
Executive Summary
of the
Serious Case Review
in respect of
Mrs B

The Serious Case Review Panel and the members of the Blackpool Safeguarding Adults Board wish to extend their sincere condolences to members of the family of Mrs B.

April 2012

Blackpool Safeguarding Adults Board

1 Introduction

- 1.1 This report summarises the findings of a Serious Case Review that was undertaken during 2011 following the death of Mrs B.
- 1.2 Mrs B died on the 6th November 2010. The cause of death was aspiration pneumonia, with secondary factor being fractured vertebrae of the neck.
- 1.3 Following a request for consideration for a Serious Case Review, the Serious Case Review Group convened on 18 February 2011 and recommended that a Serious Case Review be undertaken as it met the following criteria from within the Serious Case Review Protocol:
- an adult whose circumstances makes them vulnerable dies (including death by suicide or caused by self-neglect) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the Safeguarding Adults Board should always conduct a review into the involvement of agencies and professionals associated with the adult immediately prior to and after death.
 - an adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard adults.
- 1.4 The purpose of a Serious Case Review is to:
- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of adults at risk.
 - Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result
 - As a consequence, improve inter-agency working and better safeguard and adults at risk
 - Establish whether the safeguarding adults procedures are effective or whether they need to be amended
- 1.5 Serious Case Reviews are not designed to investigate a case, nor are they to apportion blame. The Panel have therefore not formed an opinion in relation to this.
- 1.6 The Serious Case Review Panel in relation to Mrs B reviewed information provided by agencies and, where necessary, sought

clarification so as to ensure as full a picture as possible was gained of how local professionals had engaged with Mrs B and each other.

- 1.7 The actions and practice of the agencies which provided services to Mrs B were analysed. As a result of this analysis, lessons to be learnt were identified and recommendations for improvements in practice were made.

2 Key Lines of Enquiry

The following Lines of Enquiry formed the basis for the review:

- 2.1 What was the extent of each agency's involvement from January 2010 to November 2010?
- 2.2 What assessments were completed by each agency, and what was the appropriateness of timeliness, actions and/or referrals to other services?
- 2.3 Were actions taken in line with local, national and procedural guidelines?
- 2.4 What was the role and involvement of family members/significant others during the period January 2010 to November 2010?
- 2.5 What is the evaluation and critical analysis as to each agency's involvement?
- 2.6 Are there details of any incidents that occurred or any concerns that were raised between January 2010 and November 2010?
- 2.7 Were there any social and/or environmental factors that could have contributed to any incidents recorded?
- 2.8 Were there any equality and diversity issues or any cultural aspects that may be apparent within the care setting and that may have had an effect on care or treatment provided?
- 2.9 Is there any other information that may be relevant to the Serious Case Review?
- 2.10 Were any issues encountered that may have been apparent because of a cross-boundary placement?
- 2.11 Was the care and treatment offered sufficient to meet all health and social care needs?
- 2.12 Identify any areas of good practice within each agency?
- 2.13 Were the views of family taken into account during the review period?

3 Membership and Methodology of the Review Panel

3.1 The Serious Case Review Panel was comprised of the following people:

- Head of Safeguarding, Blackpool Council
- Head of Adult Social Care, Blackpool Council
- Head of Safeguarding (Children and Adults), NHS Blackpool
- Director of Nursing and Quality, NHS Blackpool
- Detective Inspector, Lancashire Constabulary

A Safeguarding Board Business Manager has been in post since Dec 2011 and attended panel meetings subsequent to this date.

The Independent Author of the Overview Report was in attendance at each panel meeting.

3.2 The Independent Author was an Independent Consultant in Social Care Health and Management. He has worked in the Personal Social Services since 1973. He was a Director of Social Services from 1997 – 2011. From 2008 – 2011 he was also an Executive Director of a Primary Care Trust. He has been a Chair of an Adult Safeguarding Board

3.3 Each contributing agency prepared an Individual Management Review which critically reflected on the work undertaken by the agency. In order to maximise independence of the process, each Individual Management Review was written by an officer who had no previous operational involvement with any aspect of the service delivered to Mrs B.

3.4 The Panel considered these Individual Management Reports, including a full chronology of involvement with Mrs B and her family from each of the contributing agencies.

4 Summary of Events

4.1 Mrs B arrived in Blackpool in January 2010 from the WCC area. She had been admitted to hospital, prior to which she had been found at home on the floor following a fall, doubly incontinent and confused. She had lost the sight in her left eye. Mrs B had history of frequent falls and was known to have vascular dementia and a range of other health issues.

4.2 She moved to Blackpool to be nearer her granddaughter and was placed by WCC as a resident in BNH.

- 4.3 In April 2010 BC were informed about the placement by WCC and completed an assessment at their request. Mrs B's granddaughter also contacted BC to raise concerns about the standard of care her grandmother was receiving at BNH and requesting information about how to arrange an alternative placement. A multi-disciplinary assessment was undertaken and it was agreed that Mrs B was eligible for NHS funded care on 5 May. Her care was reviewed regularly by the NHSB CHCT.
- 4.4 In September 2010, Mrs B's granddaughter again raised concerns in relation to Mrs B's care at BNH. These concerns included incidents of apparent poor care, poor staffing levels and a degree of restraint being used.
- 4.5 An unannounced joint visit to BNH took place 13 October 2010 by a Social Worker and Nurse. Some of the family's concerns had been addressed and the family are reported as feeling that staff were being more attentive to Mrs B. An alternative placement was discussed. The family agreed for Mrs B to remain at BNH and the owner of BNH was advised to apply for a Deprivation of Liberty Authorisation with regards to Mrs B's best interests.
- 4.6 On 20 October 2010 Mrs B was taken to hospital in an ambulance following a fall at BNH. She was seen in Accident and Emergency and a cut on her forehead was glued. Mrs B was then transferred back to BNH.
- 4.7 The NHSB CHCT advised BNH, on 22 October 2010, to contact the Falls Matron for advice and to discuss possible specialist equipment.
- 4.8 BNH contacted the GP Led Health Centre on 23 October 2010 to discuss bruising which Mrs B had developed following a fall. Accident and Emergency attendance was advised. This advice was not taken.
- 4.9 Mrs B was admitted to hospital on 24 October 2010 following a fall at BNH and general concerns about her health. A safeguarding referral was made and a strategy meeting took place, followed by a full safeguarding meeting on 5 November 2010. At this meeting it was agreed that allegations could not be substantiated and that it had not been possible to establish what happened to Mrs B.
- 4.10 Mrs B died in hospital on 6 November 2010.
- 4.11 Additional information and ongoing concerns led to a request for consideration for a Serious Case Review.

5 Key Learning Arising from the Case

There are a number of issues which emerge from the review of the Individual Management Reviews which Blackpool Adults Safeguarding Board should ensure are addressed.

- 5.1 Mental health assessments should be obtained where there is any evidence which suggests that patients may be suffering from dementia.
- 5.2 Staff should be clear about the importance of mental capacity issues and assessment within safeguarding. They need to ensure they have an understanding of:
 - the circumstances in which it might be appropriate to intervene in an individuals' best interests, and
 - the process to apply for a Deprivation of Liberty Safeguards Authorisation
- 5.3 Staff must consider the additional communication and information sharing requirements involved in cross-boundary placements.
- 5.4 All staff have a professional accountability for ensuring actions from meetings are completed, and recommendations from assessments are followed up and implemented.
- 5.5 Accurate and complete record keeping particularly related to assessments should be maintained

6 Learning from conducting this first SCR

- 6.1 The SCR Panel worked well together and with the Chair and author of this report. There is some learning to be done about double-checking the involvement of all agencies at the beginning of a Review as this led to some delay in this instance.
- 6.2 There is also learning about the engagement of agencies and the timeliness of their responses, especially those from the private sector as some considerable delays have been experienced during this review.

7 Multi-Agency Recommendations

Each participating agency in this Serious Case Review process has set out a set of recommendations applicable to their own specific agency. The following

multi-agency recommendations have been identified by the Independent Author from the individual recommendations.

7.1 Assessment and Reviews

Mrs B's care was considered on a multi-agency basis on a number of occasions. However, these multi agency reviews and discussions should also consider the current need as well as the specific issue in question (e.g. eligibility for funding) to ensure that the holistic needs of the person are addressed.

All agencies should also review any pre assessment and transfer in documentation to ensure that all health needs are considered and assessed.

7.2 Professional Accountability and Supervision.

It was evident that there were issues related to ownership of problems. Assumptions were made that others were doing what was necessary and/or making a referral to another agency and these actions were not verified. It was the view of Social Workers and Nurses (including the owner of BNH) that Mrs B was suffering from dementia yet no one arranged for her assessment by an appropriate specialist service.

Staff should be reminded that they have professional accountability and it is therefore their responsibility to ensure that action of this nature is taken when required.

7.3 Family Involvement

Throughout the time Mrs B was a resident at BNH her family had reservations about whether she was receiving an appropriate standard of care to meet her needs.

Staff with whom relatives discuss their concerns should explore the reasons for these concerns and discuss alternatives with them. Decisions and reasons for these should be clearly recorded in the file notes.

The family were told they could not attend the safeguarding meeting which is in direct contravention to the Board's safeguarding procedures and accepted best practice. Staff should be reminded of correct procedures.

7.4 Recording

The Individual Management Reviews identify a number of issues in respect of case recording which will need to be addressed by each organisation. In addition to these actions, records of all meetings should

include a list of clear action points with an indication of who is responsible, timescale and a mechanism to review progress.

The Safeguarding Board should monitor the actions taken and ensure that sample file audits take place.

7.5 Out of Area Placements.

Blackpool is a significant importer of residents from other authorities who choose Residential Care or Nursing Homes in the Borough. The responsibilities which are associated with this in relation to advice and information given to families should be clearly provided to professionals.

7.6 Multi Agency Awareness Raising

Each of the above issues should be reinforced as part of the Safeguarding Board's lesson learned dissemination process. Emphasis should be placed on the need for staff to understand how to make appropriate safeguarding alerts.

Blackpool Safeguarding Adults Board should further publicise to the Blackpool care home sector the availability on Mental Capacity Act and DOLS training courses.

7 Conclusion

- 7.1 This report describes events prior to the death of Mrs B, a ninety four year old woman, during the final eleven months of her life when she was a resident in Blackpool. She was blind, suffered from dementia, and was physically frail having had at least one stroke.
- 7.2 The individual management reviews identify areas of concern about the care of Mrs B. Her family visited her most days and had raised their concerns with the statutory agencies and Mrs B's carers at BNH.
- 7.3 There is limited evidence to show that her needs were adequately met and there were at least two occasions when safeguarding procedures should have been triggered. However, from the information available it is not possible to state whether these areas of concern contributed to her death. That is not to say that a more proactive and timely response to Mrs B's care needs would not have had a positive impact on the quality of her care.
- 7.4 Each agency has identified actions and have been proactive in addressing the actions and recommendations identified. The Board has also been reassured that agencies are undertaking reviews and

revisiting issues to ensure they are doing all they can to develop and promote good practice.

- 7.5 The Safeguarding Board will regularly review the recommendations from this serious case review to ensure that agencies have taken action and that the outcomes inform good practice across all agencies.