Slough Safeguarding Adults Partnership Board

Serious case review in respect of female adult DD

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Executive Summary

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1 Introduction

This Executive Summary provides a brief headline summary of the main findings, conclusions and recommendations of a Serious Case Review (SCR). This was commissioned by Slough Safeguarding Adults Partnership Board in October 2012 following the death of a female adult, DD in May 2012.

2 Background summary

2.1 Ms DD was born on 29th December 1913. She lived alone in a house in Slough. She had lived in the same house since she was in her late teens. DD was one of 8 siblings and has one surviving sister who lives with DD's nephew (Mr T) in Basingstoke.

2.2 Ms DD died on 8th May 2012. The coroner recorded the cause of death as: Myocardial Infarction/Hypertension/Dementia. Ms DD had, on 4th May 2012, been admitted to hospital when carers became concerned about her. On the evening of 5th May 2012 she was discharged home from hospital and was subsequently found dead on the floor on 8th May by a carer from the care agency.

2.3 DD first became known to SBC Adult Social Care in December 2007 when, following an admission to hospital, the GP referred DD for social care assessment. Following assessment at this time SBC involvement with DD soon concluded as she was managing relatively independently with low level input from Age Concern; her nephew and niece and assistance with housework funded and arranged privately. There were further concerns in late 2008 and in the first half of 2009 relating to DD's ability to manage independently and references in particular to her memory and a level of confusion. There were concerns about safety in relation to DD's use of the gas cooker and an incident where she had locked herself out. She was in receipt of a meals service. Following a fall in November 2009 DD was again admitted to hospital and following discharge a package of care was arranged including three calls daily to assist with daily living tasks. DD continued to receive care from the care agency from this point until her death in May 2012. A number of SBC Adult Social Care teams maintained some involvement over this time through reviews and being alerted to developments often by the care provider. DD was referred to the Community Mental Health Team for Older People in January 2010. The GP was also involved during this time, including responding to calls from family and from carers from the care agency.

2.4 Following her discharge from hospital in May 2012, DD died in circumstances which gave rise to significant concerns about the way in which local professionals and services had worked together in this situation. As a result of these concerns this Serious Case Review was established.

2.5 Whilst the initial focus for this SCR was on the immediate information and circumstances surrounding DD's admission to and discharge from hospital in May 2012, this SCR acknowledges the importance of the impact of

preceding practice on that situation. The quality of hospital discharge relies upon that cumulative picture which informs the assessment on discharge: the quality of assessments and reviews up to that point; whether the needs and risks were fully understood and whether the current level of care was addressing those issues. This is the rationale for a focus on the period from late 2007. It acknowledges that hospital discharge is built on: accurate and complete information; effective communication of that information; an understanding of the individual's circumstances from the point of view of the person and those who know them best; empowered individuals and their families; involvement of front line carers; good quality individual professional practice. The effectiveness of hospital discharge relies on those aspects of practice having been established and maintained over time.

3 Examples of positive practice

The focus of this review is on learning lessons and therefore the emphasis is on areas where improvement is required. However there were also examples of positive practice. These included:

- the practice of ambulance staff who took DD home from hospital in May 2012 and their diligence in ensuring she was settled and comfortable;
- the practice of the meals provider who repeatedly alerted other agencies to concerns about risk of fire to DD;
- the practice of DD's regular carers who also brought a number of concerns to the attention of other agencies and who communicated regularly with DD's family where they felt this would enhance the care they could offer DD.

4 Conclusions reflecting the key lessons learned from this analysis of the care and support of DD

4.1 This review has highlighted inadequacies in the identification, assessment and management of needs and risks. The situation merited a robust multiagency approach to achieve a holistic overview of those needs and risks. There needed to be associated clarity in recording so that accessible information could be more easily shared across disciplines and agencies, with associated strategies put in place to monitor, manage and review the known needs and risks. Practice was largely reactive and often took place without the benefit of insights from colleagues across agencies.

4.2 The significance of the role of provider services in detailed communications around significant events (such as hospital discharge) and in the assessment and management of need and risk is a particular issue for all concerned including commissioners. The case of DD serves to underline the importance of statutory agencies both seeking out information from front line carers to inform assessment, monitoring and review processes and sharing information with them.

4.3 The lack of a person centred approach at times impacted significantly on the quality of intervention. Aspects of DD's past experiences and of her present wishes and preferences remained unknown to a range of professionals whose assessments and decision making would have benefited from these insights.

4.4 In the same way available information about the extent to which Mr and Mrs T were able to be involved in DD's day to day care was not shared and often actions were based upon misconceptions in this respect. Mr and Mrs T cared deeply about the wellbeing of DD but their role in supporting Mr T's mother and their own grandchildren prevented them from carrying out routine and regular care tasks. This was the role of the staff of the home care agency. A formally recorded carers assessment might have assisted in this respect. Mr and Mrs T usually visited their Aunt fortnightly and offered as much support as other responsibilities allowed.

4.5 Set against national guidance on working with risk as well as local SBC guidance the quality of risk assessment and risk management was called into question by this review. Across agencies and between teams there was a failure: to coordinate information and decision making around the known risks; to record a comprehensive assessment accessible to all at crucial points; to put in place appropriate actions; to be clear about accountability for those actions; and to put in place robust monitoring and review processes. This issue was closely bound up with the failure (highlighted above) to engage sufficiently with DD and her family and to empower them with an understanding of the known concerns and of who they might consult if they had concerns. It was closely linked to the failure of statutory agencies to engage sufficiently with front line carers. There is evidence of these issues throughout the period scrutinised by this review and culminating in problematic assessment and decision making surrounding DD's discharge from hospital in May 2012.

4.6 There was an absence of robust recording which is an essential part of practice especially in circumstances of risk. Standard recording formats need to be agreed in respect of key areas such as risk; safeguarding adults; mental capacity assessments. Furthermore the request for information to be contributed to this review has identified significant gaps in the records of single agencies. The importance of comprehensive and accurate recording needs to be impressed upon staff and addressed in the action plans of those agencies

4.7 DD presented a challenge to those involved with her in respect of achieving a balance between choice and safety/wellbeing. That challenge was often met with inadequate decision making that failed to connect with the level of risk in DD's situation or with her level of capacity to understand the choices she was making or with the available information and capability across agencies. On numerous occasions DD declined support and treatment and this was taken at face value without the necessary challenge to those decisions. Indeed on several occasions her reluctance to engage was

met with a decision (often without management oversight) to withdraw and close/suspend activity with DD.

4.8 Failings in relation to practice in the context of the Mental Capacity Act were prominent across agencies. The principal failings included: understanding and putting into practice the five core principles of the Act; failure to formalise and document an assessment of capacity at any stage; a consequent failure to consider DD's "best interests". Any consideration of the issue of DD's capacity was based on assumption.

4.9 There was no formal diagnosis of dementia and therefore none of the potential assessment or good practice associated with such a diagnosis was carried out. This omission contributed to an absence of personalised care in this context and of any clear strategy to manage things well for DD or to put in place plans and contingencies to optimise her care.

4.10 There were a number of incidents/concerns that should have provoked a safeguarding adults alert / referral. There is a need to address this lack of understanding as to what constitutes a safeguarding "alert" and when and where to refer such concerns. The failure to address the concerns within the framework provided by the safeguarding procedures meant that they became "lost" within other assessments and recording and they were left unresolved, with no assessment of whether the concern needed to be pursued. There are "grey areas" surrounding issues of neglect and self neglect which require clarity as to how risk is assessed and managed and a willingness to facilitate consideration of these issues across agencies. There needs to be clarity as to the place of neglect in the context of safeguarding adults.

4.11 The absence of management oversight of decision making and of staff support and supervision is inherent in the identified shortcomings. Managers must challenge decision making as well as supporting staff in challenging colleagues in other agencies when necessary actions/information are not forthcoming. Supervision must balance managerial oversight with support and identifying necessary development needs as well as making available opportunities for development.

4.12 Practice in relation to the hospital admission and discharge which immediately preceded DD's death indicates the need for significant learning across agencies in Slough. It was a culmination of issues which have been highlighted above in respect of practice in the 4 years prior to this hospital admission. It also represents a microcosm of all of those issues. Policy and practice in this area requires attention within and across agencies.

4.13 The agencies involved in this Serious Case Review are committed to ensuring that the issues represented here are addressed. They have identified actions within their own agency which will help to ensure that single agency shortcomings are addressed. These will be monitored by the Slough Safeguarding Adults Partnership Board. The recommendations set out below will form the basis of a Safeguarding Adults Board action plan designed in the main to address multiagency failings.

5 Recommendations

These recommendations are reflected in a detailed action plan, which has been drawn up on behalf of the Slough Safeguarding Adults Partnership Board (SAPB) and will be closely monitored by the Board. Particularly significant actions are reflected below *in italics*. These are not an exhaustive list of the actions but give some indication of a commitment to learning and improvement.

1. Hospital admission / discharge policy and practice

Slough SAPB will in the light of this SCR influence the development of single and multiagency policy and practice on hospital admission and discharge. In particular the specific issues raised in this SCR must be addressed in the context of the relevant DH guidance. Commissioners will monitor practice in this respect against core expectations. *Actions include drawing up and implementing a new multiagency policy aiming to facilitate robust and safe discharges from hospital and taking on board some of the practical messages learned from this SCR. It is intended that this will be in place by June 2013.*

Slough SAPB will engage with SCAS, their subcontractors and their lead commissioner to put in place *across all commissioned ambulance services* the recommendation put in place by Alpha Care Ambulance Services Ltd. This is that ambulance crews will confirm centrally with care providers (branch manager/out of hours service) when a patient arrives home. Assurance will also be sought that ambulance crews carry contact details for Adult Social Care out of hours services in case of the need to report concerns.

2. Working with risk

"Risk, choice and control" is a stated priority of Slough SAPB. As such it merits a particular focus in this SCR. Guidance outlining a joint approach to identification, assessment and management of risk will be developed and agreed across all partner agencies to the Slough SAPB. This will build on the Slough Adult Social Care *Positive Risk Taking Principles and Guidance, 2012.* Training in risk assessment and risk management will be reviewed in the light of this SCR across agencies. *There will be a greater emphasis in guidance, support and training of staff to enable them to identify, assess, keep track of and manage risk in the lives of individuals who use services.*

Guidance will include:

- a focus on working across agencies with individuals who decline support/services/treatment
- guidance on how and when such reluctance can result in closure of a case
- a focus on recording and the need for stand alone robust risk assessments and action plans which are readily accessible within and across agencies
- adopting a structure/template for recording risk assessments and decisions including at safeguarding meetings
- a focus on achieving continuity through effective reassessment and review of action plans/protection plans over time.

- prompting professionals to include service users, their families and informal networks in understanding and managing risks.
- underlining the crucial role of service providers in assessing and managing risk and their inclusion in relevant processes and information sharing
- cross reference to clear guidance in hospital discharge policies relating to risk
- guidance for commissioners of services in monitoring this aspect of practice
- putting clear pathways in place within and across agencies for escalation of concerns to senior managers
- the need for processes that identify individuals who are particularly vulnerable and associated necessary actions

3. Risk of fire

Slough SAPB will engage with Royal Berkshire Fire and Rescue Service to raise awareness of and to put in place processes and practice to ensure joint working in cases where risk of fire is an issue for a vulnerable adult. The aim will be to provide a joined up approach across all organisations whose staff work directly with adults at risk. This approach will ensure that staff in the statutory, independent and voluntary sectors are able to identify those adults most at risk; know how and to whom to refer them in BFRS, who will then assess the risks and provide the best equipment and advice to the person, their family and their carers. BFRS will monitor and report to the Slough SAPB the frequency of referrals to them from members of the Board. *Advice and support has already been sought from BFRS for operational staff with a view to training and guidance being implemented by September 2013.*

4. Safeguarding Adults

4a) The Slough SAPB must respond to the lack of clarity demonstrated by this SCR as to what constitutes a safeguarding adults alert or when to refer issues in to the multiagency process. It needs to draw attention to the value that the safeguarding adults process adds in terms of identifying required multiagency actions and monitoring progress on these to ensure that action does not simply fizzle out. *Guidance will be issued across agencies and an understanding of the value of the multiagency safeguarding process imparted.*

4b) There needs to be clarity about the issues of neglect and self neglect in the context of safeguarding adults. Related actions must be put in place across ***all*** agencies so that there is more effective identification of neglect and a commitment to joint action where it is identified. This includes understanding that referral in to the safeguarding process may serve to determine the most appropriate response even where the whole process is subsequently not followed through. Procedures and training will underpin this clarity. There are significant links with recommendation 2. *Clear guidance will be issued including underlining the requirement for joint working across agencies in these situations.*

5. Effective joint working to deliver single agency and collective responsibilities

This SCR highlights occasions when agencies experienced either an absence of any action in respect of concerns which they reported to a partner agency or unease about a partner agency's decision-making or assessment. It is not sufficient to simply pass on a concern. Individuals who observe/perceive concerns remain accountable for ensuring that these are acted upon. Organisations must nurture a culture which encourages and values **constructive challenge and debate**. Managers and staff at all levels must be encouraged to seek clarity, to challenge decisions and to escalate issues or concerns within a well defined process. This point is underlined in the DH safeguarding adults statutory guidance, *No Secrets*, 2000"…Joint investigation there may be but the shared information flowing from that must be constantly evaluated and reviewed by each agency" *Actions across agencies will ensure that managers and staff at all levels understand their responsibility to seek clarity, challenge decisions and escalate concerns where necessary. Supervision of staff and relevant guidance will underline this. The Slough SAPB will monitor this aspect of practice.*

6. Practice in the context of the Mental Capacity Act

Agencies from all sectors including service providers will ensure that local guidance and training is in place so that assessments of mental capacity are undertaken where appropriate and in a manner consistent with the guidance set out in the Mental Capacity Act Code of Practice.

A working awareness of the principles of the Mental Capacity Act, 2005 must underpin all work in the context of managing risk in the lives of people who use services in Slough. *This aspect of practice has already recently been tested out through case file audit. The findings are being fed back into practice through staff supervision and seminars. Further multiagency case file audit will investigate this aspect of practice.. New training material based on real case studies will developed to support effective learning. There will be a responsibility across all agencies to commission effective training.*

7. Case File Audit

Statutory agencies across the safeguarding adults partnership board will ensure that multiagency case file audits direct attention to the issues raised in this SCR and, in particular, the presence of a person centred approach; the key elements of an agreed approach to assessment and management of risk; the assessment of mental capacity and adherence to the 5 core principles of the MCA; an awareness of safeguarding adults procedures. The Slough SAPB will monitor this. *Such case file audits will take place twice yearly. The outcomes will be shared with the Slough SAPB and learning disseminated accordingly. The SABP will monitor subsequent changes to practice.*

8. Training across agencies in safeguarding adults and the related issues of risk and mental capacity will be provided and monitored across all partner agencies by the safeguarding adults' board (alongside the above audit process) with a view to ensuring that all relevant staff have appropriate training and that the ***effectiveness*** of the training is evidenced. The Board

will take a partnership approach to ensuring the availability of resources to implement the required training.

9. Diagnosis of dementia/working with dementia

In the context of national guidance on dementia pathways all agencies must ensure awareness of appropriate pathways for referral for individuals with dementia including diagnosis.

10. Engagement of GPs in the issues raised within this SCR

In the handover from the PCT to the CCG the Slough SAPB , the PCT and the CCG will work together to support measures to ensure that as the CCG emerges safeguarding adults/working with adults at risk is built into commissioning and governance processes. *This includes training for GPs which is already underway and representation of the CCG at the Slough SAPB.*

11. Single agency action plans

Progress on these action plans will be monitored by the Slough SAPB along with progress on the multiagency recommendations which are set out here.

12. Learning relating to the SCR process

The SCR subgroup will on behalf of the Slough SAPB, take the learning from this process and implement this in a revised SCR protocol.