

DORSET SAFEGUARDING ADULTS BOARD

Executive summary of serious case review in respect of an adult female JT who died on 29th May 2012

1 Introduction

This Executive Summary provides a brief headline summary of the main findings, conclusions and recommendations of the Serious Case Review (SCR) that was commissioned by Dorset Safeguarding Adults Board (DSAB) following the death of a female adult, JT in May 2012.

2 Background summary

2.1 JT died on 29 May 2012 as a result of a stroke. She had, in January 2012, been admitted to a care home. This was an emergency measure because her husband, who was her main carer, had suffered a stroke and was admitted to hospital. In March 2012 JT transferred to a nursing home, where she died. The move was in order that she could be nearer to her husband who had then returned to their family home in Weymouth.

2.2 JT had been known to an increasing range of agencies since suffering a first stroke in 1990. Ultimately she was well known to the following agencies: Dorset County Council Adult and Community Services (DCCACS); Dorset Healthcare University Foundation Trust (DHUFT); NHS Bournemouth and Poole/Dorset Cluster (NHSBPDC); Dorset County Hospital NHS Foundation Trust (DCHNHSFT); Synergy Housing (SH); Care South (CS); South West Ambulance Service NHS Foundation Trust (SWAST); latterly, a care home and a nursing home.

2.3 JT's general condition and health on admission to the care home in January 2012 gave rise to significant concerns as a result of which a safeguarding alert was raised and an investigation ensued. This subsequently gave rise to questions about the way in which local professionals and services had worked together in this situation.

2.4 The period scrutinised by the serious case review panel was the period from 01.01.1990 to JT's death on 29.05.2012.

3 Conclusions reflecting the key lessons learned from this analysis of the care and support of JT

3.1 JT was an adult at risk known to a range of health and social care agencies. She had a range of health related conditions which rendered her increasingly dependent and isolated. JT was, for her own reasons, at times reluctant to accept care and treatment offered by professionals. This should have been explored with her by staff and professionals. This reluctance, combined with the increase in health and care needs was challenging to the effective management of risk. The situation demanded basic good practice, a high level of continuity and communication across agencies as well as an

ability to keep track of a situation, which continued over two decades, in order to ensure that needs and risks were adequately addressed. A number of failings combined in this situation leading to agencies and professionals failing to recognise, acknowledge and address the serious level of deterioration in JT's condition.

3.2 There were a number of identifiable and specific issues which must form the basis of learning from the case of JT. However this report has underlined too the extent of individual poor basic practice evidenced by the poor condition that JT was in when admitted to a care home in January 2012 despite the involvement of a wide range of professionals. This individual practice is being addressed outside of this serious case review (which is itself a learning process) but it highlights the essential need for robust supervision of staff and the need for training on basic as well as specialist areas of practice in some cases.

3.3 In the **1990's** when JT suffered a first stroke (**and ongoing**), issues associated with working with **stroke patients** emerged. The *range* of necessary assessments was not considered. In particular psychological assessments were never carried out. These might have been helpful in respect of capacity issues at a number of points. They might have been helpful to guide carers, including MT. Indeed following JT's second stroke in 1998 there is no evidence of any assessments or reviews taking place in relation to the implications and effects of the stroke. There was clear evidence that national guidelines for working with stroke illness did not apply in JT's case. The National Stroke Strategy was not published until December 2007 but the core principles would have been known.

3.4 Carer assessment: The significant difficulties which MT experienced in caring for JT were first recorded in **1995** and then again in 2002 following which this issue arose repeatedly. There is only one formal carer assessment recorded in July 1995. This was never formally reviewed.

3.5 A theme relating to the **reluctance to accept / refusal of care, respite, treatment by JT ran throughout the chronology. This decision making should have been informed by and explored by professionals alongside JT.** JT had reasons for her reluctance and she should have been supported to understand the alternatives and the potential outcomes of her decision making. MT also at times refused offers of care and treatment on behalf of JT. He too required that professionals be more proactive in these situations. Right at the beginning in **1990** when JT suffered the first stroke records make us aware that there was an issue with JT failing to attend appointments and concerns about the extent to which she would comply with therapy appointments. This theme continued. In 2003 for example JT was discharged from hospital without having had an examination because she said this would set off spasms. Professionals were complicit with her wishes despite the presence of significant risk and the distinct possibility that neither JT nor MT had any real insight into the possible consequences of such decisions. There is no indication of any questioning of JT's capacity in this

respect. There were no recorded attempts to support JT's or MT understands of the consequences of these "refusals".

3.6 There was little attempt to establish a relationship of trust and cooperation with JT and MT which might have supported staff and professionals in gaining greater acceptance of care and support by JT and MT. There is little insight in the chronology into their family and background or their motivation in decision making.

3.7 Associated with this, **practice lacked a person centred focus**; an approach which sought to both understand and inform the perspective and the decision making of JT and of her husband.

3.8 In **2007** concerns began to accumulate so that a **holistic assessment of need and risk** was very clearly indicated. This assessment would have informed judgements as to how to respond to those instances when care, respite, treatment was refused/declined by JT. It would have formed the basis of an action plan for managing and addressing the risks across agencies with clarity around who was coordinating the action plan, who was responsible for specific actions and how and when this would be monitored and reviewed. This was never achieved.

3.9 One of the evident flaws was that a lack of clarity existed even within individual agencies about role and responsibility. This clarity of role as well as clarity around mutual expectations across agencies was required. This issue is relevant to commissioners as well as to providers (as they set out expectations of providers in contracts and monitoring of those expectations).

3.10 One of the key features of the risk assessment and a plan to manage those risks should have been in relation to **pressure ulcers**. These were **first recorded in May 2007**. The assessment of pressure ulcer risk needed to draw on related issues such as nutrition/weight (which again began to emerge as a clear issue in 2007). This was not evident in records. One formal "Waterlow"¹ assessment of the risk in respect of pressure ulcers was undertaken in June 2007. A Braden pressure ulcer risk assessment would have given an accurate focus on nutrition. There was no evidence that such an assessment ever occurred. Inadequacies in recording contributed to the inability to recognise the escalating risks.

3.11 Mental Capacity should have been a key consideration **throughout the chronology**. The presence of a disorder of the brain (following two strokes) along with regular refusal of services/treatment resulting in significant risk might have indicated a need for such an assessment. JT's refusal of the offer of admission to hospital (by the ambulance crew) in January 2012 might for example have been questioned. The core principles of the Act were not evident in practice. Of particular importance was principle 2 relating to supporting decision making. Practice around the DNAR decision at the end of

¹ <http://www.judy-waterlow.co.uk/downloads/Waterlow%20Score%20Card-front.pdf>
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JT's life was not in line with national guidelines (however, this would not have affected the outcome).

3.12 Failures in effective multiagency working became most apparent from **2007 onwards** although this issue was prominent throughout. During 2007 the number of agencies represented in providing care and treatment accumulated. By the end of that year the following were involved with JT: nurses; GP; Housing Support Officers; Community rehabilitation team (CRT) OT and physio; DCC Community Care Officer; Social Worker; Dietician; Chiropodist. The failure of any effective joining up of professional input and assessment was marked from this point and became even more marked in 2010. There were clear issues about ownership of decisions and a need for challenge across agencies and disciplines.

3.13 In the context of multiagency working and of identification and management of risk the **absence of challenge across disciplines and agencies** as well as a lack of challenge to the decision making of JT (and of MT) was significant.

3.14 Practice in the context of the Bournemouth, Dorset and Poole safeguarding adults procedures was found wanting. There should have been a number of alerts raised notably in the period from **2007 to 2012** by a range of professionals. This did not happen until **January 2012** when JT was admitted to a care home on MT's admission to hospital. When the situation was referred into the safeguarding process in January 2012 the practice in carrying out that process was not consistent with guidance in the local policy and procedures nor was it robust.

4 Multiagency recommendations

4.1 Fulfilling commissioning responsibilities by ensuring that contracts and the monitoring of contracts ensures that the practice of provider services addresses the learning from this review

That commissioners fulfill their statutory role in ensuring, through robust monitoring of contracts, that the care arrangements they have a responsibility to fulfill are provided by organisations and staff whose practice demonstrates: sound assessment of need and risk; involvement and empowerment of service users; effective partnership working; good practice in respect of safeguarding adults. This requires that contract monitoring officers are trained to monitor performance against these issues.

4.2 Establishing a clear framework and principles for the identification, assessment and management of risk across agencies including a focus on working with those who are reluctant to engage with services and treatment.

4.2 a) That Dorset Safeguarding Adults Board agrees a framework and principles in line with underpinning legislation for the effective identification, assessment and management of risk, including a commitment to multiagency meetings where the need for this is indicated. This is especially important in the context of cases falling outside the safeguarding adults' framework or

which are perceived to fall outside it. However the principles will apply in all cases involving risk.

Training will embed this guidance in practice.

The Board will monitor the impact of this new guidance on practice.

4.2 b) That there is a review across agencies of existing procedures and advice addressing issues presented by those who are reluctant to engage with services and treatment. That this includes revising the current Dorset Safeguarding Adults Board Interagency Community Risk Management Protocol, July 2012 and incorporating this into the above risk framework so that practice with those who are reluctant to engage with services is grounded in robust approaches to risk as well as an awareness of mental capacity principles and practice. That there is training and multi disciplinary discussion about approaches to working with vulnerable people who refuse services

4.2 c) That Dorset safeguarding adults board adopt a structure/template for recording risk assessments and decisions at safeguarding meetings

4.3 Improving and monitoring practice in relation to the Mental Capacity Act

That the effectiveness of MCA training is monitored in respect of a) assessments of capacity and b) evidencing in practice of the 5 core principles of the Act. That this SCR is used as a case study (alongside others) to inform learning and development, in a variety of forums. The Board will undertake to monitor the effectiveness of MCA training, looking for evidence in practice and leading change in respect of training and practice accordingly.

4.4 Implementing best practice in working with stroke illness

That relevant agencies ensure that local guidelines for working with stroke illness are in line with national guidelines and that these are implemented

4.5 Improving practice in working alongside carers and in carrying out carers' assessments

That DCCACS carry out an audit to ascertain practice in relation to carer assessments and that appropriate action is taken according to the findings. That the Board adopt a Carers Charter (such as that in use in Worcestershire-see link) requiring that all agencies take account of this in their practice with carers. This charter should take account of the ADASS guidance on carers and safeguarding adults and the seven key messages set out within this.

<http://www.adass.org.uk/images/stories/Policy%20Networks/Carers/Carers%20and%20safeguarding%20document%20June%202011.pdf>²

<http://www.worcestershire.gov.uk/cms/carers-unit/carers-charter.aspx>³

² carers and safeguarding adults – working together to improve outcomes

³ The Worcestershire Carers Charter

4.6 Strengthening understanding of the relationship between pressure ulcer care and Safeguarding Adults

That there are clear expectations on making the links between pressure ulcer care and safeguarding adults for all staff across agencies. That these links are made clear in the local safeguarding adults policy and procedures and that this is integrated into practice through training and supervision. This area of practice will be monitored by the Safeguarding Adults Board.

4.7 Learning and Development: Safeguarding Adults. Evidencing of effective training and supervision particularly in respect of: issues of neglect and reluctance to accept services; clarity in understanding of what constitutes safeguarding adults “alert”

That Dorset Safeguarding Adults Board audits the evidence of safeguarding training having taken place across agencies; that the training includes a clear focus on strategies for dealing with issues of neglect and reluctance to engage with services; that it enables a clear understanding of the issue of what constitutes an alert; that supervision policies across agencies include mandatory reference in supervision sessions to safeguarding adults

4.8 Ensuring that all identified risks associated with the case of JT have been addressed via the Safeguarding Adults process

That the Board satisfies itself that the safeguarding process has adequately addressed all of the risks and issues presented by the case of JT via the safeguarding process through a final case conference review to follow up any outstanding issues from the review of 23 August 2012

4.9 Challenge across agencies /individual professional accountability

Organisations must nurture a culture which encourages and values constructive challenge and debate. Managers and staff at all levels must be encouraged to seek clarity, to challenge decisions and to escalate issues and concerns within a well defined process. There were examples where agencies passed on concerns which they were aware were not subsequently acted upon. It is not sufficient for professionals/staff simply to pass on those concerns. Each has a responsibility and accountability to ensure that issues concerning the safety and wellbeing of individuals with whom they are working are addressed. This includes active follow up of referrals, contacts, concerns to ensure that actions are taken to reduce perceived risk/concern. No Secrets, 2000, (quoting from the Independent Longcare Inquiry 1998) states *“no individual agency’s statutory responsibility can be delegated to another. Each agency must act in accordance with its duty when it is satisfied that the action is appropriate. Joint investigation there may be but the shared information flowing from that must be constantly evaluated and reviewed by each agency”*. The development of a culture where mutual challenge at practice level (as well as at a strategic level) is embraced as positive is important learning in the context of this SCR.

4.10 Ensuring robust practice in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNAR)

Practice in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNAR): that the Board assures itself that providers of Health and Social Care are following national guidelines on DNAR.

4.11 Embedding person centred principles in practice and guidance

That member agencies to the safeguarding adults board ensure that person centred principles are embedded in practice and guidance and that this is underpinned by training and supervision.

In particular practice must engage with the individual and be built on a service user led perspective rather than on the available services and interventions.

Service users and their carers must be empowered with information so that they know what to expect of services and can be involved and supported by that information.

5 The agencies involved in this Serious Case Review are committed to ensuring that the issues represented here are addressed. They have already made significant progress in addressing some of the most serious concerns. In addition to the above multiagency recommendations for action, they have identified actions within their own agency which will help to ensure that single agency shortcomings are addressed. Both the recommendations outlined above and the action plans of individual agencies will be closely monitored by the Dorset Safeguarding Adults Board until it is satisfied that all of the issues have been satisfactorily addressed.

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