hospital, information about the couple's situation was not shared with the local social services agency by the hospital, as the couple had refused a referral to social services. From what we now know, it seems unlikely that sharing that information at the time would have changed Mr and Mrs Randall's decision regarding refusal of post discharge support, although there would have been a record for inclusion in the consideration of their situation in 2009. The panel do not believe, however, that this was a critical issue in this situation.

3.6 Local arrangements have changed in the intervening period and there are now integrated teams in place in the hospital, who deal with people in need of support at the point of discharge from hospital. Information sharing is now simpler as it takes place across a joint team, rather than as it was previously across different organisations. The Single Assessment Process is a process tool that brings together all the agencies' information about an individual, thus potentially enhancing decision making. It will be important that the new integrated service considers how this tool is now applied consistently in the new arrangements.

3.7 There was a 6 day gap between referral to Age Concern and the Principal Care Manager and Advocacy Worker from Age Concern being able to speak directly with each other. There was confusion about what service Age Concern was able to provide locally, which was not resolved until the two workers were able to speak to each other. This therefore introduced delay in accurately informing Mr Randall of the local service offer available, although by then he had already had telephone advice from Age Concern.

3.8 Mr and Mrs Randall had sufficient funds for them to pay for the costs of residential care themselves and they were therefore not dependent upon the County Council to cover the costs or to arrange the admission. This defined the couple as 'self-funding'. Although 'self funders' do not have to rely on councils to arrange their care, it remained an option for Mr and Mrs Randall to seek County Council support to assess Mrs Randall's care needs and arrange the admission through the County Council; this was not explained to Mr Randall. Mr Randall was always clear, however, that he wanted little more than information and advice from the County Council and he refused various offers of support, even as late as 24 December 2009.

3.9 Neighbour A was providing support to the couple in the form of meals and shopping, but her concern extended to contacting the County Council and Age Concern to seek help for the couple. The information she provided to the County Council was only recorded onto the Customer Service record system. Had Neighbour A's information also been recorded onto the CareFirst recording system for social care, it would have provided the opportunity for the Care Management service to obtain a fuller picture. This meant that the information could not be triangulated and weighted with other information available to the Principal Care Manager.

3.10 Feedback was not provided to referrers at several points during the management of this situation. Whilst this might not have resulted in any different actions by agencies or choices by Mr and Mrs Randall, it is an important part of interagency working and would potentially have made clear that the case had not yet been resolved and what action, if any, was being progressed. Sometimes these feedback loops are a courtesy but on other occasions the feedback may prompt

partner agencies to have further discussion about pace of response and actions taken.

3.11 It is inevitable that each agency has technical language, specific to their organisation or discipline. Terminology also develops as policy and practice develop and so meanings can change over time. There were a number of instances where terminology was not as clear as it could have been. One such case is that there was an incomplete understanding of the terminology for prioritisation that was internal to the County Council, but shared with a key partner and then by the partner with Mr Randall. This was unhelpful and may have led Mr Randall to believe that his request was being progressed, and would be concluded, more quickly than was in fact the case. The agencies need a better understanding of the language of priority that is being used in a multi agency setting. It can be confusing for agency specific terms to be shared with partners, unless all parties are very clear on the meaning.

3.12 The MP's letter, prompted by Mr Randall's concerns for his wife, was dated 22 December 2009 and arrived with the County Council on 31 December 2009. The Corporate Director responded on the next working day, agreeing to initiate an assessment as requested. The Principal Care Manager tried to contact the couple on 7 January to follow through. The time frame for the arrival of, and response to, the MP's letter were undoubtedly extended owing to the interruptions caused by the Christmas and New Year period. There had already been contact with Mr Randall prior to the arrival of the letter and he had refused the various offers of interim and home based support that were made by District Nurse, GP and County Council. It is not possible to judge whether, without these interruptions to the timeframe of the arrival of and response to the letter, a different outcome would have resulted from a further attempt to offer support to the couple.

4 Conclusion

4.1 Neither Mr and Mrs Randall, nor the agencies who became involved with the couple, were fully aware of the extent and seriousness of their health conditions. For both Mr and Mrs Randall their decline was inevitable and probably rapid. Various offers of interim care and support were offered to the couple, which could have been put in place quickly. All these offers were refused and the couple instead decided to await a permanent admission to residential care for Mrs Randall. The situation is unsatisfactory in that Mr and Mrs Randall have died without the benefit of the care and support that could have provided some relief to their situation and thus potentially a more comfortable final period of their lives. However, given the health position and causes of death of both Mr and Mrs Randall, this Serious Case Review does not find that different actions by local agencies would have avoided the couple's deaths.

5 Recommendations

1. The agencies should review their joint understanding of how to respond in situations where the client, who has mental capacity, refuses service input that the professionals of the day consider would be critical or beneficial, along with the support needs of professional staff where customers are left (through their own choices) in what are perceived to be risky situations.

2. The issue of when customer consent is, and is not, needed when discussing post hospital discharge arrangements, and how it relates to both discharge meetings and service refusal, was reviewed. It was recommended that where support is refused, as well as recording this refusal, good practice would entail recording of capacity at the point of refusal.

3. The Council and Age Concern should review whether the current arrangements for making referrals between the agencies, and messaging, are adequate and timely.

4. Age Concern should clarify, with its commissioners and for customers, exactly what service it is offering and how any changes are notified to key stakeholders. This applies to both locally contracted services and those offered as part of their charitable service.

Partner agencies, in turn, need to be clear how they notify their front-line staff, who refer customers to these services, of changes to the service offer. The agencies should also ensure that there are no similar issues with any other of the services to which front-line staff regularly refer.

5. The County Council should review how the service entitlement for self funding customers is understood by the workforce and partner agencies, and also how it is explained to the customers.

6. Local agencies to confirm the view that local Single Assessment Process are being utilised across the Board's membership.

7. The County Council should ensure that dual recording onto both the ‘Goldmine’ and ‘CareFirst’ systems takes places in relevant cases.

8. The agencies should, collectively, clarify expectations and processes for referral feedback, use of language to express understandings of priority, risk and vulnerability and include in this, how feedback should be provided for referrals from members of the public.

6 Governance arrangements to implement the action plan

An action plan from this Serious Case Review has been developed to take forward its recommendations. The Safeguarding of Vulnerable Adults Board, through its Quality Assurance sub-group, will take responsibility for robustly monitoring the plan until such time as it is satisfied that the recommendations have been completed and there is evidence that they have been fully embedded into practice and tested to ensure compliance.

The plan includes timescales for implementation and all agencies have the responsibility to report to the Safeguarding of Vulnerable Adults Board any obstacles that prevent the completion of the task within the agreed timeframe.

Chris Moore

Dean, School of Social Sciences

University of Northampton

Park Campus

Boughton Green Road

Northampton NN2 7AL

Tel 01604 892022 (direct)

Tel 01604 892013 (Margaret Brudenell PA to Dean)

Fax 01604 892963

Email: Chris.Moore@northampton.ac.uk