

SERIOUS CASE REVIEW CONCERNING

Mr A

**EXECUTIVE SUMMARY OF THE SERIOUS CASE REVIEW
OVERVIEW REPORT FOR THE
SOUTHAMPTON ADULT SAFEGUARDING BOARD**

JULY 2012

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1.0 Background

1.0 This Overview Report for the Southampton Adult Safeguarding Board (SASB) seeks to provide an accurate and detailed account of the deliberations and recommendations of the Serious Case Review Panel instigated by the SASB. This Serious Case Review was set up following the death of Mr A, a vulnerable male adult in his supported living accommodation on 20 December 2010.

1.1 The Panel for the Serious Case Review comprised the following people:

Lucy Butler	Hampshire County Council [Chair]
Jane Duncan	Hampshire County Council
Glenys Jones	Portsmouth City Council
Susan Lawes	NHS SHIP PCT Cluster
Sue Lee	Southampton City Council
Sharon Outhwaite	Southern Health NHS Foundation Trust
Kevin Walton	Hampshire Constabulary
Ian Allured	HASCAS - Independent SCR Author

1.2 The Terms of Reference were agreed by the Serious Case Review Panel and comprised eight specific areas of investigation:

- A. To review each organisation's involvement with Mr A.
- B. To establish the circumstances and events surrounding Mr A's death.
- C. To examine the contracting arrangements and the management of Mr A's care and his health care needs by individual agencies and to recommend changes as deemed necessary.

- D. To review the effectiveness of both multi-agency and individual organisations policies and procedures and methods of operation and to determine whether any changes in these would have altered the outcome.
- E. To inform and improve local inter-agency communication and practice and any other areas where improvement is considered necessary, including the need for any commissioning and/or contracting changes
- F. To make recommendations to improve future practice and the quality of life for service users and processes to ensure they are implemented
- G. To provide the relatives of Mr A with explanation of what happened and the steps taken to prevent any reoccurrence of events of a similar nature
- H. To establish the nature and extent of each organisation's contact with Mr A through chronologies.

1.3 Individual Internal Management Reports (IMRs) were produced by the following seven organisations:

- Choices Advocacy;
- First Wessex;
- Hampshire Constabulary;
- Southampton City NHS (Primary Care);
- Southampton City Community Learning Disability Team;
- Southern Health NHS Foundation Trust;
- Wessex Regional Care Ltd.

1.4 These IMRs were extremely useful to the Panel and provided a detailed and balanced description of both poor practice where discovered, together with examples of good practice.

1.5 A collated chronology was produced to help identify the significant issues leading to the death of Mr A.

2. Mr A

2.1 Mr A had two brothers, one also has a learning disability and the other remained in contact with both his brothers and tried to help them as best he could whenever there were difficulties. Mr A was very fond of his older brother and was reported as being very upset and anxious when he was ill with heart problems in April 2010. There was no other known family.

2.2 Mr A was a 49 year old man who had a mild to moderate learning disability as well as epilepsy and scoliosis. He had lived in supported accommodation since his early twenties following the death of his father. Mr A was initially supported for several years in an Adult Placement and on the breakdown of this placement moved to supported living provided by Wessex Regional Care Ltd in Southampton in December 2006. (This accommodation will be called 'the flats' throughout this Report)

2.3 'The flats' provide tenancies for people with learning disabilities and provide domiciliary support. Wessex Regional Care Ltd provided the domiciliary support, with First Wessex and Wessmaps providing the property and the management of the property. Mr A held his own tenancy at 'the flats'. The Core hours provide a 24 hour presence for the tenants being a 14 hour waking service with a sleep in service on site.

2.4 Mr A had been well settled in the property and had two employment opportunities, working at a gardening/horticultural project and also working in a local branch of Sainsbury's. In the 12 months prior to his death on 20 December 2010 the quality of Mr A's life appeared to deteriorate due to a number of separate but inter-connecting factors which are explored in this Report.

2.5 In the last three months of his life Mr A became physically ill and suffered from recurring stomach complaints. He was also adversely affected by the level of disturbance within 'the flats' caused by both the nature and mix of the residents and the failure of the front door bell and phone system to the office to work properly for a period of at least 12 months. This allowed tenants to let people in without their being 'vetted' by the office.

2.6 In the last week of his life Mr A had continued stomach problems which were not adequately dealt with. On Monday 20 December Mr A died from natural causes, defined by the coroner as a combination of dehydration, colitis and epilepsy. The Serious Case Review Panel was established to investigate how death could have occurred in a supporting living establishment with staff available 24 hours a day.

2.7 The Panel is grateful to Mr A's brother who met the Chair and another member of the Serious Case Review Panel. He provided some helpful information and a unique insight into Mr A's life which has greatly assisted the Panel.

Definitions

2.8 Following the feedback from the Individual Management Reports (IMR) factual accuracy process and the presentation made to the authors of the IMRs it was decided that definitions of 'support', 'care' and 'health care' would be helpful when reading this Report. For the purposes of this Report these terms are defined as:

Support:

2.9 This is usually provided within the framework of the Supporting People procedures and is taken to be low level housing related support necessary to enable the individual to sustain their tenancy. Help with cooking, cleaning and generally coping with shopping and other 'hands-off' non-invasive support.

Care:

2.10 This is care which is 'hands on' and would usually include help with dressing and eating and general personal social care. It is often funded through Social Care via Care Contracts from the Local Authority.

Health Care:

2.11 This is essentially invasive intervention such as the giving of medication and therapy and is available via the local Primary Care Trust.

3. The Findings

3.1 During the last year of Mr A's life a combination of factors led to a deterioration in the quality of his life. The factors which caused the continued deterioration of Mr A's quality of life were:

Reduction in 1:1 Support Hours

3.2 When Mr A first moved to 'the flats' in December 2006 it was agreed that he would be supported for 38 hours a week with 1:1 support. The needs identified were for assistance with cooking, shopping, laundry, cleaning, financial management and correspondence and additional help when he was stressed.

3.3 Mr A's hours of support were reduced to 22 hours a week following a review when he had been resident at 'the flats' for two months. There was no evidence to demonstrate that Mr A had ever had all these 22 hours a week.

3.4 It does appear that some of the staff working at 'the flats' were inexperienced and did not have a clear understanding of their roles. The change of focus from 'support' to 'personal care' as Mr A became unwell was not understood and the manager also did not appear to have made this clear to the staff. In many ways this also mirrors the staffs' lack of assertiveness when Mr A declined their help, as they appeared to think he was independent and therefore was in a position to refuse their help without question. The staff should have challenged his refusal but were not trained in the techniques to achieve this.

The Overall Environment within The Flats

3.5 The lack of the concierge system and the resultant inability for staff to see who was entering 'the flats' meant that there was no proper check on who was actually in

the building. The nature of some of the drink related incidents and violent behaviour were due to 'outsiders' getting into the flats, and to the unacceptable behaviour of Mr C and another two tenants. The termination of tenancies due to anti-social behaviour for these three tenants were thwarted due to elementary mistakes being made in their eviction process, such as quoting the wrong dates for examples of such behaviour.

3.6 The lack of authority of the sleeping in staff who appear to have disregarded the behaviour of some of the residents, or to have summoned the police to deal with matters which were really their responsibility. In the period from January 2006 to December 2010 there had been 149 instances where the police had been called to 'the flats' with 51 during 2010 of which 20 were between 01 November and 20 December. The Serious Case Review Panel considered that when the Hampshire Constabulary Safer Neighbourhood Team and/or a Police Safeguarding Officer notice an increase in the level of calls from an address where vulnerable adults are known to live they should alert the Adult Safeguarding Team. (See Recommendation 7)

3.7 In addition there were several violent and unpleasant serious incidents occurring at 'the flats' during the period from September to December 2010 which were reported by staff. These incidents also contributed to the overall difficult environment experienced by Mr A and Miss B. They also confirm Mr A's fears about leaving Miss B alone during the day and thereby placing his work placement in jeopardy.

3.8 The general poor level of cleanliness and hygiene within Mr A's flat and the effect this could have had on Mr A's diarrhoea went largely unnoticed, and was not addressed until the weekend prior to his death. The confusion of whether Mr A's fridge/freezer was broken or just switched off, which could have been a cause of his stomach problems, and which when reported to the GP caused a change in medication as he could have eaten 'bad' food.

Communication Issues

3.9 GP3, who had visited Mr A on 17 November, explained what the Care Worker should do and how to administer the medication and advised that if staff were

concerned about Mr A they should contact the Out of Hours GP Service over the weekend. When staff were concerned about the health of Mr A they contacted NHS Direct and not the Out of Hours Service. From the information provided by the staff the advice received from NHS Direct was to wait until Monday or Tuesday and if Mr A was still ill to contact the GP. This information, together with GP3 not having sought hospital care for Mr A on 17 December led the staff to think Mr A was not as ill as they had thought.

3.10 One of the main contributory factors leading to the death of Mr A was the level of communication between staff from different professions and agencies, and the assumptions some staff made about who and which agencies were involved in providing support to Mr A. Both the Learning Disability Nurse and GP 3 thought that the general environment was poor but were under the impression that the Adult Social Care Services were involved due to 'the flats' being classified as "supported care".

3.11 There had been at two attempts to provide the GP with a stool for analysis but the one which was provided was too old to be used by the time it reached the laboratory. It remains unclear what happened to the second stool.

3.12 At the Safeguarding Strategy Meeting on 01 December 2010 the Serious Case Review Panel considered that whilst the Meeting had made some moves to provide Mr A with some additional help, assistance and support, his real needs and anxieties were not being addressed. This was because they were in fact being masked by his relationship with Miss B. The meeting appeared to have treated them as a couple, and that the needs of Miss B obscured the specific individual needs of Mr A.

3.13 The Serious Case Review Panel considered that where a Safeguarding Strategy Meeting deals with more than one service user there should be a separate 'Review' within the meeting of each individual. This separate 'Review' should also identify and assess any wider risks, health considerations and safeguarding issues.

3.14 The Commissioning side of the Southampton City Council Learning Disability Team did not visit 'the flats' very often, and would only visit if a complaint had been received. The failure of Wessex Regional Care staff to provide the correct number of 1:1 support hours should have been known, as should the deficiencies in the physical environment, the number of incidents being reported by staff and the high level of police involvement at 'the flats'. All these factors when considered together paint a clear picture of a service which was not fulfilling its contracted obligations, and which was not meeting the needs of its vulnerable tenants.

The Experience and Quality of the Staffing at The Flats

3.15 It is evident that the staff on duty on 19 December 2010 were relatively new and untrained, and the lone sleeping duty member of staff had not had much experience of working with Wessex Regional Care Ltd. In the morning the senior support worker contacted NHS Direct to ask for their advice about Mr A as he was concerned that he appeared to be getting worse. The advice gained served to reassure him that Mr A was not as seriously ill as he had thought.

3.16 Care Support Worker 1 who was the sleep-in night worker on 19 December 2010 had been visiting Mr A every two hours to check how he was. At 20.00 that evening he visited Mr A, who was weaker than he had been in the morning, and was unable to stand and walk and just flopped back onto the settee. He decided not to visit him overnight and Mr A was left for 13 hours until he was found dead at 09.20 on the Monday morning.

4. Conclusion

4.1 The Serious Case Review Panel concludes that Mr A's death was preventable. Had all care staff been aware of all the facts of his illness and the advice of the GP to ring the Duty Doctor, and had used their own observation of Mr A being unable to walk or get out of bed to summon an ambulance, appropriate action would have followed. The actions were not malicious or deliberate, but were the consequence of an organisation having too few experienced care workers and duty managers to

cover an urgent situation and inadequate policies or protocols to describe the actions to be taken if staff thought a tenant at the flats was really ill and required health care.

4.2 The cause of Mr A's death was systemic. A group of contributory factors combined to create a situation where a vulnerable adult was allowed to die in circumstances where he was living in supported accommodation.

4.3 It is noted that the Coroner in his narrative report came to the conclusion that Mr A's death had been "preventable and unnecessary" and "that the systems in place to deal with Mr A's health generally were inadequate and insufficiently robust"ⁱ

4.4 In memory of Mr A it is vitally important that lessons are learned from his death and this Serious Case Review and that recommendations are made which will help prevent further similar incidents.

5. The Serious Case Review Panel Recommendations

1. Where a Safeguarding Adults Strategy Meeting has been called which involves more than one vulnerable adult the meeting must give equal attention to each vulnerable adult. This individual review for each vulnerable adult should ensure that:
 - his/her needs are assessed and appropriate steps taken to address them;
 - wider safeguarding issues are taken into account to include healthcare, the provision of social care and any other risks;
 - the effects of the interrelationship with the other vulnerable adult(s).

Safeguarding Meetings should only deal with one individual at a time and it is strongly recommended that this is taken forward by the four Local Authorities within their pan-Hampshire Review of the Adult Safeguarding Policy.

2. The monitoring of contracts with organisations providing the care and support and/or individual 1:1 support for service users in accommodation for vulnerable adults must include:

- initial monitoring of the level of support needed for each individual tenant, and confirmation that the agreed care plan accurately reflects the identified needs;
- ongoing review of the level of support offered and quarterly checking of the records showing how that support has been provided and the outcomes of the interventions;
- provision for spot checks of the property to ensure the cleaning and maintenance of the physical environment is of a satisfactory standard and that there is the opportunity to talk to service users and to see their personal accommodation if they agree.

These three areas of monitoring should be added to the Contract Review Schedule.

3. When professionals visit service users in accommodation for vulnerable adults the provider staff have the responsibility to write a summary of their assessment, advice or the outcome of their visit in the service user's ongoing record.
4. When professionals visit service users in accommodation for vulnerable adults and have any concerns about the standard of care and/or the general state of the environment they should:
 - raise their concerns with the senior member of staff on duty;
 - ask for details of the provider organisation and the commissioning organisation contracting the service;
 - be aware of their professional code of practice to highlight any sub-standard care;
 - be aware of their responsibilities for the safeguarding of vulnerable adults.

All organisations must ensure that their staff know their responsibilities regarding the safeguarding of vulnerable adults.

5. The senior managers of all provider and commissioning organisations of supported accommodation for vulnerable adults must ensure that their staff are aware that:

- the assessed needs identified and the services arranged to meet those needs in the service users' care plans must be provided;
- when a service user disengages or refuses support there are techniques available to assist service users to positively use their support;
- the use of the Mental Capacity Act 2005 is required so staff can check whether a service user has capacity in relation to a particular decision, such as whether or not to make use of services.

The senior managers must ensure that there is a simple tool outlining the principles of the Mental Capacity Act, which can be used to aid care workers in understanding the Act and its role in decision making.

6. When a service user is ill, and he/she is known to have close relatives, then the care providers should inform the close relatives about the illness and offer them the opportunity to visit so that they can be involved in decision-making around the service user's care.
7. When the Hampshire Constabulary Safer Neighbourhood Team and/or a Police Safeguarding Officer notice an increase in the level of calls from an address where vulnerable adults are known to live they should:
 - alert the Adult Safeguarding Team about the level of incidents at the address;
 - **not** raise a CA 12 Form (Vulnerable Adult at Risk) for each individual living at that address but a general alert regarding the incidents logged from the property.
8. The four Local Authorities involved in the pan-Hampshire Review of Adult Safeguarding Policy should provide a clear Policy Framework for situations where service users disengage from, or refuse, support.
9. It was evident in some of the Internal Management Reviews that there were discrepancies in the accounts given about Mr A's physical condition and the actions taken by care staff. It is therefore recommended that:
 - organisations should revisit their investigations in the light of established facts highlighted by the Coroner's Narrative Verdict and the Serious Case Review Panel's Findings;
 - re-examine the areas where the discrepancies occurred in order to validate their investigation.

