



Hampshire County Council

SAFEGUARDING ADULTS BOARD

**SERIOUS CASE REVIEW: “Mr A”
EXECUTIVE SUMMARY REPORT**

June 2013

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1. INTRODUCTION

In July 2011, a decision was made by the Hampshire Serious Case Review Panel to set up a Serious Case Review (SCR) into the death of Mr A. Mr A had a severe learning disability and complex needs. Mr A died at the Queen Alexander Hospital, part of Portsmouth Hospitals Trust (PHT) on 31st May 2010. Many agencies had been involved in Mr A's care prior to his death and it was considered that an SCR would be the best approach in which to capture learning on a single and multi-agency basis. Given that Hampshire County Council had had some involvement as an agency, it was agreed that the SCR would be chaired by a senior executive at Portsmouth County Council. It will be apparent throughout the report what agencies were involved and to what degree.

The purpose of the SCR is:-

- 1. To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults.**
- 2. To review the effectiveness of procedures, both multi-agency and those of individual organisations.**
- 3. To inform and improve inter-agency practice.**
- 4. To improve practice by acting on learning.**
- 5. To commission an overview report after an in depth consideration of the case that brings together and analyses the findings of the various reports from the agencies in order to make recommendations for future action.**

Structure of this Executive Summary

This executive summary gives a synopsis of Mr A's care pathway. The next section of the executive summary then sets out the findings based upon identified key practice episodes relevant to the learning points and associated findings. Alongside the findings are the recommendations emanating both from the IMR and the SCR process. The recommendations are agreed by the SCR panel collectively. The methodology used for this SCR dispenses with a chronology but there is a narrative of the care pathway below.

2. SUMMARY NARRATIVE

Background

Mr A was aged 52 when he died. This SCR has sought to obtain as much detail as possible to understand Mr A as an individual, as well as the complex factual circumstances surrounding his care.

There was consensus by professionals involved in caring for Mr A throughout his life that he was at the severe end of the spectrum of learning disability and autism. Mr A also had a needle phobia.

Based on information already known by professionals caring for Mr A and an assessment in 2003 by a Speech and Language Therapist (SALT), the following provides a good insight into the nature of Mr A's condition. This states:-

- Inflexibility of thought
- Easily distressed by change in routine
- Lack of inhibition
- Repetitive language
- Fixed routines must be very set
- Needs to feel secure in environment as unable to gain sense of security from other people

The therapist advised that Mr A needed highly skilled carers and that a consistent and more objective world of expected routines was more comforting to him than the complex world of human interactions. The therapist went on to say that when Mr A does interact, he would be seeking to make people as predictable as he could. He recommended a plan involving:-

- An audit of receptive vocabulary
- A picture exchange communication system
- A TEACHH programme (Treatment and Education of Autistic and Related Communication Handicapped Children) – this is a holistic approach to develop strategies toward the individual
- Consistent daily routine
- Stress reduction plan

2.1 DENTAL CARE

Throughout his life, Mr A required dental care.

In 2007, Mr A's dental hygiene was very poor, despite carers endeavouring to clean his teeth on a daily basis. The dentist found retained roots and lost fillings with cavities. This required treatment under a general anaesthetic, (GA) and Mr A's condition was stable throughout. He was subsequently discharged and seemed well. There was a domiciliary visit by the oral

hygienist on 15th November 2007 and it was reported that there had been behavioural changes with Mr A since the anaesthetic.

Mr A's next-of-kin remains convinced that something fundamental happened as a result of the GA in 2007. In 2009, the 2007 GA was reviewed by a senior dentist. While it was noted that Mr A had required extensive treatment and that the fillings had been difficult, there were no indicators that anything adverse had occurred or that the GA was anything other than straightforward.

At the March 2009 dental appointment, it was noted that two of the teeth that had been filled in 2007 required further treatment. Mr A's next-of-kin agreed but asked if the teeth could be extracted rather than filled to avoid future problems and the need for any future GA to treat the particular teeth in question. Mr A had several other dental treatments with no apparent adverse effects. He did, however, at times suffer with dental pain. Mr A had other health problems, including in his last year a chest condition called empyema. This is a serious condition which can ultimately cause death.

On discharge from hospital for this chest condition in January 2010, Mr A had two dental appointments, one which was attended on 15/2/10 and one which was postponed on 21/4/10. The dentist was aware that Mr A had on-going health problems with his chest and concluded that Mr A would require treatment under the maxillofacial surgeons in the main hospital for any further dental treatment in view of this. A letter was sent from the dentist to the consultant maxillofacial surgeon at the hospital in May 2010, requesting advice and urgent attention. It was explained that urgent help was requested as his family were concerned about the time it was taking to resolve Mr A's dental care. This was the last contact with dental services.

2.2 OTHER HEALTH AND SOCIAL CARE

Mr A was supported by NHS Learning Disability Services throughout his life and was under the care of a Consultant Psychiatrist who also noted a change in Mr A's demeanour and behaviour after the GA for dental care in 2007.

By 2008, concerns were growing that Mr A's behaviour was not settling and there were safeguarding concerns around him and other residents with whom he was interacting negatively. Despite an increase in carers, consensus was reached that Mr A needed to be cared for elsewhere.

A psychology report in April 2008 sets out triggers for Mr A's behaviours which included:-

1. GAs (though a Consultant Anaesthetist had opined that it was extremely unlikely that Mr A had experienced any adverse physiological reaction in 2007).
2. Dental pain – there was evidence that Mr A was, at times, in varying levels of dental pain and had a possible dental infection.
3. Physical illness.

4. Lack of preparation for any change in routine.
5. Disruption and change in environment – admission to hospital could represent a “psychological jolt” causing a level of trauma that Mr A could not necessarily communicate. Therefore, any clinical interventions, be they dental or otherwise, needed careful planning.

Sadly, the position became untenable at the placement at which Mr A had been cared for for many years. Mr A was moved in October 2008 to another residential service, provided by a reputable care provider. Before this move, there was some consideration by social services and others in the team whether a single placement would be best for Mr A but there was confidence that the new residential placement would meet Mr A’s needs. The new carers agreed to accept Mr A into their care, but they needed further training and support. The move went ahead with a transition plan which was reliant on training being provided and external support.

Unfortunately even after the move to the new placement, incidents involving Mr A were an on-going concern. These resulted in several safeguarding meetings throughout 2009 with varying attendance of the multi-agency team. The meetings tended to deal with several vulnerable adults rather than focussing on one individual. The themes are ones of Mr A’s conflict with other residents at the new placement, and a strong incompatibility with one in particular.

By September 2009, despite a great deal of support to the carers, there were serious doubts whether accommodating both Mr A and the other resident was going to be workable and an action point was agreed to look at alternatives for Mr A. At this point, the transition period was still on-going. It was agreed that other providers would be looked at and could involve a hospital admission or the possibility of moving Mr A in the interim. It was also identified that it could be necessary to look further afield than inside the County to ensure that alternative accommodation was available quickly in a worst case scenario.

In October 2009, Mr A was urgently taken to PHT as he was not sleeping, was withdrawn, was crying or manically laughing and was severely agitated. He was distressed and saying: “I am broken, I need mending.” The GP had seen Mr A three days before and taken bloods. The results were abnormal with increased enzymes. The GP also prescribed Diazepam to help Mr A sleep but he only slept for three hours at a time and the medication made him confused. The differential diagnosis was one of a neuroleptic malignant syndrome due to increased enzymes thought to be due to the long-term use of the medication, Haloperidol. Subsequently, both Haloperidol and another drug, Procyclidine were stopped immediately. Both these medications had been administered to manage Mr A’s behaviour to try and reduce anxiety and keep him calm. There was a discussion with the carers as the doctor was keen for Mr A to be admitted for further assessment and, after some encouragement, Mr A agreed to stay and a side room was arranged for him given that he would find the main ward difficult to tolerate. A carer stayed with Mr A throughout. His condition settled and Mr A was discharged.

In November 2009, Mr A's care was transferred to a new Consultant Psychiatrist employed by the Mental Health Trust. The Consultant Psychiatrist in question is a specialist in learning disability who had the responsibility for reviewing and managing Mr A's psychiatric medication. All other medication was managed by Mr A's GP. The Consultant noted Mr A to have a severe learning disability who presented with a variable mental state, depression, aggression and some self-harming. He was aware of the October admission for neuroleptic malignant syndrome.

Throughout the rest of 2009, the Consultant Psychiatrist worked diligently with carers, monitoring Mr A's behaviour, and involving others in the multi-disciplinary team. However, it was noted that Mr A's physical health was poor and this was affecting his behaviour. The Consultant Psychiatrist discussed this with the GP but the GP said he would not send Mr A for an admission into hospital but would treat the chest problem with antibiotics.

In December 2009, there was another safeguarding meeting. The conflict between Mr A and the other resident remained prominent. All were agreed that Mr A would have to move again.

In early January 2010, a "moving on" meeting was held which was a multi-disciplinary meeting that agreed that Mr A would be moved to a single setting. The GP attended and diagnosed a severe chest infection but the GP considered that a hospital admission was not indicated due to the distress this could cause Mr A.

In January 2010, a further safeguarding meeting took place. Mr A's physical health had not improved and on 22nd January 2010, he was admitted to hospital as an emergency via the GP. He had lost a stone in weight in the previous two weeks and the impression was of a left pleural effusion secondary to pneumonia. The cardiothoracic team assessed Mr A and the plan was for a CT scan of the chest, insertion of a central venous line and insertion of a chest drain. This was discussed with the anaesthetists and the Intensive Care Unit (ICU) staff. Carers were involved in this decision on 23rd January 2010 and this was led by the Respiratory Consultant. There is no record of a discussion with Mr A's family at this point. Mr A did not have an independent advocate. His sister was his next-of-kin. The carers expressed concern to the anaesthetist and Consultant that when Mr A woke up, he would pull the chest drain out. There was, therefore, further discussion that Mr A may require an ICU bed to be sedated and ventilated or heavily sedated on the ward. It was agreed the plan would need some co-ordination and that a gas intubation was the best approach.

In January 2010, a chest drain was inserted but without post-operative sedation or an ICU bed so when Mr A woke up, he pulled the drain out. Mr A was discharged soon afterward.

Carers attending with Mr A during this admission reported to the SCR panel serious concerns about a lack of understanding of staff at the hospital about Mr A's learning disability and his complex needs. Further, following

discharge, Mr A was still unwell. Carers reported a high volume of contact with the GP in and “out of hours” and expressed frustration that at times they were made to feel that they were contacting unnecessarily, and yet Mr A’s physical health was further deteriorating and his challenging behaviour was not settling. The carers were unable to put an accurate number on the number of GP contacts but the medical records appear to indicate fifty-one contacts from 16th September 2009 to 21st January 2010. The GP practice has indicated it was more in the region of twenty-one contacts for the core hours service. However, even at the lower number, it is fair to say there was considerable contact to seek clinical assistance and advice via the GP.

Safeguarding was resumed with a meeting in March 2010. It was reiterated by the carers at HAS that Mr A needed to move on. A three month notice had already been given by HAS to Mr A and the search for a single setting was on-going.

On 9th March 2010, Mr A was seen in an outpatient appointment in the respiratory clinic. He had consolidation in his left lung and it was noted that Mr A had pulled out his drain previously. He was recommenced on antibiotics. There is no record of treatment rationale.

The respiratory consultant was invited to provide an additional report to the SCR Panel but did not contribute further.

On 19th April 2010, a professionals meeting was held and the purpose of the meeting, called by HAS, was to try and get into place a co-ordinated plan. A number of key professionals were absent. There was, however, a letter from the Respiratory Consultant advising that a GA could go ahead for Mr A to continue his dental treatment. However, this meeting was made much less effective by the absence of the GP, dentist and Respiratory Consultant. It is recognised that it is difficult to engage senior clinical professionals at short notice, due to their planned workload (fixed clinics, ward rounds and surgeries). Under these circumstances, it is important to contact the key professionals in advance to understand their views and to feed these into the meeting.

On 20th April 2010, Mr A was seen by the Respiratory Consultant who was of the opinion that there was no change in Mr A’s chest condition. He said he would be in touch if he planned to insert another drain. The Respiratory Consultant had not attended the key meeting the day before so it may be that he did not fully appreciate the on-going deterioration, both physically and mentally, for Mr A. Conservative treatment continued. Further, the GP was not informing the Consultant of the many contacts being requested by the carers due to their serious concerns about Mr A’s health.

On 26th April 2010, the senior community nurse wrote to the Respiratory Consultant to express concerns that Mr A needed the physical healthcare for his chest problem which was not improving. This and Mr A’s dental problems were impacting upon Mr A’s mental state and his behaviour significantly.

On 5th May 2010, the Consultant Psychiatrist attended again at the new placement and noted some moderate success with his changes in medication but that Mr A's physical problems were prevailing. A further review took place on 12th May 2010 but there was no change in Mr A's condition.

On 18th May 2010, the carer reports that Mr A attended a pre-planned outpatient appointment to see the Respiratory Consultant. During this appointment, the carer was advised that Mr A would be admitted. The hospital had apparently written to Mr A. The hospital's perception in their IMR is, therefore, that this was a planned elective admission but the HAS carers are very clear that they had no knowledge of an admission being planned that day. Clarification by the hospital now states that this was an emergency admission with a view to a planned admission later. Either way, the requisite planning was not in place.

Mr A was clerked in at 16.30hrs on 18th May 2010 and at that time was on the main respiratory ward. There is no reference to the hospital passport, though carers believe that a nurse in charge did look at this on admission. (A hospital passport is a pack of information that professionals can share and follow the individual through the health and social care system. It contains key information on how to care for the individual. Mr A had a hospital passport which was with him when he went into hospital.)

Mr A would not comply with blood being taken and the anaesthetist advised this was not essential. A consent form was completed by a Consultant Physician with confirmation that Mr A lacked mental capacity to consent to the procedure. Two other doctors concurred, as did the carers. This doctor sets out the rationale for acting in Mr A's best interest given that he had "an on-going empyema (pus in the pleural cavity) which was causing him to be physically unwell and this is adversely impacting upon his mental state. He has not improved despite a long course of oral antibiotics and the only way forward is to drain the pus".

A locum anaesthetist then visited the ward to see Mr A with a junior doctor. Accounts were presented to the SCR Panel by the Hampshire Autistic Society carer which is thought to be the most probable explanation of events.

The carer described that the locum anaesthetist came to see Mr A on the ward to explain the procedure. The carer explained that, due to autism and communication difficulties, Mr A would not understand the information being given. The anaesthetist said that they were going to take Mr A to the operating theatre and put in an intravenous cannula to give the anaesthetic. The carer explained that Mr A had a needle phobia and this would result in challenging behaviour from him and said that this had happened before. The anaesthetist reassured the carer and Mr A that this was the quickest way and they could distract Mr A whilst it happened. The carer highlighted that Mr A had received dental work and had been successfully anaesthetised using a gas mask to settle him in order to insert the cannula. The carer reported that the anaesthetist had agreed that, despite it being a much longer process, he would use this method.

Pre-medication was not discussed. Reports were given to the SCR panel that nursing theatre staff were not aware of Mr A's complex needs prior to his arrival in theatre. There are differing accounts of what happened in theatre and the locum anaesthetist has not been available to assist in the SCR, as he left the UK some time ago.

The carer described going into a room prior to the theatre with Mr A and when the anaesthetist arrived, he told the staff they would be inserting a cannula. The carer pointed out the previous agreement but the anaesthetist said that it would take too long. The anaesthetist attempted to approach Mr A from behind but Mr A saw the needle and became distressed and attempted to sit up. Despite reassurance from the carer, Mr A continued to shout so two hospital staff were reported to have held Mr A's arms against the bed. The carer made clear that this restraint should not happen. The anaesthetist stated that they had to insert the cannula otherwise the operation would have to be cancelled. Mr A continued to struggle and shout. The carer continued to ask the theatre staff to stop. At this point, the anaesthetist attempted to put the gas mask on Mr A's face from behind him but poked him in the eye with it. The carer was forced to raise her voice to try and make the anaesthetist listen. The carer asked the anaesthetist what he was doing and the anaesthetist was reported as saying that the mask didn't work. The carer explained that Mr A needed warning and was very frightened. A member of staff then intervened and stopped events and it was agreed that Mr A could return to the ward.

Mr A had been able to take some Midazolam (a sedative) during the event that the carer was asked to give him. However, insufficient time was given for this to take effect and Mr A remained non-compliant. Further staff attended and further limbs were held by additional staff brought in to assist. The carer estimates that about seven people were in the room around Mr A and the period of time in theatres lasted fifteen to thirty minutes. By the time the restraints came to a halt, Mr A was significantly distressed and he required calming down before he could be safely taken back to the ward.

Following this, the plan now was to take Mr A into ICU so he could be safely sedated and the procedure performed there.

A chest drain was inserted without event at 18.30 hrs. Mr A was sedated in ICU overnight. On 20th May 2010, a scan showed that the chest drain was in the wrong place. This was subsequently repositioned and a rib resection was performed.

Mr A's carers were less involved during this period as he was sedated but the ICU medical records show that he was stable and between 21st and 26th May 2010, several attempts were made to reduce the sedation and ventilation with varying success.

Throughout the admission, there was an on-going debate between the support carers and the hospital about payment for the carers being present.

There was no set protocol and this created tension, however, this situation was not uncommon across the wider NHS at this time.

Mr A was taken off ventilation on 26th May 2010. Mr A was stable though reliant on oxygen. His chest drain was removed (it had not been draining). His naso-gastric tube was removed, feed was stopped and all non-essential medical lines removed. (A naso-gastric tube is a small bore plastic tube that is passed from the nasal passage into the stomach which drains the stomach if a patient is unconscious or is used to provide medications.)

Mr A was transferred to the main ward at 12.00hrs on 26th May 2010 into a side cubicle. He was fairly drowsy and initially lying on his back. The doctor was asked to see Mr A as soon as possible for possible aspiration. (An aspiration is when secretions or vomit passes into the lungs and/or airway- this can cause serious respiratory problems). Mr A had vomited at around 13.30hrs with respiratory distress and his oxygen saturations levels dropped. The doctor recorded that he was not coughing much and questioned if Mr A was protecting his airway properly. A large amount of vomit was suctioned from Mr A's upper airway. Mr A was alternatively drowsy and agitated. Mr A required a nurse to constantly hold a mask over his face for administration of oxygen. Whenever Mr A was touched, he became agitated. The doctor concluded a probable aspiration and sought to discuss with ICU as he considered that Mr A was not protecting his airway and that he was very difficult to manage in an ordinary ward environment. A portable chest x-ray was aborted as Mr A was too agitated to comply.

The ICU team reviewed Mr A at 16.30hrs and declined a transfer back to ICU on the basis that Mr A was tolerating oxygen and was generally stable from a cardiovascular perspective (though he had an increased heart and respiratory rate). It was acknowledged by ICU that Mr A was difficult to manage from a nursing intensity point of view but that he did not require medical management in ICU.

However, Mr A was readmitted to ICU later that evening as the nursing staff were unable to provide the 1:1 care Mr A required.

He was discharged again a few days later. Back on the ward, Mr A required oxygen and medication and the carers said they would assist with this. A discharge planning meeting took place on 27th May 2010, though Mr A was not yet medically fit to be discharged from hospital. It should be noted that advance discharge planning, in appropriate circumstance, is in line with best practice.

On 29th May 2010, Mr A fell out of his bed and an incident form was completed. Mr A was made subject to a falls assessment. He fell on another occasion however there is no evidence in the records to indicate Mr A sustained injury during this fall. He was unwell but stable. The Physiotherapist managed to provide some chest physiotherapy for a very short period of time. Mr A was becoming more short of breath. The plan was to persevere with the oral antibiotics and oxygen. The attending junior doctor

was concerned and discussed Mr A's worsening condition with senior colleagues and ICU. The consensus was that another ICU admission was not appropriate.

At 20.45hrs, Mr A's deterioration was more marked. On 30th May 2010 at 03.50hrs, it is recorded that Mr A had deteriorated further. He suddenly stopped breathing at 10.15 hrs. There was no pulse and the doctor and next-of-kin were informed. The doctor certified Mr A dead at 10.45 hrs. Because a decision had already been made not to resuscitate Mr A, no attempts were made by clinical staff to revive Mr A.

The suggested cause of death conveyed to the Coroner was:-

- 1a) hospital acquired pneumonia;
- 1b) empyema;
- 2) autism and learning difficulties.

(On post mortem reports, "1a and 1b" refer to the terminal events resulting in death while "2" refers to any relevant underlying condition that may have contributed to the death.)

Hospital acquired pneumonia is a common complication of mechanical ventilation and Mr A had contracted this within the context of a period of planned ventilation.

A post mortem was held and the findings reflect the opinion given by the hospital for cause of death. A full inquest into the death was not deemed necessary by the Coroner on the information provided.

The SCR Panel noted that the issue of restraint in theatre was not raised by PHT with the Coroner and in line with good practice, it is expected that this would happen in future cases.

3. FINDINGS and RECOMMENDATIONS

The SCR panel identified key practice episodes in chronological order:

- A) Dental care**
- B) Change of care setting**
- C) Management of empyema and chest drains**
- D) Admission planning**
- E) Aborted anaesthesia and restraint**
- F) Application of the safeguarding process for vulnerable adults.**
- G) Communication around medical deterioration**
- H) Care coordination – factor of most impact**
- I) Mental Capacity Act considerations**

A) Dental care

Maintaining sound dental hygiene and dental health for Mr A was a challenge. He would not always allow carers to assist him in his dental hygiene and that meant that at intervals during his life, he required dental interventions as well as the usual dental check-ups. He did not tend to see the same dentist so there was not the continuity of care and rapport that is preferable, nor did Mr A always attend the same location for dental treatment due to a change of address and the fact that he needed a general anaesthetic for any dental work. The community service endeavoured to meet Mr A's special needs and act in his best interests and there are examples of best practice from the dental community service. However, taking into account all perspectives, including that of Mr A's next-of-kin and carers and other professionals caring for Mr A, there are learning points arising from the dental care and management he received.

There is compelling evidence that Mr A's behaviour changed after his GA for dental treatment in 2007. That is not to infer that there was any sub-optimal care afforded to Mr A during this treatment and the dental service was very open in reviewing this care episode when concerns were expressed by Mr A's next-of-kin. In the review, there was no indication that anything adverse occurred in the anaesthetic process itself but having had informal senior anaesthetic expert advice into the SCR, it is clear that it is possible that some cognitive change occurred during this anaesthetic that resulted in a different pattern of behaviour.

Within the SCR process, advice was sought from two experts in the field and research conducted. This has indicated that there is little research on the effect of anaesthesia on individuals with either severe cognitive impairment before surgery as most studies exclude patients with cognitive impairment. Another opinion expressed was that it is likely that there would have been a period of confusion and cognitive disturbance but the question is whether this would persist and have a permanent effect. It is also thought that the GA may have had a psychological impact that may be difficult to disentangle.

There is no consensus between professionals upon the causative affect the 2007 GA had upon Mr A. Social care put this marked change in behaviour down to a disruption in Mr A's routine necessitated by the dental treatment. However, the GAs and dental treatment on two earlier occasions did not cause this reaction and the evidence of Mr A's long term carers and his next-of-kin, who knew him best, is compelling. It was this change of behaviour that started a chain reaction that led to Mr A being moved from a long term and previously successful placement and this was a significant development for Mr A. It is fair to say that despite the efforts of many professionals, he did not recover the level of stability he had achieved before the move.

The community dental service have demonstrated that they had appropriate policies in place in 2010 to inform the service when dealing with patients who lacked the mental capacity to consent to treatment and/or had complex needs. However, when such issues were discussed before the panel, there did seem to be a slight confusion on the practical application of the Mental Capacity Act. There was reference to Mr A's refusal for treatment on one occasion which resulted in carers being requested to apply reasonable restraint, which they refused to do. Hence, treatment did not proceed.

There was also some concern that the view of the next-of-kin should take precedence. The next-of-kin's view is important and part of the decision making around best interest but the clinical decision whether or not to treat must be based on sound clinical rationale, preferably including the multi-agency team and, if required, an advocate.

Mr A had on-going dental problems throughout the last years of his life, which treatment did not entirely resolve. It is probable that he experienced a fair amount of dental pain, though it is well recorded that he could not always express his experience of pain or the severity. After 2007, Mr A's next-of-kin was also concerned about the possible impact of GAs upon Mr A and had a preference for tooth extraction rather than more proactive treatment to maintain and conserve his teeth. As it was, this was not successfully achieved until the hospital admission in May 2010, partially because of further attempts to treat more proactively, an aborted attempt to treat in December 2009 and the fact that Mr A's chest problems caused delay, in that the dentist needed to seek clarification whether Mr A was fit for a GA. Mr A therefore experienced dental pain and on-going problems throughout 2009. The dental plan over these last years of Mr A's life consisted of cleaning and hygiene advice to carers and fillings and extractions where necessary. The impact of Mr A's pain may not have been appreciated by the dental service given that no one dentist had the overview of Mr A's dental care.

Dental pain, if Mr A could express this, was generally treated with paracetamol. It is likely that he required stronger analgesia on numerous occasions but this was not fully addressed by the dentists, or indeed any of the agencies.

In terms of systems and governance, Mr A's dental care was impeded by a lack of continuity of care from the dental service. For one with such complex needs, this meant that the dental service was acting in isolation. There was no overall, proactive strategy to address the patient's dental care in order to avoid unnecessary treatments or move away from a reactive stance. Other agencies report a lack of communication between the dental service and others, even in health. The dental service seems to have been reticent in contacting the GP, although they did contact the Respiratory Consultant when Mr A needed treatment but they were concerned about proceeding in the light of his chest problem. Mr A's next-of-kin was very concerned about the on-going delay for Mr A's dental treatment and was raising concerns. The carers were doing all they could to move matters forward and take some co-ordination role under best interests but the meeting on 19th April 2010 was made less effective by the lack of attendance of key professionals, including the dental service.

RECOMMENDATIONS FOR THE COMMUNITY DENTAL SERVICE (CDS) - dental care

The recommendations a) to e) emanate from the CDS and the SCR panel endorse these recommendations. These are:-

- 1) To ensure that all CDS staff are aware of how to contact Learning Disability (LD) colleagues for their area.
- 2) Develop closer working relationships with LD colleagues.
- 3) Establish a programme of LD training for staff.
- 4) Embed LD dental protocol in everyday practice.
- 5) Involve LD specialists when appointments are not kept or no response to recall.
- 6) Involve LD colleagues to assist with behaviour modification for patients.

In addition, the SCR panel recommend:-

- 7) **CDS should review its practice to ensure continuity of care for complex cases.** This will support best practice for LD patients to have one main dentist rather than several to aid continuity of care and assist in greater understanding of the service user's special needs.
- 8) **CDS workshops around the application of the Mental Capacity Act.** That CDS reinforce the importance of the Mental Capacity Act in practice in terms of ascertaining consent and the role of the advocate.
- 9) **CDS to engage in best interest meetings.** That the CDS commit to attend best interest and/or safeguarding meetings and, indeed, understand that the service can call such multi-agency meetings where necessary.
- 10) **LD and complex needs Champion within CDS.** That there be an LD "champion" within the dental service who will ensure that the CDS's own recommendations and those of the SCR become embedded.

- 11) **CDS to adopt the passport concept.** This is a useful tool by which care to the service user is enhanced by the communication of key information about the service user, e.g. needle phobia.
- 12) **Improved interface with other agencies, particularly with primary and secondary care in health.** There needs to be more proactive communication within health, involving primary and secondary care, to more effectively, and in a timely manner, gain an overarching appreciation of the health issues being presented by the individual and closer working to ensure that the care plan in the dental service is more patient centred.

B) Change of Care Setting

The move from a long term residential setting to a new one was a significant event for Mr A, though it is clear that social care and others in the multi-disciplinary team did not make this decision lightly. Increased levels of support were tried but to no avail. As Mr A was social care funded, Hampshire Social Services were the commissioners of Mr A's placements.

The new team caring for Mr A were employed by the Hampshire Autistic Society (HAS) and, therefore, were deemed appropriate to care for Mr A in a care setting that afforded higher levels of care and behaviour management. A single placement was considered at this juncture but dismissed at this point, though it is unclear on what basis. Single placement bespoke packages of care are costly and also Mr A's next-of-kin supported the move to BR in favour of a single placement on advice.

What transpired very quickly in the transition work after Mr A moved was that HAS staff at BR had training needs to fully meet the requirements to care for Mr A and there was also a compatibility issue with another resident which prompted safeguarding meetings as well as a serious practical problem for staff managing Mr A at BR. Many of the incidents occurring were relating to another resident who himself was vulnerable. It is not clear to what extent staff skill sets or issues of compatibility were considered before the move. Certainly, after the transfer it became apparent the amount of training and support that HAS required such as de-escalation. This raises a real query whether BR was sufficiently tested out before making the decision to move Mr A there. Mr A's needs had become more complex. After the 2007 GA, Mr A's next-of-kin states his behaviour became more destructive from being a "gentle giant". This meant that compatibility with other residents needed to be considered carefully and risks fully assessed.

The move to BR was managed in such a way that a trial period was not accommodated. This was such a key but complex move for Mr A that a trial period would have been preferable.

The multi-disciplinary team worked hard to support HAS but even taking into account the expected reaction from Mr A as he needed to adjust, there were very early signs that the care setting at HAS was not suitable for Mr A. It is fair to say that Mr A did not ever really settle at BR. Mr A's next-of-kin described the environment as less homely than his previous placement. The Consultant Psychiatrist and associated team were closely involved with Mr A and medicines management for his behaviour through 2009 but toward the end of 2009, Mr A was displaying other physical health problems in addition to his dental problems and this was conspiring against him and created another layer of complexity around his behaviours. While a fast track application for continuing healthcare funding (CHC) was made later toward the end of Mr A's life in May 2010, an application does not appear to have been made for an assessment of CHC as Mr A's care needs became more prominent from November 2007. An assessment earlier on would have given a helpful and comprehensive assessment of Mr A's healthcare needs across the CHC care

domains and also if Mr A was considered CHC eligible, funding may have been available for wider choice around the next placement to ensure this was holistic and optimum to health as well as social care needs. One of the domains would have looked at pain control, for instance.

All the information around the severity of Mr A's condition indicates that any move, change in carers, routine or approach would destabilise Mr A's behaviour but by the end of 2009, his medical care needs were becoming much more prominent than his social care needs. This, however, did not trigger an early best interest meeting to review all aspects. Safeguarding meetings were held which focussed upon Mr A's incompatibility with another resident at BR. The consensus at those meetings was that HAS could not manage Mr A and the other resident and this was the driver to the decision to look to move Mr A on again. In this sense, the decision making around care setting became narrow and driven by the needs of another resident, not Mr A. This was the responsibility of social care and HAS but the precursor to this appears to be a lack of robust testing out before the move that BR would be the optimum environment for Mr A. Social care and HAS share responsibility for this. During this period, Mr A's next-of-kin was being advised and reassured that BR was the best option, which she accepted. Despite his lack of capacity and poor cognitive ability, Mr A did not have a separate advocate. This was suggested in 2008 but not achieved.

A Mental Capacity Act assessment was completed in May 2010 as part of a continuing healthcare assessment. At this point, Mr A was physically unwell and the assessment was driven by a desire to move Mr A to be considered for health rather than social funded care. At the time of Mr A's admission to PHT in May 2010, HAS were pressing hard to move Mr A. This is reflected in the safeguarding minutes which had become dominated by the issue and also the dialogue with the PHT to ensure that, on discharge, Mr A would be moved to a new setting. Mr A's next-of-kin was informed that this would be in Totten. Again the audit trail, consideration of placement in terms of choice policy, best interest and robust commissioning practice is not evident. Throughout the SCR process, there was some confusion as to where Mr A would be going post-discharge and assumptions made as to what his needs were likely to be. In fact, a discharge meeting was happening as he was deteriorating medically which demonstrated a real mismatch in multi-agency working. Until Mr A's medical condition stabilised, it was going to be difficult to assess what his care needs were going to be overall. It was, however, appropriate for social care to be looking toward a continuing healthcare care referral as Mr A's needs were veering toward being primarily health needs rather than social.

RECOMMENDATIONS FOR HAMPSHIRE COUNTY COUNCIL - HCC (LD Social Care) – Care setting

As indicated above, while Mr A did have NHS health input into his care, his placements were funded by social care, who were the responsible commissioners. There are some on-going developments around integration for the health and social care teams and this is reflected below. The Council

has the statutory lead role for safeguarding vulnerable adults. The safeguarding aspects are dealt with later in the executive summary.

The recommendations 13) to 16) are HCC's IMR recommendations:-

- 13) Where multi-professional meetings are called to discuss a complex case, if there is poor attendance, the service manager should be informed in order that sufficient information is made available to ensure effective outcomes.
- 14) The close working between the health and social care LD teams has led to a greater co-ordination of assessments, care delivered, and monitoring. This should be seen as a positive development and steps taken to ensure its continuation.
- 15) LD teams to ensure that those with LD going into hospital or having dental treatment have "hospital passports" and that there is understanding across the agencies on how best to use these. This is something for SHFT LD team also as the health and social care teams are not integrated as such but are co-located and work together.
- 16) To fully engage with the acute LD liaison post at PHT. The comments above re SHFT also apply here.

In addition the SCR makes further recommendations toward HCC and SHFT as set out below:-

- 17) **As commissioner, the HCC needs to review its choice policy for complex needs.** It is accepted by the SCR panel that Mr A needed to be moved and there is clear evidence that the previous placement had broken down. However, there are concerns as to the process used when considering a new placement. It is appreciated that social care will have come under some pressure to move Mr A but, nevertheless, there needs to be a fuller appraisal of all options for future placements which must be service user centred.
- 18) **HCC need to improve the audit trail for the decision making process around placements.** The responsible commissioner, as a matter of governance, must make the fullest consideration around best interest in attempts to secure a stable and long term placement. The system of commissioning an appropriate new placement was not robust, nor is there a sufficient audit trail or early consideration in 2009 of whether the health/social care needs were becoming so changed that continuing healthcare funding was appropriate. It does not appear that a bespoke and single placement for Mr A was explored fully.
- 19) **HCC need to consider, where necessary, placement trials, contingency planning and test of compatibility.** The responsible commissioner must ensure that commissioning risk is managed by the above with careful consideration of a new placement for a service user

with such complex needs as Mr A either by trialling the placement or having contingency in place. This should be an inherent aspect of any placements for service users with needs as complex as Mr A. A trial will, in many cases, indicate any incompatibility issues.

- 20) **HCC to review guidance around the use of advocates.** Social care should lead the consideration of the use of an advocate when instigating a major change for the service user such as ending a long term placement. This was an omission.
- 21) **HCC social care and other agencies such as SHFT should retain a current placement until such time as any transitional training needs are met and shown to be fit for purpose.** At the time of moving to BR, the staff had marked training needs. While these were addressed by a number of agencies and support provided, it is clear that HAS were ill equipped to manage Mr A's behavioural difficulties and were uncomfortable with the challenges with which he presented. HAS were quick to want to move Mr A. This was the worst scenario for Mr A and possibly could have been avoided by more careful consideration between HCC and HAS at the outset.

RECOMMENDATIONS FOR HAMPSHIRE AUTISTIC SOCIETY (HAS) CARE SETTING

The IMR from HAS does not define any learning points of its service in connection with Mr A's care.

The IMR does state that it can and will undertake "joint working programme with PHT to increase knowledge and awareness and influence working practice around the needs of people with autism within the hospital environment."

However, the SCR found a number of learning points for HAS:-

- 22) **HAS needs to review its agreement to provide a placement criteria.** HAS accepted Mr A before they were fully trained and had practical evidence via a trial period that they could meet his needs with the skills set they had at BR, or had fully assessed compatibility. It is recommended that HAS review their process for this.
- 23) **HAS develop an escalation procedure** - when carers are needing to heavily use services from the GP or Out of Hours service for an individual such as Mr A and there are on-going concerns about progress and best interest, carers at HAS should escalate their concerns to the attention of the health and social care LD team for management and advice. The escalation process within HAS could also be improved upon in that these matters should be brought to the attention of senior management at HAS quickly, who can then engage other agencies at a higher level if necessary.

C) Management of Empyema and Chest Drains

This has been one of the most difficult issues for the SCR panel to consider but goes to the heart of how the various components within health as an agency work and communicate around the individual. Primary and secondary care all have responsibilities within their respective roles but the best practice is to ensure that this stays patient centred. Mr A started to develop chest problems in November 2009. The first port of call around this for carers was the GP. Mr A was registered with Gosport Medical Centre but there was no continuity of care as numerous GPs were involved as well as the out-of-hours service. When Mr A became unwell with what was diagnosed as a chest infection, he was prescribed antibiotics. Mr A seemed to make a recovery but in January he became unwell again and again a chest infection was diagnosed by the GP on 15th January 2010. Antibiotics were prescribed but Mr A's condition worsened. It was later established that Mr A had an empyema. The GP related IMR states that empyema is difficult to diagnose.

Carers at BR record that the GP actively decided against a hospital admission in November 2009 and on 15th January 2010 and this was also borne out by a discussion with the Consultant Psychiatrist. Carers at BR state that they needed to contact the GP often about Mr A and that the responses varied. Some carers state they were made to feel "a nuisance" when seeking medical attention or advice for Mr A. The GP service deny that this is a true impression of their input. The carers considered that Mr A required acute medical care on 15th January 2010. He was acutely unwell and had lost a significant amount of weight. However, the GP considered that Mr A would find it difficult to tolerate a hospital admission and this informed his decision to treat conservatively with antibiotics in the community. The GP in question states that he would not see this as an act of discrimination toward Mr A because of his special needs but merely a professional judgement. The GP states that his starting point would be what would be the course of treatment for a patient who did present with complex needs and then assess what is in the patient's best interests.

In January 2010, a chest x-ray identified a left empyema of unknown duration and the GP referred Mr A to a Consultant in Respiratory Medicine at PHT on 22nd January 2010. Mr A was referred as an emergency patient as he had become acutely unwell. The referral letter was short in detail about Mr A's complex needs but Mr A was accompanied by one of his HAS carers. From this point, Mr A came under the care of the Respiratory Consultant while at PHT. The Consultant admitted Mr A and a plan was made for a chest drain to be inserted under a GA. This was considered in discussion with Mr A's carers, next-of-kin and Consultant Psychiatrist. There was an appreciation pre-operatively that Mr A would more than likely pull the chest drain out when the GA wore off and Mr A woke up. The Respiratory Consultant appears to have explored sedation and an ICU bed for Mr A post-operatively but Mr A was returned to the ward after his initial recovery and soon pulled the chest drain out. The clinical indication for the chest drain was appropriate but there seems to have been poor planning as to how the chest drain would be managed and kept in situ despite the carers expressing concern that Mr A

would pull this out. Subsequently, Mr A was discharged from hospital with an on-going chest problem and the GP was advised to treat with antibiotics in the community and keep things under review.

The next time Mr A received hospital care for his empyema was on 18th May 2010. By then, he had had a few outpatient appointments with the Respiratory Consultant and had had a considerable number of weeks of antibiotics but remained unwell. His poor physical condition was impacting greatly on his mental state and behaviour and was complicating further treatment for on-going dental pain and problems. By May 2010, Mr A had been physically unwell for a considerable amount of time. He had not had any real benefit of the chest drain in January, the purpose of the chest drain being to drain pus from the pleural cavity thus reducing pain and other symptoms. While the concerns by the GP around the difficulties of an admission for Mr A are legitimate, by the time Mr A was admitted again in May 2010, he was more frail and his general condition worse than in the January. It is regrettable that the January admission was not better planned out from a post-operative perspective and also that Mr A waited for some months before he had further active intervention, although during this time he was being monitored by the Respiratory Consultant through outpatients appointments. The carers state that by then he was very unwell and despite attempts by them to hold a professionals meetings to address this, neither the dentist, GP nor the Respiratory Consultant were able to attend. While the Consultant Psychiatrist was endeavouring to find solutions with the carers to manage Mr A's behaviours, he conveyed that Mr A's physical state was such that it was impacting greatly upon Mr A's moods and behaviours. There was also a sense by the carers that Mr A had pain from several sources, including his chest and teeth, but he could not communicate this well. The GP has the best view of how Mr A was faring in the community and was certainly being contacted a great deal. The GP states that the clinical leadership for Mr A's chest problem lay with secondary care and the Respiratory Consultant. During discussion with the Independent Chair and Author of the SCR panel, the Respiratory Consultant stated that the GP manages the patient in the community and could have referred Mr A for another admission at any time if there were concerns. As it was, the management of Mr A's chest condition relied upon many weeks of antibiotics of a duration much longer than the Respiratory Consultant, and also expert advice provided to the SCR, considered was optimum.

RECOMMENDATIONS FOR SHIP PCT CLUSTER (CORE HOURS GP SERVICE) re: management of empyema and chest drains

The GP service (core hours) refers to the main practice at which Mr A was registered and those at the practice who were involved in his care. This service was the least represented on the SCR panel as unfortunately the Medical Director nominated was unable to attend most of the panel meetings or input in any major way. This was a difficulty that the panel overcame by meeting with the GP service direct to ensure that the practice was updated as well as the IMR author. This SCR suggests that SHIP reconsider its representation on any future SCR panel. The service did, however, produce

an IMR and the recommendations are mainly around engagement with safeguarding rather than an analysis of the overarching input by the GP into the care plan. The IMR recommendations are captured in this executive summary in the safeguarding section.

The recommendations emanating out of the SCR for the GP service around management of the chest condition are as follows:-

- 24) **The Practice needs to demonstrate process around best interest considerations rather than professional judgements in isolation.** The GP was presented with a patient who was complex, vulnerable and lacked capacity. This calls for a multi-agency care planning of which the GP should be a part. This will provide the GP with the fullest picture of what is happening with the service user to enable fully informed clinical decisions to take place.
- 25) **The Practice needs to develop a robust process to respond to frequent contacts and respond accordingly.** The practice states that it can detect frequent patient contacts in core and out-of-hours. In this case, despite a major amount of contact and concern expressed by HAS to the practice, conservative treatment persisted until such time as Mr A had deteriorated. The responsibility and accountability for Mr A's care lay with primary care while Mr A was in the community. The frequent contact should have elicited a full review of Mr A's overall physical condition, including medicines for pain relief and whether the antibiotics were actually having any positive effect. The carers are clear that from November 2009 until his death, Mr A's physical health did not improve. This is also borne out by objective indicators such as weight loss, increased difficult behaviours, pain and distress.
- 26) **The Practice needs to have stronger communication lines with secondary care in complex cases.** This will support GP escalation even where secondary care are seemingly taking a conservative approach. Equally the communication from secondary care needs to be more timely and improved.
- 27) **The Practice needs to develop stronger clinical leadership for vulnerable adults with complex needs.** A number of different GPs had input into Mr A's care in and out-of-hours but no one GP appears to have the overview and, therefore, grip the medical management in the community. The GP was pivotal to this.
- 28) **Medicines management audit for complex cases.** The SCR panel recommend a medicines management audit into complex care cases at the Practice where the GP is the primary prescriber. Mr A's pain relief management was minimal and he was prescribed arguably excessive courses of antibiotics despite no objective evidence that they were having any positive effect.

- 29) **Regulatory compliance.** The care pathway for Mr A within primary care and his management was not regulated by the Care Quality Commission in 2010. Registration will be required by April 2013. It is worth noting that the above recommendations, as well as those relating to safeguarding which come later in this executive summary, will provide sound evidence of regulatory compliance under CQC standards.

In primary care, the Primary Care Trust has commissioned the provision of **out-of-hours GP services**. This means that in core hours, the main GP practice within which Mr A was registered would deal with health needs but outside core hours, this would fall to an out-of-hours service. The out-of-hours service stated in their IMR that they have a system by which frequent contacts are detected and this is fed back to the main GP.

The overall management of the chest drain around the January 2010 admission was not dealt with by the PHT IMR but the SCR panel recommend:-

- 30) **Involving carer's in the planning of care.** During admission and outpatients visits, the organisation need to ensure that – where the individual is complex and cannot express an opinion – the carer's views and concerns are given sufficient weight in planning care
- 31) **Attendance at best interest meetings.** Clinical leaders should attend all best interest meetings or send a deputy, however it is recognised that attendance at short notice, presents significant problems for senior staff who have planned clinics/surgeries. It is therefore important that these meetings are planned at a suitable time/venue. The Consultant in this case did not attend a key meeting in April 2010 and the carers were not making progress in obtaining further medical treatment, in addition to antibiotic therapy, for Mr A. By the time Mr A was admitted in May 2010, he was very unwell and frail.

D) Admission Planning

As stated above, there was confusion as to whether Mr A's second admission in May 2010 was an emergency admission or planned. It has transpired that it was not emergency admission and that the Respiratory Consultant had anticipated an admission. The Consultant states that he did ring around other professionals to plan for this admission but there is no record of that in the medical records or recollection from other professionals. In fact, when the carers did attend what they thought was an outpatient appointment, they had no idea Mr A would be admitted.

Given what was known about Mr A and the need for preparation, this put the HAS carers and Mr A in a difficult situation when he was admitted. There have also been clear indications before the SCR panel that both nursing and medical staff at PHT did not understand or appreciate the special challenges presented by Mr A and that the fact that no pre-planning had taken place was going to be a real barrier to providing care to Mr A safely.

A more appropriate approach would have been a professionals meeting after the January 2010 admission involving the GP and all other relevant professionals, and including the Respiratory Consultant, to discuss the challenges in providing acute care and treatment to Mr A safely. Mr A had been unwell since at least November 2009, so it was already known that he had a serious chest problem, though it would appear that a chest x-ray was not obtained until January 2010. A plan should have then been devised as to what was in Mr A's best interest in terms of a care plan and a careful plan set out as to how that care plan was going to be achieved to ensure that Mr A was not discriminated against or treatment delayed because of his complex needs. This should have included the hospital passport system to better understand Mr A's needs in a meaningful and consistent manner. Further, if sedation was to be part of the post-operative plan, the hospital needed to have consideration to the Deprivation of Liberty standards within the context of the Mental Capacity Act. PHT confirm that they did not have procedures for this at the time.

Further, the Respiratory Consultant did not attend or send a deputy to the best interest meeting on 19th April 2010 so he was not fully informed, however he will have understood the challenges from the experience in treating Mr A in January 2010.

The recommendations that relate to the management of the empyema and chest drains apply equally to admission planning.

E) Aborted Anaesthesia and Restraint

The circumstances around the attempts to anaesthetise Mr A on 19th May 2010 are set out above in the narrative. This is a key practice episode in which a significant amount of learning is needed. This revolves around legal, ethical and professional conduct issues and the management and restraints so described are a matter of grave concern. This SCR was unable to interview the anaesthetist involved but accepts the account given by the HAS carer for the SCR. For the anaesthetist to have conducted himself in such a way that went against all advice as to how best to manage Mr A and then to lead to restraints of a vulnerable adult raises serious conduct issues. Restraint is a last resort and even if it is in the best interest of patient to use restraint, this must be proportionate.

The anaesthetist had a number of options open to him concerning Mr A. A pre-medication to relax Mr A was one, as was simply following the advice of the carer and tentatively applying a gas induction. In proceeding as he did, he put Mr A at risk and put the carer in an impossible position. He also led other staff to an inappropriate restraint upon Mr A, though as qualified staff they are accountable in their own right. A restraint upon a patient without appropriate reason is technically an assault upon that patient. This episode showed a lack of respect, dignity and care toward Mr A which, in itself, was a physical abuse toward a vulnerable adult who lacked mental capacity. Mr A must have been very traumatised by the event and there is nothing in the internal investigation or IMR material that has been provided by the hospital that reflects the seriousness of the matter. The anaesthetist was permitted to leave the UK without being challenged about his behaviour or conduct and this represents a patient safety risk should he seek to practice in the UK again. Other staff involved appear to have lacked the training to say no to being involved in the restraint and this too is a cause of major concern. It was not until another doctor/nurse intervened, having heard Mr A shouting and in distress, that the approach instigated by the anaesthetist was brought to a halt.

RECOMMENDATIONS FOR PORTSMOUTH HOSPITALS NHS TRUST – aborted anaesthesia and restraint

The recommendations from this agency were lifted from the initial internal report prepared by the Trust as part of their serious incident investigation processes. This is part of the Trust's governance framework. The terms of reference for that report using Root Cause Analysis were very narrow but have been expanded upon to an extent for the IMR which was a rewrite of the initial RCA report.

The recommendations in the IMR are:-

- 32) Coached reflection of the anaesthetist who led the restraint upon Mr A. This is reported as completed on 29th July 2010.

- 33) One year plan (though 2011) to upskill targeted staff groups toward learning disability, adult safeguarding, joint working, best interest considerations, use of Consent 4 (form for those lacking mental capacity to consent) and early involvement of advocates.
- 34) Sensory friendly environments assessments, planned for October 2011.
- 35) Single point of access for booking theatre sessions (achieved June 2010).

In addition, the SCR panel recommendations are:-

- 36) **Review of the systems which deal with performance management and conduct issues for medical staff.** The SCR panel are not assured that PHT managed the restraint incident effectively and, in particular, the approach taken to offering coached reflection to the anaesthetist involved, was not considered adequate by Panel members. This is a serious concern for patient safety and raises issues as to how such events involving medical staff are managed.
- 37) **Review Governance framework to align safeguarding and Serious Incident Requiring Investigation policy.** The above exposes an important gap in the governance framework for PHT, as does the fact that the restraint was not initially identified as a serious matter by the Serious Untoward Incident guidance used by the NHS. The Serious Incident report produced therefore was limited in terms of content, specifically in relation to the restraint.. The SCR Panel consider this issue should have been viewed as a Serious Incident and recommend that PHT review their safeguarding policy to align with the Serious Incident Requiring Investigation policy.
- 38) **Assurance relating to staff management of patients with complex needs.** It is apparent that nursing staff at PHT are being developed in an appropriate way to increase skills toward the management of complex needs. However, the SCR is not fully assured that this extends sufficiently to medical staff.
- 39) **Use of hospital passport and on-going training.** PHT assure the panel that this has been progressed proactively but this seems to be nurse led. Medical staff, including consultants and anaesthetists, should be including using the passport and also undertake the upskilling programme being led by the Patient Experience lead at PHT. This should continue to be progressed multi-agency.
- 40) **Consideration of premedication for complex cases.** Given the heightened anxiety that learning disability patients may experience around anaesthesia, premedication should always be considered, in these cases, on an individual patient basis.

- 41) **Guidelines for use of restraint.** The report provided to the SCR panel outlining the coached reflection provided to the locum Anaesthetist, evidenced that there were no guidelines at the time, for staff covering the use of restraint outside of the Emergency Department. The SCR Panel have seen evidence that this situation has been rectified by PHT

F) Application of the Safeguarding Process for Vulnerable Adults

There is a Pan Hampshire policy and system for safeguarding vulnerable adults. This is in accordance with the guidance in place in 2010 at the time of Mr A's death. The lead agency is the local authority and there is a formal process to deal with safeguarding alerts and referrals. Mr A was subject to a number of safeguarding alerts throughout the latter years of his life and this was almost always related to his behaviours, in that this could put himself and others at risk. Each alert or referral should be managed as an individual case but there is a common theme of the safeguarding documentation seen, to deal with several individuals in one meeting, and certainly this is the case in 2009 and 2010 when Mr A and another resident at BR were presenting staff with difficult management problems. The "bunching" of safeguarding concerns of more than one individual in the way described is not good practice. It takes the focus away from a holistic consideration of the vulnerable adult as an individual and draws the safeguarding meeting and agenda toward a narrow perspective. While a safeguarding meeting should deal with the subject matter from which the alert emanated and this may involve other individuals, the focus should be on the person for whom concerns have been raised through the safeguarding process.

Another learning point and finding of this SCR is that the safeguarding boundaries became confused at times and presented more as a planning meeting rather than robust risk assessment of the individual and the environment. At some points, the Chair of the safeguarding meeting is almost acting as supervisor to the professionals and this is not part of the role. What occurred was a loosening of the formalities that should be brought by the safeguarding process and this meant it lost potency.

The other aspect of safeguarding that is a learning point is the failure of the hospital to take the restraint event through a safeguarding process. This was a serious omission and indicates that despite the HAS indicating its expectations, the systems at this time at the hospital were not sophisticated in terms of recognising a safeguarding alert and then processing this through the formal channels. While the hospital did proceed to an internal investigation, this in itself was graded at a low level because it was considered not to meet criteria set by the National Patient Safety Agency.

RECOMMENDATIONS TO PRIMARY CARE (GP's) – application of safeguarding process

The GPs' IMR from SHIP Cluster for the SCR set out the following recommendations which the SCR panel endorse:-

- 42) General Practitioners (GPs) should receive training in safeguarding adults and their roles and responsibility in relation to this. Liaison with the Local Medical Council (LMC) should be robust to secure their support for this.

- 43) Practice managers and GPs must decide how they will be able to engage in safeguarding adult's meetings in relation to their patients.
- 44) The Hampshire Multi-agency Policy and Procedures, when reviewed in the short term, should include consideration of clarity over the role and responsibility of GPs in the safeguarding adults process.
- 45) Practices need to develop their own policies for safeguarding adults where these do not exist. Work with the LMC may assist in developing core policy which can be tailored to local need.

In addition, the SCR panel makes the following recommendations:-

- 46) **Review of safeguarding process and knowledge.** All agencies should refresh their understanding of the safeguarding vulnerable adults process; what constitutes abuse; thresholds; and be clear that when a safeguarding alert or referral is raised, this needs to be passed through due process and dealt with as an alert specific to an individual with separate consideration, actions and minutes. Safeguarding vulnerable adults is everyone's business and, as such, all agencies need to know how to escalate an alert even if other agencies fail to act. It should also be understood that a safeguarding strategy meeting is not the same as a best interest meeting under the Mental Capacity Act, though one can inform the other of course.
- 47) **Safeguarding Meetings Chairs Training.** It would be helpful to remind all safeguarding adult Chairs of the above and refresh understanding around the role of the safeguarding Chair and the accountability framework for this role.

G) Communication around Mr A's Medical Deterioration

Mr A's care pathway post-operative to the insertion of the chest drain in May 2010 is set out in the above narrative. Mr A was initially cared for in ICU post-operatively after the aborted anaesthesia. Mr A was extubated and then transferred back to the ward. Mr A became unwell very soon on return to the ward and was transferred back to ICU. Mr A had hospital acquired pneumonia, which is a well known complication of ventilation, and the chest drain that had been inserted on 20th May 2010 had not been successful due to its positioning. There had been further treatment to remedy this but this gave a poor outcome. Mr A's chest was, therefore, a risk to him developing a more systemic sepsis and by 30th May 2010, he was poorly oxygenated and hypoxic. This raises issues around end of life care, management and risk of aspiration and family liaison. Mr A's next-of-kin inputted into the SCR that she did not realise until suddenly at the end how unwell Mr A had become and while she understood the decision not to transfer Mr A back to ICU, the deterioration and change of emphasis toward Mr A not being for resuscitation and palliative care was very sudden for her. This leads to the question of communication with the family around some of those clinical decisions and the records indicate that decisions were made and then communicated to Mr A's next-of-kin rather than made with her.

RECOMMENDATION FOR PHT - communication of a patient's condition

- 48) **Collaborative decision-making.** In accordance with the NHS Constitution, a patient should receive information about his medical condition to enable him/her to make informed decisions. This includes the patient being involved in decision making as to his/her treatment and choice and to have an input to the care pathway. Where the patient lacks the mental capacity to do so, family members can play a part, but also formal advocates need to be considered. In the case of Mr A, hospital staff had sought advice regarding whether an independent mental capacity advocate was appropriate from an external advocacy provider and it was confirmed that this it was not. Communication to family members should be collaborative discussions in nature to afford the relative/advocate to input before clinical decisions are made. This is particularly important for decisions around withholding and/or withdrawing care, including "do not resuscitate" orders.

H) Care Co-ordination – the factor of most impact

Mr A had a multi-disciplinary and multi-agency team working around him drawing expertise from health and social care, but the co-ordination of all the strands of care to secure a holistic and well-structured approach was poor. The best co-ordination was in the community team for psychiatry led by the Consultant Psychiatrist who monitored and sought to maintain a dialogue with the carers, community team and GP throughout. The Consultant Psychiatrist's rationale around medication is easy to follow and there is good evidence of sound medicines management. The senior community nurse also worked closely with the Consultant and pulled in other professionals on a needs basis.

HAS are also to be commended to have sought to bring all agencies together in April 2010, in the face of very serious concerns about Mr A's health, welfare and the best care environment, but driven by the on-going difficulties and the need to move Mr A on.

Despite this strong management of the psychiatric care, the general medical management and leadership offered by Mr A's GP practice was disparate and reactive. The carers report a huge number of contacts they made with the GP service, in and out-of-hours, but describe having real problems at times in getting the GPs to take their concerns seriously and they were left feeling they were seen as a nuisance. There were a high number of contacts recorded with the GP practice and out-of-hours and yet this high level of contact does not seem to have triggered a consideration of why there were so many contacts and what this may be indicating about Mr A's health and wellbeing. Mr A's GP practice were the lead clinicians in the community and should have had a pivotal role to play.

That is not to say that the GP needs to be the care co-ordinator. In a Care Programme Approach (CPA), commonly applied in mental health services, this is often a nurse or social worker. What is important, however, is that the GP had a strong overview of Mr A's care and his health to ensure that all relevant services were acting in a co-ordinated manner in Mr A's best interests. There was no evidence of the GPs undertaking a pain review of Mr A or a review of medicines management for his dental or chest pain.

This lack of understanding of each other's role at a multi-agency level and then the lack of co-ordination meant that Mr A's care drifted and much of the care provided was reactive rather than proactive. The GP was not keen to refer Mr A for a hospital admission knowing this was a challenge rather than identifying that Mr A required this despite the challenges and seeking to actively work with the other agencies to overcome these challenges by planning and securing a co-ordinated care plan.

The GP service were also disengaged from the safeguarding process and agenda regardless of the fact that this is a core consideration when being involved with an individual with such needs as Mr A. While the lead agency for safeguarding is the local authority, other health professionals are expected

to play an active part as professionals in safeguarding meetings. They are required to make the time to do so and yet this SCR clearly identified that neither Mr A's main GPs or out-of-hours gave safeguarding sufficient priority. This situation is untenable and meant that the GPs involved with Mr A were "out of the loop" for periods of time when some key issues were being discussed and actually needed GP input.

When agencies were asked during the SCR who was leading the overall care plan for Mr A, the agencies named each other or didn't know. Many agreed it was unclear who had the overview for Mr A and accepted this was impacting upon the management of his care across all elements. A CPA approach is adopted in complex care cases to good effect but even then there has to be a good understanding between the agencies of each other's roles and boundaries.

RECOMMENDATION TO ALL AGENCIES - care co-ordination

The SCR panel was struck by the lack of care co-ordination for Mr A. That no one professional or agency had the overview was detrimental to Mr A and has allowed a number of agencies to take a view that they did not have full responsibility and accountability toward Mr A. While some agencies endeavoured to work together around certain needs Mr A had, the agencies that he needed to support him were unable to properly come together in a meaningful way in his best interests.

The IMR from Southern Health NHS Foundation Trust (SHFT) is very helpful in setting out its learning points and these are set out below as endorsed by the SCR panel:-

- 49) **Care Programme Approach (CPA) adoption for complex learning disability clients.** That a Care Programme Approach (CPA) be adopted as a framework for service users with complex needs, such as in this case. This model of care is commonly used in mental health services and what underpins this is a care co-ordinator who has the overview of the services required by the service user across the agencies and supports partnership working and "follows" the patient through the system. The findings are clear that while many services were inputting into Mr A's needs, the overall management cross agency was disparate and lacked co-ordination. A recent update indicates that the CPA model is being tested but requires evaluation.
- 50) **Use of Risk assessments.** Formal and comprehensive risk management plans should be evident and include medicines management. (a recent update indicates this is well progressed).
- 51) **Health action plans and annual health checks.** All service users with complex needs such as Mr A should have health action plans and annual health checks in accordance with national expectations.

- 52) **Strategic development.** That the strategic work of the Health Action Group and the Health Improvement Project continues to address the significant areas where the care of people with learning difficulty falls short of quality standards that should be expected and to avoid discriminatory practices. (A recent update indicates that this is on-going).
- 53) **Specialist posts in acute hospitals.** That there be a continuation of the posts supported by SHFT, namely Strategic Health Facilitators and for PHT Acute Liaison Nurses, to improve outcomes for those with learning disability and complex needs. The use of the liaison nurse is very helpful though evaluation indicates this is very much a part time service. The service needs to be expanded and have a higher profile with relevant families.
- 54) **Timely Information sharing.** That the process of transferring medical records and, therefore, the sharing of information is achieved in a timely fashion.

I) Mental Capacity Act (MCA) Knowledge and Consideration

A theme that runs throughout the care pathway for Mr A is both single and multi-agency understanding of the Mental Capacity Act 2005. While training has been rolled out to professionals within health and social care, it is apparent in the SCR consideration around Mr A that the appropriate practical application of the Act was lacking across the agencies. The impact upon this for Mr A was that despite his lack of mental capacity and severe cognitive impairment, Mr A was not subject to a formal and comprehensive multi-agency consideration of best interest. While a number of single agencies clearly sought to assist Mr A moving forward, the structured approach of the MCA and its essential safeguards were simply not enacted. This meant that the care pathway was not co-ordinated nor considered fully within legal parameters.

While Mr A had a supportive next-of-kin for whom an advocate was arranged, Mr A could have benefitted from the input of an independent advocate in his own right given some of the decisions concerned serious medical treatment and the provision of longer term accommodation. Safeguarding meetings were taking place but these cannot take the place of a fully co-ordinated MCA best interest meeting which, by its virtue, also considers any deprivation of liberty issues. This was very relevant to Mr A given that chemical sedation was used to manage Mr A during the May admission. That is not to say that sedation cannot be used and, in fact, arguably, had sufficient best interests been considered in January, sedation may have been helpful at that point to ensure the chest drain stayed in place and timely and effective treatment secured. However, in such circumstances where the patient is mentally incapacitated, deprivation of liberty should have been considered.

As it was, the multi-agency care around Mr A was often reactive and his medical treatment after the January medical intervention of antibiotic therapy continued for some considerable time. Though the Respiratory Consultant was seeing a snapshot at intervals, the carers were very clear to the GP, through many communications in core and out-of-hours, that Mr A had ongoing and persistent medical and behavioural symptoms that were causing him pain and distress. Conservative treatment was predicated on the basis that it was not in Mr A's best interest to be readmitted to hospital to resume the treatment that failed due to a lack of best interest planning in January. This arguably created a health inequality toward Mr A. A multi-agency best interest meeting would have brought all professionals together to work in partnership and devise a plan that would have best afforded Mr A the care that meant that he could have been admitted to hospital quickly and safely with well planned provision for his complex needs to ensure that he was then able to receive the medical attention he required. The GP was the lead clinician in the community and could have facilitated a proper consideration of best interests and ensure that secondary care were more fully appraised that Mr A was not improving. Despite the high level of contacts, a more considered approach was not triggered. This created great frustration to those

who were caring for Mr A on a day-to-day basis and looked to other professionals for leadership and guidance.

There are occasions under the MCA, such as in complex cases, where the Court of Protection's involvement can be helpful as a safeguard and an endorsement of a plan of care. This was not something that was considered and the reason for this was that no single agency or the multi-agency team were fully co-ordinating care to Mr A nor did they appear to fully appreciate the provisions within the MCA and apply them in the practical setting for Mr A. HAS did seek to hold a professionals meeting but due to short notice given, was unable to secure the attendance of key professionals. This meeting did not achieve its objective. By the time that Mr A was admitted to hospital, despite monitoring in the outpatients department, he had been unwell for some considerable time. He had also been unable to have further dental treatment due to the concerns around his chest condition. The SCR therefore finds that the lack of appreciation and practical application of the MCA had a detrimental impact upon the care pathway afforded to Mr A.

RECOMMENDATIONS TO ALL AGENCIES - MCA knowledge and considerations

- 55) **Multi-agency MCA and DOLs training.** Most agencies involved in the SCR had had some form of training on this crucial legal framework for those who lack capacity. However, application of the principles of the MCA and Dols were not well applied and this indicates a lack of understanding in application. It is, therefore, recommended that further training is provided soonest. This should be scenario based, applying the MCA and Dols rather than the bare principles, and be multi-agency to increase understanding of roles and how and when to escalate to the Court of Protection. PHT have demonstrated through assurance evidence that progress is being made in this area.

The other agency involved with Mr A for a very short period was TPH , whose help was sought to support Mr A in hospital. However, due to the fact that Mr A spent some time sedated in hospital and then deteriorated quickly, the input from TPH was minimal. TPH state that should a similar situation arise again, TPH staff will endeavour to agree a more precise action plan with a clear named contact person within the hospital team with whom to liaise.

The fact there is now an acute LD liaison nurse in place at the hospital will hopefully actively improving standards for those with learning difficulties and complex needs. Recent evaluation evidence (" Has the Implementation of a Learning Disability Service improved the experience of patients and their Carers with Learning Disability, within an acute hospital setting") demonstrates good progress in this area. Its recommendations include:-

1. A wider service – currently the role of the LD liaison is a part time resource and the evaluation report indicates a wider service is needed to offer more than a simple core hours service and to reflect the

complexities of some cases which require increased time and support in and outside core hours.

2. That the LD nurse role needs a much higher level profile so that patients, their families and carers are clear that the service is available. The report recommends an advertising initiative of the service in key health and social care areas and local news outlets. The report also recommends looking at the possibility of adding the LD contact details to letters being sent to those with LD.
3. The evaluation evidence demonstrates that the role and remit of the LD nurse is very broad at present, but as this develops it is anticipated that it will become more defined and targeted.
4. The evaluation report indicates that while positive action had been taken to educate nurses around the needs of patients such as Mr A there is still much to do. The evidence of education of nurses is much stronger than that of medical staff. For outcomes and the patient experience to be improved, clinicians also at all levels need to have the requisite understanding of best interests, the care environment and the importance of a planning phase. (Interestingly the evaluation report does not refer to “hospital passports” which are a useful tool in understanding an individual’s complex needs and requirements on admission.) It is recommended in the evaluation report and the SCR endorses this, that the effectiveness of current training in this area needs more exploration and that one of the considerations is whether to include people with learning disability and their Carers in the training.
5. Within the training, it is recommended by the evaluation report that communication skills for staff caring for LD patients need to be developed further and that the LD liaison nurse can support on this. This also extends to handovers to carers and other staff.

It should be noted that during the SCR, it was apparent that many professionals in their specialist fields endeavoured to follow best practice to care effectively for Mr A but they were hugely hampered by the lack of care co-ordination and understanding as indicated above. It is therefore imperative that the work around CPA continues to be strongly led and then formally evaluated so this can be effectively implemented with the positive engagement of all agencies.

4. Summary of Key Recommendations

Delivery of recommendations will be the responsibility of each organisation named below and this will be monitored by the Hampshire Safeguarding Adults Board.

Rec No	Page No	Recommendation	Responsible Organisation
1	15	To ensure that all CDS staff are aware of how to contact Learning Disability (LD) colleagues for their area.	Community Dental Service (CDS)
2	15	Develop closer working relationships with LD colleagues.	CDS
3	15	Establish a programme of LD training for staff.	CDS
4	15	Embed LD dental protocol in everyday practice.	CDS
5	15	Involve LD specialists when appointments are not kept or no response to recall.	CDS
6	15	Involve LD colleagues to assist with behaviour modification for patients.	CDS
7	15	CDS should review its practice to ensure continuity of care for complex cases	CDS
8	15	CDS should run workshops around the application of the Mental Capacity Act	CDS
9	15	CDS should ensure engagement with Best Interest meeting Engagement	CDS
10	15	LD and complex needs Champion within CDS	CDS
11	15	CDS to adopt the passport concept	CDS
12	15	Improved interface with other agencies, particularly with primary and secondary care in health.	CDS
13	17	Where multi-professional meetings are called to discuss a complex case, if there is poor attendance, the service manager should be informed in order that sufficient information is made available to ensure effective outcomes.	HCC LD Service
14	18	The close working between the health and social care LD teams has led to a greater co-ordination of assessments, care delivered, and monitoring. This should be seen as a positive development and steps taken to ensure its continuation.	HCC LD Service

Rec No	Page No	Recommendation	Responsible Organisation
15	18	LD teams to ensure that those with LD going into hospital or having dental treatment have “hospital passports” and that there is understanding across the agencies on how best to use these. This is something for SHFT LD team also as the health and social care teams are not integrated as such but are co-located and work together.	HCC LD Service
16	18	To fully engage with the acute LD liaison post at PHT. The comments above re SHFT also apply here.	HCC LD Service
17	18	As commissioner, the HCC needs to review its choice policy for complex needs	HCC LD Service
18	18	HCC need to improve the audit trail for the decision making process around placements.	HCC LD Service
19	18	HCC need to consider, where necessary, placement trials, contingency planning and test of compatibility	HCC LD Service
20	18	HCC to review guidance around the use of advocates	HCC LD Service
21	18	HCC social care and other agencies such as SHFT should retain a current placement until such time as any transitional training needs are met and shown to be fit for purpose.	HCC LD Service
22	19	HAS needs to review its agreement to provide a placement criteria	Hampshire Autistic Society (HAS)
23	19	HAS develop an escalation procedure	HAS
24	22	The Practice needs to demonstrate process around best interest considerations rather than professional judgements in isolation	Core GP Practice
25	22	The Practice needs to develop a robust process to respond to frequent contacts and respond accordingly.	Core GP Practice
26	22	The Practice needs to have stronger communication lines with secondary care in complex cases	Core GP Practice
27	22	The Practice needs to develop stronger clinical leadership for vulnerable adults with complex needs	Core GP Practice
28	22	Medicines management audit for complex cases	Core GP Practice
29	22	Regulatory compliance	Core GP Practice
30	23	Involving carer’s in the planning of care	Portsmouth Hospitals Trust (PHT)

31	23	Attendance at best interest meetings	All agencies
Rec No	Page No	Recommendation	Responsible Organisation
32	25	Coached reflection of the anaesthetist who led the restraint upon Mr A.	PHT
33	25	One year plan (though 2011) to upskill targeted staff groups toward learning disability, adult safeguarding, joint working, best interest considerations, use of Consent 4 (form for those lacking mental capacity to consent) and early involvement of advocates.	PHT
34	26	Sensory friendly environments assessments, planned for October 2011	PHT
35	26	Single point of access for booking theatre sessions (achieved June 2010).	PHT
36	26	Review of the systems which deal with performance management and conduct issues for medical staff.	PHT
37	26	Review Governance framework to align safeguarding and Serious Incident Requiring Review policy	PHT
38	26	Assurance relating to staff management of patients with complex needs	PHT
39	26	Use of hospital passport and on-going training	PHT
40	26	Consideration of premedication for complex cases	PHT
41	26	Guidelines for use of restraint	PHT
42	27	General Practitioners (GPs) should receive training in safeguarding adults and their roles and responsibility in relation to this. Liaison with the LMC should be robust to secure their support for this.	Hampshire Primary Care Trust (SHIP Cluster) / Clinical Commissioning Groups (CCGs)
43	27	Practice managers and GPs must decide how they will be able to engage in safeguarding adult's meetings in relation to their patients	SHIP Cluster/CCGs
44	27	The Hampshire Multi-agency Policy and Procedures, when reviewed in the short term, should include consideration of whether there is a necessity to make more explicit the role and responsibility of GPs in the safeguarding adult's process.	SHIP Cluster
45	28	Practices need to develop their own policies for safeguarding adults where these do not exist. Work with the LMC may assist in developing core policy which can be tailored to local need.	SHIP Cluster/CCGs
46	28	Review of safeguarding process and knowledge	All agencies

47	28	Safeguarding Chairs Training	All agencies
48	29	Collaborative decision-making	PHT
Rec No	Page No	Recommendation	Responsible Organisation
49	31	Care Programme Approach (CPA) adoption for complex learning disability clients	Southern Health Foundation Trust (SHFT)
50	31	Use of risk assessments	All agencies
51	31	Health action plans and annual health checks	All agencies
52	31	Strategic development	SHIP Cluster
53	31	Specialist posts in acute hospitals	SHFT/PHT
54	32	Timely information sharing	All agencies
55	34	Multi-agency MCA and DOLs training	All agencies