

Leeds Safeguarding Adults Partnership Board

Serious Case Review

Executive Report

Mr A

Age at incident: 47

Date of incident: 27th October 2007

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07July 09

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Serious Case Review

1. Circumstances that lead to a review of this case

- 1.1 This Serious Case Review was commissioned by Leeds Safeguarding Adults Board (LSAB), and the terms of reference agreed on 19 December 2008 in relation to the care of Mr. A.
- 1.2 Mr A is a 49 year old man, with complex physical disabilities resulting from a head injury road traffic accident in 1976.¹ He now lives in a nursing home in a vegetative state following a choking incident in the residential care home where he was a long term resident.
- 1.3 Following the choking incident there were a number of issues that caused difficulty in supporting him, including his lack of a next of kin and the need to appoint an Independent Mental Capacity Advocate (IMCA) under the Mental Capacity Act 2005 in relation to the decision to switch off his life support machine and other care and treatment decisions.
- 1.4 It was anticipated that a serious case review could help the partnership improve its understanding of issues such as capacity and consent and also consider the factors leading up to the choking incident and help consider whether staff at the residential care home need better training around how to support people with extremely complex needs.
- 1.5 The review has been undertaken by Margaret McGlade, an independent consultant in social care and health, a Registered Social Worker and a former Director of Social Services.
- 1.6 The independent author was appointed in October 2008 but there were delays beginning the review because of the pressure of other priorities within Leeds Safeguarding Adults Unit. The review commenced on 28 January 2009 and was completed on 07 July 2009

¹ In the reports presented to the Independent author the date for the accident varies between 1976 and 1979

2. Conclusions and analysis of effectiveness and areas for improvement

2.1 Conclusions

- 2.1.1 The review concluded that the choking incident was a tragic accident and neither it nor its consequences for Mr. A could have been prevented by anyone involved. It had tragic consequences for Mr. A and caused great sadness for staff at the care home and the social welfare officer at Leeds Adult Social Services and others who had known him for very many years.
- 2.1.3 The review concluded that an IMCA should have been appointed in relation to two decisions concerning Mr. A's care after the accident but that the lack of an IMCA appointment for these decisions did not affect the outcome in either case.
- 2.1.3 The review concluded that there were many examples of good practice in relation to Mr A's care but that there were significant areas for improvement in practice relating to the Mental Capacity Act, Leeds Safeguarding Adults investigation process and the Serious Case review process.

2.2 What was effective?

- 2.2.1 Mr A was suitably placed at the care home and received the standard of 24 hour care and support he required and there were no issues about the quality of his on going care.
- 2.2.2 He had ongoing care management by a social welfare officer who had known him prior to his admission to the care home. His care was reviewed in April 2007 and a comprehensive reassessment by the Social Welfare Officer and an OT as part of a commissioning review of all residents was undertaken in May 2007.
- 2.2.3 His ongoing health care from his GP, the Community Rehabilitation Unit at St Mary's and neurology and gastro-surgery at St James' was appropriate.
- 2.2.4 On the day of the accident there was nothing untoward about Mr A's health which would have made a choking episode more likely, or which could have caused special measures to be taken which might have prevented the accident.
- 2.2.5 It is clear that Mr A had made an informed choice to have solid, albeit softened, food. He had the mental capacity to understand the risks and was sufficiently well informed of the risks as to be able to have made an informed decision.

- 2.2.6 The risks were inherent in his condition as described in 2004 by the gastro-surgeon at St James's as a result of the original serious head injury and potentially exacerbated by potential vacant spells from his intermittent mild epilepsy. There was no medical or dietary requirement that he should have liquidised food, but in May 2004 he was advised to consider this. He may have done so from July 2004 but by November 2006 he had opted to have solid food cut small and softened. The risks were properly documented.
- 2.2.7 Mr A clearly had the capacity to make his own decision and there is ample evidence that he made choices on other occasions not to follow medical or professional advice.
- 2.2.8 The number or severity of previous choking incidents, three in the twelve months from October 2006 were not such that further medical or specialist medical or SLT advice should have been sought.
- 2.2.9 Given that he opted to have solid food that there does not appear to have been anything which would have reduced the likelihood of a choking incident of varying degrees of severity occurring at some time, and to have prevented it. Whilst a general prediction could be made that such choking incidents would occur at some time, there was no possibility of predicting this specific incident or of preventing it.
- 2.2.10 The immediate responses of the care staff and of the emergency services, the Ambulance Service and St James's A&E were prompt and appropriate.
- 2.2.11 The IMCA service, once engaged, was provided promptly and effectively.
- 2.2.12 Leeds City Council acted appropriately in raising the need for an IMCA with St James's and in continuing trying to resolve the issue.

2.3 What could have been improved?

- 2.3.1 It was generally accepted in the review panel that Speech and Language Therapy services in Leeds are inadequate, and in need of improvement to meet need; but this does not appear to have been a factor in this incident.
- 2.3.2 The member of staff who was feeding Mr A had less than three months experience and had not yet had her first aid training but there is nothing to suggest that this affected the outcome. She was supported by two trained senior carers.
- 2.3.3 Once emergency medical intervention was completed St James's should have applied the provisions of the Mental Capacity Act and appointed an IMCA to contribute to the decision to extubated Mr A.

- 2.3.4 That this was the first case in an acute hospital setting following the implementation of the Act on 1 April 2007 and IMCA training had not been rolled out in the hospital will have contributed to this; however the matter was dealt with at an appropriately high level within the Trust and with the Trust's solicitors and the decision followed their interpretation of the legal requirements at that time.
- 2.3.5 It is not clear on what basis it was considered that the Mental Capacity Act did not apply or why the Trust continued to expect the care home and the Social Welfare Officer staff to act as next of kin when advised clearly and promptly that they could not do this.
- 2.3.6 Current Trust IMCA training appropriately identifies the circumstances in which an IMCA should be sought but it is not clear if this is integrated within the risk management procedures or the adult safeguarding procedures of the Trust.
- 2.3.7 The Trust in the interests of partnership working could have sought to resolve the issue of the appointment of an IMCA with Leeds City Council before acting without an IMCA and it appears that there was no agreed process for resolving this kind of disagreement in a timely manner.
- 2.3.8 Leeds Adult Social care, having accepted responsibility for care planning for Mr. A on discharge should have arranged or requested the appointment of an IMCA in relation to the decision to move Mr. A to a Nursing Home. It is not clear why one was not appointed, as the IMCA had advised the Care Planning meeting on 12 December 2007 that one was required.
- 2.3.9 The management of the Adult Protection Investigation lacked clarity. It was appropriate for the matter to have been considered very seriously given its tragic consequences but it is not clear if a safeguarding adults investigation was the most appropriate process; other processes may have been more suitable. Once initiated under this procedure there appears to have been no attempt to manage it on a multi-agency basis; and no outcome to the investigation was formally reached or recorded.
- 2.3.9 The member of staff on the ward refused the investigating social worker's request for information; however it is not clear if she understood this was a safeguarding adults investigation within multi-agency procedures or if she was aware of these procedures. It is not clear if ward staff generally have been trained in adult protection and are familiar with the multi-agency procedures in place.
- 2.3.10 The attention of the SAEC moved from the initial investigation into the choking incident to the hospital's decision to extubate Mr. A, without this being formally communicated to other partners. It is not clear if the absence of an IMCA was being pursued within the interagency adult protection procedures, and it is clear that St James's staff did not see it

in this way.

- 2.3.11 The choking incident in itself does not appear to have warranted a full SCR review despite the tragic consequences for Mr A. However the dispute between the Hospital and the Leeds City Council staff about the application of the IMCA in this case was a serious matter; the review appears to have been the only available forum for understanding what happened and why and seeking to prevent it recurring.
- 2.3.12 The review itself could have been completed in a more timely manner, with more thorough and challenging Management Case Reviews for some agencies prepared at the outset.

3. Learning points from the review

- 3.1 When a critical incident arises the best learning will be obtained from a prompt review in the first instance by the provider or agency where the incident happens; every service provider should have a timely critical incident review process.
- 3.2 Known shortfalls in services which impact on the independence and safety of disabled people should not be allowed to persist indefinitely. Where significant service shortfalls exist which are known to impact on the safety and independence of vulnerable adults in the community it should be apparent how these are to be met and in what time frame.
- 3.3 The Mental Capacity Act needs to be followed in relation to Mr A on future occasions where significant medical intervention is proposed other than in an emergency or where there is a proposed change of accommodation. It is situation specific.
- 3.4 Understanding of the requirements of the Mental Capacity Act is partial and still presents operational difficulties for the IMCA service particularly in healthcare settings.
- 3.5 People with no next of kin are very vulnerable in the event of a temporary or permanent loss of capacity to make their own decisions; where such people are known to services they could be supported to make arrangements to cover the circumstances in which they may not be able to make their own decisions.
- 3.6 Challenging doctors' actions in an acute hospital setting can be very difficult both because of the seniority and status of medical staff involved and the number of different doctors and nurses who may be involved on each ward; Leeds City Council staff, including their lawyer were unable to influence this outcome; the hospital could seek to make it easier for those raising issues to be heard.
- 3.7 Significant issues may from time to time arise between professionals in different agencies; where a dispute arises there should be a

recognised mechanism between the partner agencies to resolve disputes whilst the issue is still current.

- 3.8 Adult protection processes are still underdeveloped and not fully understood; more needs to be done to improve the process and its implementation.
- 3.9 Adult protection, risk management and Mental Capacity Act provisions need to be interlinked in agency processes.
- 3.10 The learning from serious case reviews is most easily gathered and put to use if reviews are conducted in a timely manner, and every agency produces a management case review to the required standard.
- 3.11 Other ways of obtaining learning from significant incidents should be considered before deciding if a SCR is required.

4. Recommendations

- 4.1 The Disabilities Trust should develop a process for undertaking a critical incident review in a timely manner when a serious or life threatening incident takes place.
- 4.2 Leeds Adult Social Care contracting should have such an expectation built into their standard contracts with providers.
- 4.3 Leeds NHS should resolve the known and long standing shortfall in Speech and Language Therapy services in Leeds.
- 4.4 Leeds Teaching Hospitals NHS Trust should review the level of understanding of the requirements of the MCA in the Trust and ensure that it is implemented routinely in relation to Mr A as required and more generally.
- 4.5 Leeds Adult Social Care should undertake a similar review.
- 4.6 All agencies, particularly Leeds NHS Teaching Hospitals Trust and NHS Leeds should be represented on the Leeds MCA Implementation group at a sufficiently senior level to enable practice in relation to the appointment, use and liaison with the IMCA service to be improved and progress should be monitored by the Leeds Safeguarding Adults Board.
- 4.7 Leeds City Council care management services should identify whether there are other care managed cases in Leeds where the user has no next of kin and encourage the user to make arrangements to cover the circumstances in which they may not be able to make their own decisions.

- 4.8 Channels should be developed for resolving disputes between professional staff in partner agencies which do not require SCR reviews to be seen as the only way of exploring an issue.
- 4.9 LSAB should revise the Leeds Adult Protection procedures to clarify the respective role of the SAECs where the service user is an open case in one area but lives in another, set time standards for completing investigations and ensure that investigations are appropriately managed on an interagency basis and that a clear conclusion and decision is reached and recorded.
- 4.10 Adult protection, risk management and Mental Capacity Act provisions should be interlinked in agency procedures.
- 4.11 Leeds Safeguarding Adults Board should revise its SCR processes to ensure that SCRs, where required are undertaken in a timely manner.
- 4.12 Agencies should ensure that their internal MCRs have the appropriate level of independence and oversight and that there is robust internal and interagency challenge in the process.
- 4.13 Alternative processes to obtain the learning from significant incidents should also be considered.
- 4.14 The Disabilities Trust and Leeds Advocacy have each made a relevant change in procedures following this incident, these are appropriate and should be maintained.

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