



**HAMPSHIRE SAFEGUARDING ADULTS BOARD**

**SAFEGUARDING ADULTS REVIEW CONCERNING MS B**

**EXECUTIVE SUMMARY - DECEMBER 2015**

**INDEPENDENT CHAIR – MARGARET SHEATHER**

## **1. Introduction**

This is a summary of the Overview Report of a Safeguarding Adults Review commissioned by Hampshire Safeguarding Adults Board (HSAB) following the death of Ms B on 12<sup>th</sup> September 2014. A Safeguarding Case Conference had concluded that the case met the threshold for a Safeguarding Adults Review because of concerns about how well care and health systems had worked and how decision-making had been led.

A Review Panel was established with an Independent Chair, Terms of Reference for the review were agreed and reports were requested from all the organisations that had been involved in Ms B's care and support. The Panel worked from a chronology of the activities of the agencies involved, the reports they provided and further information sought for clarification. Because of the complex mix of learning disability, physical and mental health and care issues involved in Ms B's case, the Panel appointed an independent consultant psychiatrist to support their discussions. The Panel carried out its work between June and November 2015.

## **2. The Background to the Review**

Ms B was a 46 year old woman who had a mild learning disability, personality disorder and epilepsy. She was a Portsmouth City Council client who lived in a residential home in Hampshire. She was born in 1968, and died in 2014 at Queen Alexandra Hospital Portsmouth, with the cause of death recorded as (a) heart failure and (b) obesity and depression.

Ms B's care and support in the last weeks of her life had involved a complex mix of physical and mental health and care services. Her behaviour had changed significantly and different approaches to respond to this were attempted, but with limited success. Finally her physical health required her admission to hospital and was found to have deteriorated so substantially that little effective treatment was possible. This sequence of events made it appropriate to examine more closely how well the partner agencies and systems in place had worked in responding to Ms B's needs.

## **3. The Panel's Discussion and Analysis**

The Panel's detailed discussions and analysis were focussed on a few main topics:

- The recognition of Ms B's complex needs and how they were handled, including how her views were taken into account and how well her health deterioration was managed.
- The overall co-ordination of the care and support provided to Ms B
- Communication and sharing of information between the agencies providing that care and support

From its discussions and identified learning points the Panel agreed a number of conclusions.

## 4. Conclusions

- 4.1. The Panel was concerned to find so little immediate review of the circumstances of Ms B's death by the agencies that had been caring for her in the longer term, and which had not been expecting that she might die. She was only 46 years old and physically unwell but not, as far as we could establish, considered to be terminally ill. Her death should therefore have been viewed as unusual and prompted an examination of the factors that may have contributed to it so that lessons could be learnt for the future. It would also have been helpful to know more about why the Coroner decided not to take any further action.
- 4.2. We did not identify any single factor that, had a different course been taken, would have led to a different outcome for Ms B, but we did find a number of missed opportunities to provide better management of her needs that may have influenced the course of events. These related to three main themes that emerged from the review.

### *The impact of Ms B's underlying mental health needs*

- 4.3. These needs had a substantial impact on responses to her physical health needs, particularly the dominance of a behavioural interpretation of her symptoms and requests. Her learning disability also had an impact on the way that her health needs were viewed, particularly as part of her overall complex needs, but also as she became acutely unwell. The missed opportunities related to this were:
  - the complexity of Ms B's needs should have entitled her to an annual health check which may have detected her underlying heart condition at an earlier stage
  - as a patient discharged on section 117 aftercare, Ms B should have been the subject of the Care Programme Approach (CPA) and have had an appointed care co-ordinator; this would have provided Ms B with an up to date needs assessment, annual reviews and a framework providing a clear process within which to assess and manage risks around her behaviour
  - the lack of a Mental Capacity Act assessment which, formally completed, could have provided a more accurate picture of Ms B's ability to make decisions about her care and treatment particularly as she became more unwell; key professionals could have then focused on factual information rather than relying on hearsay and made more consistent responses to her requests for care

### *Communication when she was discharged from hospital in August 2014*

- 4.4. The Panel concluded that the lack of comprehensive communication about Ms B's heart condition when she was discharged from hospital had a significant impact on her care over the following weeks. The missed opportunities were:

- a discharge planning meeting may have established an effective plan for managing her physical health needs, and so reduced the influence of her known previous behaviour pattern
- most of the people caring for Ms B were unable to take her heart condition into account in assessing her health needs during the crisis that developed in the following weeks
- in addition, having been placed on new drugs as a result of her diagnosis, Ms B should have had routine blood tests which would have given her access to appropriate monitoring of her health post-discharge and would have allowed any side effects from her new medication to be detected
- greater involvement of Learning Disability liaison nurses may have improved communication during and after the hospital admission

*Assessment, information sharing and decision making*

4.5. There were missed opportunities in these areas, in particular:

- the involvement of an advocate (to which Ms B was legally entitled) would have ensured that her voice was heard and could have provided checks and balances throughout the process
- the greater involvement of Ms B's Next of Kin at an early stage could have provided invaluable information about how out of character Ms B's behaviour was and an alternative person to try and elicit the reasons for that behaviour from Ms B
- the differences in her behaviour that were in any case identified justified an earlier visit by her usual psychiatrist for a face to face assessment
- it would have been preferable for the Mental Health Act assessment that was completed to have been undertaken during working hours so that a GP and psychiatrist familiar with Ms B could have been involved
- better recognition of her deteriorating physical health could ultimately have altered the outcome for Ms B or resulted in appropriate end of life care had it been identified

4.6. Finally, it was clear from references the Panel made to other recent reviews about people with learning disabilities and other complex needs that the learning from earlier inquiries and reviews is proving hard to embed both locally and nationally.

## **5. Recommendations**

From its conclusions the Panel made the following recommendations to the Hampshire Safeguarding Adults Board

5.1. In responding to all these recommendations, the HSAB should take into account the actions arising from the review undertaken by the Board in 2012-13 on Mr A and the findings of the other reports referenced in the Overview Report.

- 5.2. Care and Support plans must be clear about how physical health problems are to be monitored and responded to and regularly updated to reflect changing needs.
- 5.3. Arrangements for communicating discharge information following a hospital admission for a person receiving care and support need to be strengthened so that all the relevant parties are aware of the outcome of the assessment or treatment and discharge summaries are clear and comprehensive.
- 5.4. Care organisations need to assure themselves that their staff are as alert to physical health care changes and conditions as to the mental health or learning disability conditions that may be the main focus of care.
- 5.5. Care homes and nursing homes need to put proactive arrangements in place to ensure that they are well-informed about changes to care arising from hospital assessment or treatment.
- 5.6. In view of the continuing national evidence about the disadvantage experienced by adults with a learning disability, the HSAB will want to seek assurance that an effective learning disability liaison service is in place across the hospitals that routinely receive Hampshire residents.
- 5.7. Programmes of awareness-raising and training about the Mental Capacity Act need to be in place across all agencies, its role reflected in policy and practice guidance and arrangements made to monitor the Act's implementation in practice
- 5.8. The local CPA framework should be reviewed to ensure consistency with national guidelines
- 5.9. Policy and practice guidance needs to promote the involvement of advocacy services and the role of the next of kin in assessment and decision-making. This should include awareness of guidance about involvement and consultation when a Do Not Attempt Resuscitation proposal is considered.
- 5.10. An annual health check should be provided for all people with a learning disability in Hampshire
- 5.11. Arrangements for managing complex cases need to be reviewed to ensure:
  - allocation of a case co-ordinator
  - firm expectations of multi-agency decision-making
  - clear escalation protocols in all agencies for the resolution of conflicts or stuck situations
- 5.12. Responsible councils need to ensure that clear information is available about publicly funded funeral arrangements and that good communication takes place with those closely involved.