THE SUMMARY REPORT

ON THE SERIOUS CASE REVIEW (SCR)

CONCERNING

MS A (deceased)

November 2011

1. Introduction

1.1 This Serious Case Review was commissioned by the Bath and North East Somerset Local Safeguarding Adults Board (LSAB). The LSAB is a multi-agency group that oversees safeguarding strategy and practice across Bath and North East Somerset (B&NES). The Board appointed an independent chair to take forward the Serious Case Review in February 2011.

1.2 This is a summary report of the Serious Case Review concerning Ms A (deceased) and will summarise the details of the case, outline the key findings of the Serious Case Review Panel, present a summary of the recommendations and examine the process of the Serious Case Review. It will also describe how the LSAB will actively monitor progress against the recommendations and hold organisations to account for implementing the required changes and improvements detailed in the recommendations.

2. Serious Case Reviews

2.1 In principle Serious Case Reviews are undertaken in the circumstances when:

- a vulnerable adult dies and abuse is known or suspected
- a vulnerable adult has sustained a potentially life-threatening injury through abuse, neglect or serious sexual assault
- a vulnerable adult has sustained serious and permanent impairment of health or wellbeing through abuse or neglect

All the Agencies and workers involved in this case had to identify concerns in the way they work together to provide a service for, and safeguard, vulnerable adults.

The purpose of a Serious Case Review is:

- to establish whether there are lessons to be learnt from the past circumstances of the case
- to improve future practice by acting on that learning
- to inform and improve multi agency working
- to review safeguarding adults procedures

3. The Background to the Case

3.1 Ms A, who died in 2010, had a long history of involvement with services dating back to 1969. The management reviews, which are provided by all agencies connected to the case, showed that she had received considerable community support from both Mental Health and Learning Disability services prior to moving into a residential setting in 1995 and subsequently to a Nursing Home in 2002. Avon and Wiltshire Partnership's (AWP) Mental Health Services took responsibility for Miss A's Care co-ordination at the point of that move to the Nursing Home in 2002.

3.2 Although it was acknowledged her placement in the Nursing Home was not ideal, it should be noted that it did enable her to be placed at the same home as her mother and was not at that time intended to be permanent. However, later it was

decided in her best interests that she should remain at the Home as she was well placed and as a result no alternative would be sought.

3.3 During the period Ms A was resident at the Nursing Home, at various times she received a service from the Avon and Wiltshire Mental Health Partnership Trust's Adult Community Mental Health Team (CMHT) who had case co-ordination responsibility, the NHS B&NES Funded Nursing Care and Continuing Health Care Teams, the NHS B&NES Community Matron and the local GP practice.

3.4 When Ms A moved to the Nursing Home she was suffering from bowel problems including constipation and was regularly incontinent of faeces with faecal smearing. She had other health issues in addition to her mental health conditions. She had been prescribed aperients (laxatives) for her constipation for some time but these were stopped by the nursing staff at the Nursing Home in January 2010 due to her bouts of diarrhoea. The prescription was halted by her GP the following month.

3.5 After Ms A's laxatives were ceased there were no concerns until late April 2010 when she said she felt unwell and a visitor noticed she was in pain, but the first record at the Nursing Home of stomach pains was not until two days later. From this point, Ms A's condition deteriorated rapidly and she was admitted to the Royal United Hospital (RUH) in May and had an emergency manual evacuation under general anaesthetic to relieve an impacted bowel. She died three days later of peritonitis, perforation of the sigmoid colon and distension of the large bowel.

3.6 Prior to this surgery, staff at the RUH expressed concerned about possible neglect at the Nursing Home and referred the case to the hospital Safeguarding Lead, who referred it to B&NES Adult Social Care Department. On the same day they forwarded the referral to AWP, the organisation responsible for the safeguarding process because of AWP's professional care co-ordination responsibility for Ms A.

3.7 A Safeguarding Strategy Meeting was held later in May with multi-agency attendance. Although a number of practice concerns in relation to palliative care and bowel care management were recognised, it was decided at that meeting that there was no need to investigate further under the safeguarding adult procedures on the basis there was no identified evidence of neglect and the police reported there would be no criminal investigation.

3.8 Nevertheless, key professionals continued to be concerned by the circumstances that led to Ms A's death and as a result the SCR was commissioned by the Local Safeguarding Adults Board (LSAB). A Panel of representatives from all the organisations who had direct or indirect care for Ms A, or who were involved in the subsequent enquiries, was appointed. An experienced independent chair was chosen to lead and co-ordinate the process.

4. The Key Findings

4.1 Each organisation was required to complete a comprehensive Individual Management Review (IMR) detailing their part in Ms A's case, the aim being to look critically at both individual and organisational systems and practice. As part of the

IMR, the organisations also identified lessons learned, organisational and individual training needs, and recommendations for the future as well as action plans to deliver the required changes aimed at reducing risk in the future.

4.2 Through the IMR, the SCR examined Ms A's case in three tranches:

i. The period from her admission to the Nursing Home in 2002 to the end of 2009
ii. January 2010 to May 2010
iii. The period after Ms A's death

4.3. i. Admission to Nursing Home in 2002- to the end of 2009.

The Panel finds it was not in dispute in 2002 that the Nursing Home placement was not really appropriate for Ms A but no other placement was considered suitable. A key factor in the decision to place Ms A in this particular Nursing Home was that she could be with her mother who was already resident there.

4.4 After three years her placement was reviewed and it was then thought it would be too disruptive for Ms A to be moved. However, the IMR have shown there was no Mental Capacity Act assessment carried out to determine Ms A's capacity to make informed choices. Furthermore, the GP surgery highlighted that the last contact they had with social care colleagues about Ms A was before she moved to the Nursing Home.

4.5 The Panel finds it was clear that there were problems in her case management due to the lack of a co-ordinated approach to her mental health and no evidence of any overall active case management responsibility for her.

4.6 There were other serious deficiencies in Ms A's care management. There were virtually no visits by her mental health social workers and the Care Plans and Reviews were out of date with some of the latter simply not taking place. The Panel finds it concerning that it was only at the SCR Panel meetings that her faecal smearing (that should have been a crucial factor in the consideration of her care package) became known to everyone. The Panel considers this kind of shared knowledge should be one of the outcomes of effective case management and represented a lost opportunity to have provided Ms A with the care she clearly needed.

4.7 The SCR Panel considers the Nursing Home must bear at the very least some of the responsibility for this lack of knowledge and co-ordination of Ms A's care, along with the AWP Mental Health Service. The Nursing Home knew Ms A had bowel problems on the day she was admitted. They knew of her constipation and the medications provided, and were obviously well aware of her faecal smearing. Their IMR showed they also realised that reviews and care plans were not up to date or taking place when they were due and the last visit from a social worker was in 2007. The Panel acknowledges that AWP Mental Health Services should have provided care plans and reviews, but also considers the Nursing Home should have contacted the AWP in the interests of their residents and made it very clear that they saw a lack of a co-ordinated approach in care and health management.

4.8 ii. January 2010 - May 2010

Turning to the period from January 2010 to Ms A's death in May 2010, Ms A's bowel problems veered from constipation to diarrhoea, and her diarrhoea was bad enough for the nursing staff to withhold her prescribed aperients with the GP subsequently stopping the prescription in February 2010 due to her ongoing incontinence of faeces.

4.9 The matter of "post laxative bowel" (the potential problems for a patient abruptly ceasing long term laxatives) was discussed at length during the SCR. The Nursing Home's parent company believed the GP surgery should have told the staff at the Nursing Home that Ms A may face constipation as a result of stopping her aperients particularly as she was continuing with codeine. Whilst the Panel accepts there was merit in that argument, and the consequence of the abrupt cessation of the aperients should have been made clear by the GP, the Panel considers it was not that simple. The Nursing Home had qualified nursing staff who should have been well aware of the possible consequences and should have raised and discussed the matter with the GP surgery. The Panel also accepts that after the aperients were stopped Ms A still suffered from diarrhoea and that could have masked the increasing bowel blockage. The Panel considers better liaison and attention to the detail of her long term condition by both her GP and the qualified nursing staff could and should have been provided.

4.10 During April 2010, there was nothing of note recorded for Ms A until the end of the month when events then moved swiftly. On 28 April she was feeling unwell and refusing main meals, on the 29th she was still unwell and a family friend visiting was sufficiently anxious that he contacted Ms A's brother. On 30 April, Ms A's blood pressure and abdomen were checked by the Nursing Home, on 1 May she had stomach pains and the Nursing Home's Registered General Nurse (RGN) wanted to contact the out-of-hours GP but Ms A wanted to wait for her own doctor. In the early morning on 2 May the Nursing Home noted that her abdomen was distended and she was admitted to the RUH in an emergency later in the day.

4.11 Senior nursing staff at the RUH later observed that they expected any registered nursing staff should have identified the degree of constipation present in Ms A and raised a safeguarding alert. The RUH IMR recorded that, given the severity of the case, possible neglect should have been considered sooner, but the ward nurse and the Matron acted quite properly. There was nothing to suggest in their IMR that Ms A had anything but appropriate medical care, but the Hospital was self-critical about their approach to Ms A's learning difficulties which they consider could have been improved through the involvement of an advocate and intend to ensure this is provided in future.

4.12 iii. The period after Ms A's death

The last period relates to the time following Ms A's death, and the safeguarding alert. There are a number of areas that, in the Panel's opinion attract criticism and where lessons should be learned. She died on 9 May and a post mortem was conducted but the police were not informed until 13 May. The criticality of the sequence was

important to any possible criminal investigation and prosecution, albeit in this case there were no suspicious circumstances. The problem with timing continued as the Strategy Meeting was held on 20 May, 16 days after the initial alert and outside the set timescales. AWP who managed the process must and indeed do accept responsibility for these errors.

4.13 The mistakes continued. The police had taken possession of the records from the Nursing Home. The records were reviewed by the Home Office Pathologist who said Ms A's considerable physical and mental medical problems made it difficult to identify the level of constipation and impacted faeces from which she was suffering, and thus no responsibility for her death could be attributed to the Nursing Home. The Pathologist also said the records were amongst the best he had reviewed but the Panel notes this was at variance with the view of the Care Quality Commission (CQC) inspectors. The Pathologist drew a number of conclusions from the records giving the opinion the documents clearly demonstrated that Ms A had been afforded a great deal of quality care whilst resident at the Home. The Panel finds there was no evidence to support this opinion and moreover believes it to be inaccurate; nevertheless the Pathologists view influenced what followed.

4.14 The Strategy Meeting, to which the Nursing Home was not invited, was shown a diagram of Ms A's impacted bowel by the RUH Safeguarding Lead. At the meeting practice concerns were raised, including Ms A's palliative care, bowel care management, and what was described as 'excessive' contacting of the GP surgery. The Strategy Meeting also heard of the opinions of the Pathologist, and from the police that there was no criminal culpability that could be linked to Ms A's death. The Strategy Meeting decided certain issues would be followed up by the Community Matron but there was no need to investigate further under the Adult Safeguarding Procedures as there was no identified evidence of neglect.

4.15 That decision was clearly flawed and, as one IMR commented, may have been influenced by the Pathologist's comments. In addition, there were important outstanding matters and complex issues surrounding Ms A's initial admission to the Nursing Home, to her mental and physical medical state and to her stay there. Moreover, the Panel considers the events prior to her admission to the RUH should have been taken into account.

4.16 The Panel believes it is important to consider the role of the inspection process by CQC/CSCI in this case. The last inspection of the Nursing Home was in February 2008 when the service was rated as "good", two stars. The then inspection regime meant the next planned inspection was to have been in 2010 with an Annual Service Review in 2009. The 2009 review was self-assessment and from the information provided, CQC concluded an inspection was not required until the planned one in 2010. During 2008 and 2009, CSCI received a number of concerns and complaints about the Nursing Home but the 2009 review made no reference to them. CQC have acknowledged an opportunity for further review was not taken. The Annual Service Review in February 2010 decided an inspection was not required at that time. The Panel considers there were clearly some shortcomings in these reviews. On the basis of the information discussed at the Strategy Meeting, CQC decided there was no urgency to complete an inspection. It was only when further concerns were raised and a separate Safeguarding Investigation was undertaken by

B&NES Community Health and Social Care Services into care of another service user, and subsequently more widely into the standards of care in the Nursing Home, that an urgent unannounced random inspection was undertaken. This resulted in the Nursing Home receiving a rating of "poor", zero stars with numerous shortcomings identified. Significantly CQC commented "*for the service to be in such a poor state at this time, it is the inspector's opinion that the service had been deteriorating for some time"*, a contrast with their previous findings and decisions.

4.17 In addition to the operational aspects of the case and the Strategy Meeting, the Panel finds there are some observations that need to be made in relationship to the SCR. This was the first adult care SCR for B&NES and the Multi-Agency SCR Protocol that was available was not wholly satisfactory and had to be adapted at short notice. It must be acknowledged that whilst there was a positive and serious professional engagement in the process from some organisations, it is also true that some IMRs were not submitted to the agreed time scales, were of variable quality, and in some cases lacked the comprehensive responses that had been requested. This, the Panel considers, highlights the priority that must be given to raising awareness of Adult Safeguarding generally, and in particular for organisations and independent professionals to understand their responsibilities in relation to the Serious Care Review process.

5. Recommendations from the Independent Management Reviews

5.1 The following multi-agency recommendations have been made in the IMRs and have been formalised as recommendations for the SCR:

Recommendation 1:
The LSAB requires each organisation to produce a detailed action plan in response to the recommendations, which will be monitored by the LSAB and all organisations will be held to account by the LSAB for delivering the improvements.

Recommendation 2:
The development of New Multi-Agency Guidance for Practitioners in relation to:

- managing referrals of cases where a death occurs during Safeguarding Adults procedures in relation to post mortem
- managing safeguarding adults cases where there is another investigation open
- the rights and responsibilities in terms of seizure of service users notes from provider settings

Recommendation 3:
A Review of existing Multi-Agency Guidance / Protocols for Practitioners – in particular to:

- review and improve definitions and thresholds for neglect and safeguarding adult actions
- review and improve arrangements between primary and secondary care for managing care pathways
- review and improve arrangements for case management/coordination where the service user has both learning difficulties and mental health needs
- review and amend the SCR Protocol and supporting documentation

Recommendation 4:
To review Multi-Agency Training (including that for senior managers in organisations and independent practitioners such as General Practitioners) to ensure this includes:

- a requirement for the provider in the alleged abuse setting to be invited to participate in strategy meetings / discussions
- a requirement for the B&NES Council Commissioning Team to be informed routinely of safeguarding referrals by all organisations
- training to support improvement in practice for key staff in safeguarding thresholds, neglect, self neglect and poor practice in relation to serious illness and palliative care to ensure high standards of professional assessment and practice
- working with organisations to ensure they contribute to effective SCR processes
- to focus on procedural timescales

Recommendation 5:
For CQC to provide the police with intelligence information on registered care homes that should be incorporated in neighbourhood profiles

Recommendation 6:
To ensure that CQC, NHS and Council Commissioners and health and social care professionals work collaboratively to reduce risk of harm and improve quality of care provided to people by registered providers. In particular for:

- Health care professionals to be involved in quality monitoring of Care Homes
- B&NES Council Strategic Director for People and Communities Services and Divisional Director for Safeguarding and Practice Development meet with the Clinical Commissioning Group to agree an action plan for further engaging GP practices and develop a robust Quality Assurance Framework in relation to multi-agency Safeguarding expectations and practice.

6 Summary

6.1 It will be evident from this report that many, if not all, of the organisations who had direct, or indirect, contact with Ms A, and the subsequent safeguarding enquiries, have been found lacking to a greater or lesser degree.

6.2 What the SCR has done is to identify those areas where mistakes have been made and where improvements to service provision and the protection of vulnerable adults can be enhanced. This has been the SCR's key purpose and it is currently the responsibility of the organisations and individual professionals not only to ensure that they learn, but also take action to prevent reoccurrence. The LSAB will now draw up an overarching Action plan and ensure that organisations are held to account for delivering the improvements that all the organisations identified and that the important lessons are learnt.

Peter Norris
SCR Independent Chair
November 2011