Executive Summary of the Serious Case Review in respect of VA 1

Author:
M Muir

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1. Introduction

Circumstances leading to the decision to undertake a Serious Case Review

1.1 VA 1 was first referred to Adult Social Care (ASC) in March 2008 when she was assessed as being in need of domiciliary support, respite and day care. These services were offered but were never taken up by VA 1. At the time of the assessment VA 1 was noted to be suffering from Alzheimer's Disease, which resulted in her having cognitive impairment. In addition, she had a tendency to 'wander'. VA 1 was receiving extensive daily support from her daughter.

1.2 In September 2008 VA 1 was admitted to Acute Hospital 1 complaining of pain in her right hip, believed to originate from an old previously undiagnosed injury. She underwent a hip replacement operation from which she was seen to recover well.

1.3 At the time of the operation, the plan was for VA 1 to return to her own home, but it was felt that she required a period of rehabilitation before this could happen. There had been some concern, while on the ward, about the impact of VA 1's dementia on her behaviour, (for example she regularly pulled out her catheter) and how this would influence her rehabilitation plan. She was the subject of a psychiatric assessment that concluded that her rehabilitation could be progressed in a nursing care Community Intermediate Care (CIC) bed.

1.4 On the basis of the psychiatric assessment, VA 1 was discharged to an intermediate care bed in Care Home with Nursing 1 on 20th October 2008. Following her placement it quickly became evident that Care Home with Nursing 1 was unable to meet her needs and, following a further psychiatric assessment, she was moved to a spot-purchased intermediate care bed in Care Home with Nursing 2 on 30th October 2008. This was a dementia unit within a care home with nursing. The plan at this time was still for VA 1 to be rehabilitated to her own home and the Intermediate Care Team (ICT) was involved to facilitate this.

1.5 VA 1 initially made good progress, rehabilitating well. However, at a review meeting on 21st November 2008, her daughter expressed her anxiety about her ability to support her mother, should she be discharged home. A decision was therefore made for VA 1 to become a permanent resident at Care Home with Nursing 2.

1.6 VA 1 was readmitted to hospital on 13th December 2008 following a fall which had resulted in a fracture to her left hip. She had a second partial hip replacement operation and was discharged back to Care Home with

Nursing 2 on 16th December 2008.

1.7 In the early months of 2009, VA 1 was the subject of a number of safeguarding concerns following falls and alleged assaults by other residents. During this time also, her daughter began to express concerns about her mother's care, particularly in relation to her recent weight loss. Also during this time, VA 1 developed a pressure ulcer which her daughter was concerned was not being treated properly.

1.8 VA 1's condition deteriorated rapidly between early February and late March 2009. She was referred to the Joint Care Management Team (JCMT) by her GP on 30th March 2009 for end of life care and this referral was received on 31st March. When the JCMT made contact with her daughter on 1st April 2009 she made a complaint about her mother's care which led to a safeguarding alert being raised by the JCMT Team Manager.

1.9 VA 1 died on 11th April 2009. The cause of her death was bronchial pneumonia with associated sepsis, malnutrition, dehydration and Alzheimer's disease.

1.10 Following her death VA 1's case became part of a much wider safeguarding review of possible institutional abuse at Care Home with Nursing 2, during which all admissions to the Home were suspended.

1.11 On 27th April 2010 the Chair of the Leeds Safeguarding Adults Partnership Board (LSAPB) was asked by two agencies to commission a Serious Case Review (SCR) into the practice of agencies involved in VA 1's care before her death. These were accepted by the Chair of the LSAPB and the SCR process commenced on 1st May 2010. A criminal investigation by West Yorkshire Police delayed the start of the review.

2. Terms of Reference

These terms of reference were questions for all agencies to consider when producing their Individual management Reviews and were subsequently considered in turn by the Serious Case Review Panel.

2.1 The following terms of reference were agreed by the Safeguarding Adults Partnership Board:

- Were the assessments that were completed on VA 1 comprehensive and 'fit for purpose' and did they accurately identify her needs and inform appropriate intervention strategies?
- To what extent were the indicators of risk present in this case recognised and taken into account by your agency in the decision making about VA 1?
- Were adequate arrangements made within your agency to consult with and take account of VA 1 and her family's views, wishes and feelings about the services that were provided?
- Did your agency adhere to single and multi-agency policies and procedures in this case?
- Did your agency communicate effectively and work together with other agencies to safeguard and promote VA 1's welfare?
- Did the staff involved with VA 1 receive adequate supervision and was there sufficient management oversight of the case?
- How were the concerns expressed by VA 1's family managed and taken into account by your agency when providing services for VA 1?
- From the information available, could VA 1's death have been predicted or her life have been prolonged? Could the way in which she died have been prevented?
- Did the staff involved with VA 1 have the necessary training, skills and experience to discharge their duties to an acceptable standard?
- Did those people involved in caring for and safeguarding VA 1 exercise their duty of care appropriately?

2.2 The timeframe for the SCR is from 1st October 2008 (VA 1's admission to Acute Hospital 1) until 15th April 2009 (VA 1's case closed by key agencies following her death).

3. Methodology

3.1 The Serious Case Review Panel was constituted of senior managers from each key agency involved in providing services to VA 1 during the time period of the review.

3.2 The Panel received Individual Management Reviews (IMRs) from the eight agencies providing services to VA 1 during the period of the review.

3.3 The Overview Author also had sight of a letter from the Consultant Geriatrician who completed an assessment on VA 1 while she was resident at Care Home with Nursing 1 and he was also given access to the Police report to the Crown Prosecution Service (CPS)* and to the information provided for the Coroner's Enquiry into VA 1's death.

3.4 In order to promote independence and transparency of process there was a separation of role between Panel Members and IMR Authors, none of whom had had contact with VA 1 or her family prior to the SCR, nor had they had line management responsibility for any of the practitioners involved in this case.

3.5 In an effort to ensure high quality reviews, arrangements were made to provide all IMR authors with training and support to enable them to produce 'fit for purpose' single agency reviews.

3.6 In order that she had the opportunity to give her views within the Serious Case Review process , the independent author met with VA 1's daughter and heard her opinion of the care her mother received from all the agencies involved in the SCR.

3.7 The Serious Case Review Panel met on met on seven occasions.

*The CPS was asked to consider (1) gross negligence manslaughter and (2) an offence contrary to section 44 of the Mental Capacity Act (2005).
It was the view of the CPS that while it would, without doubt, be in the public interest to proceed, there was insufficient evidence of either offence to allow a reasonable expectation of conviction.

4. Family Involvement

4.1 VA 1 had two adult children; her daughter was notified that an SCR was to be conducted into the circumstances surrounding their mother's death in May 2010. She was informed of the purpose of the SCR and was invited to make a contribution if they wished.

4.2 VA 1's daughter responded to the notification of the SCR and said that she wanted to contribute to the process, both to clarify the sequence of events from her point of view and also to promote learning and development within the agencies that were involved with her mother.

4.3 VA 1's daughter was met by the Independent Author and the Safeguarding Adults Partnership Manager on 7th June 2010.

5. Overview of What Was Known prior to the SCR

Brief chronology of events

Date	Event
27/09/2008	VA 1 admitted from home to Acute Hospital 1 with fractured hip.
05/10/2008	Operation – successful.
15/10/2008	Intermediate Care Team (ICT) referral received from Acute Hospital 1.
17/10/2008	Psychiatric assessment completed. 'Generic bed required'.
20/10/2008	Move to Care Home with Nursing 1.
20/10/2008	VA 1 seen by Community Geriatrician. Immediate concerns were raised about the suitability of the placement.
29/10/2008	Agreed that Care Home with Nursing 2 should assess VA 1.
30/10/2008	VA 1 moved to Care Home with Nursing 2.
10/12/2008	VA1 fell.
14/12/2008	VA 1 fell and was admitted to Acute Hospital 1. Diagnosed with a fractured neck of femur, which was operated on.
16/12/2008	VA 1 discharged back to Care Home with Nursing 2.
20/01/2009	VA 1 fell.
25/01/2009	VA 1 was allegedly pushed over by another resident.
26/01/2009	VA 1 fell.
02/02/2009	VA 1 was allegedly pushed over by another resident. Care Home with Nursing 2 staff raised a safeguarding alert.
04/02/2009	VA 1 was allegedly pushed over by another resident.
10/02/2009	VA 1 fell.
12/02/2009	VA 1 was allegedly pushed over by another resident.
12/02/2009	A safeguarding meeting was held.
26/02/2009	VA 1 was assessed as meeting Continuing Care nursing care funding criteria.
13/03/2009	VA 1 was referred to the Tissue Viability Nurse.
30/03/2009	VA 1 was referred for end of life care (Fast Track Continuing Care) by her GP.
31/03/2009	This referral was received and VA 1 was allocated to the Joint Care Management Team (JCMT).
01/04.2009	VA 1's daughter expressed concerns about the standard of care her mother was receiving and a safeguarding investigation began, together with an immediate protection plan.
03/04/2009	NHS Leeds and Leeds City Council decided to suspend all placements at Care Home with Nursing 2 and to review all residents.
03/04/2009	Twilight District Nursing service began caring for VA 1.
04/04/2009	Complex and Palliative Continuing Care Service (CAPCCS) began providing care to VA 1.
06/04/2009	CAPCCS withdrew from caring for VA 1, satisfied that Care Home with Nursing 2 staff would now care to an adequate standard.
11/04/2009	VA 1 was certified dead at 19.31 by her GP. The cause of her death was bronchial pneumonia with associated sepsis, malnutrition, dehydration and Alzheimer's disease.

6. Analysis

This section covers each of the questions which agencies were asked to address in their Individual Management Reviews and which were considered by the Review Panel.

6.1 Were the assessments that were completed on VA 1 comprehensive and fit for purpose and did they accurately identify her needs and inform appropriate intervention strategies?

6.1.1 VA 1 was the subject of many assessments during the timeframe for this SCR, including assessments by her Social Worker, by staff at Acute Hospital 1, by the Psychiatric Liaison Team, by Care Home with Nursing 1, by the Community Geriatrician, by staff at Care Home with Nursing 2, by her GP, Continuing Care and in the last few weeks of her life, by the Joint Care Management Team, the Twilight District Nurse, the Tissue Viability Nurse and the CAPPC Service.

6.1.2 The quality of assessments undertaken on VA 1 was variable and there were periods of time when her needs were clearly not properly assessed and consequently were not being met. The Panel noted that a number of assessments were not recorded well and there was a lack of clarity about the outcomes of assessments and recommendations for action. This was particularly the case when the responsibility for VA 1's care was shared or passed from one agency to another and was exacerbated by the fact that there was no single professional taking responsibility for coordinating the care and services that VA 1 required. This issue is addressed in the multi-agency recommendations of this report.

6.2 To what extent were the indicators of risk present in this case recognised and taken into account by each agency in the decision making about VA 1?

6.2.1 It was the view of the Panel that the record of most of the agencies involved with VA 1 in recognising risk and taking it into account in the decision making about her was not of the standard that it should have been. VA 1 was prone to falling, she had difficulties in relation to weight loss and she suffered from pressure ulcers. All of these matters were the subject of risk assessments on occasions by various agencies with little evidence of effective risk management plans being produced and implemented (except for the last few days of her life).

6.2.2 The Panel considered that while there some recognition of the safeguarding risks that VA 1 was exposed to as a result of the aggression

of other residents, these were addressed inadequately.

6.2.3 The Panel also considered that none of the agencies providing care to VA1, prior to the involvement of the JCMT recognised the risk of neglect that she was experiencing and seemed to attribute her deterioration as a natural result of her age and mental health diagnosis. As a consequence, no safeguarding action was taken.

6.3 Were adequate arrangements made within each agency to consult with and take account of VA 1 and her family's views, wishes and feelings about the services that were provided?

6.3.1 Many agencies had difficulty in responding to this term of reference due to the poor recording of conversations and discussions that were reported to have taken place with VA 1's daughter.

6.3.2 It was the view of the Panel that consultation with VA 1's family was limited and a number of opportunities had been missed to consult with her daughter and involve her more closely in the planning of her mother's care. The Panel noted with concern that there was not a single reference to an attempt by any agency to speak directly to VA 1herself about her circumstances and what she wanted to happen. The Panel was aware that VA 1 suffered from dementia and there were concerns about her capacity to make informed decisions, but believed that, nonetheless, attempts should have been made to engage with her and provide her with the opportunity to express her views. If this was considered to be beyond her capacity, then a capacity assessment should have taken place with careful recording in line with the requirements of the Mental Capacity Act (2005). The issue of involving service users with limited capacity in the decision making about their care and support is addressed in the multi-agency recommendations of this report.

6.4 Did each agency adhere to single and multi-agency policies and procedures in this case?

6.4.1 With the exception of the response by the JCMT to the Fast Track Continuing Care referral on 31st March 2009 and the subsequent support offered to VA 1 by the Twilight Nurse, CAPCC Service and Continuing Care, the record of most agencies in relation to adherence to single and multi-agency procedures is not of the standard that is expected.

6.4.2 The Care Home with Nursing 2 IMR noted that a range of policies in relation to personal care planning, assessment, reviewing care plans, direct work with aggressive residents, professional practice and whistle-

blowing were not followed.

6.4.3 Almost all IMR Authors identify shortcomings in adherence to expected standards in recordkeeping and there is a near unanimous agreement that safeguarding policies were not followed in relation to the incidents in January and February 2009. It was suggested that these procedures were not fit for purpose at that time, although the Panel was informed these have now been rewritten, endorsed by the Safeguarding Adults Board and their adoption was accompanied by significant investment of resources from across the safeguarding adults partnership. However, the ASC IMR reports that there is as yet no ASC single agency safeguarding procedure in place. This is a significant omission and if replicated in other agencies would be a serious cause for concern. This issue is the subject of a multi-agency recommendation of this report.

6.5 Did agencies communicate effectively and work together with other agencies to safeguard and promote VA 1's welfare?

6.5.1 The Panel was of the view that both inter and intra-agency communication in this case was generally poor and that there was little evidence of professionals working together to promote VA 1's welfare.

6.5.2 The Panel had concerns in relation to collaborative, multi-agency working. There is little evidence of agencies working together on a single care plan which addressed all of VA 1's needs. Rather, professionals tended to develop their own plans in relation to VA 1's specific needs and as a consequence, there was a failure to develop a holistic assessment of need and a tendency towards silo practice by professionals. Examples of this would include the lack of clarity by Care Home with Nursing 2 about the role of ICT up to 21st November 2008, Care Home with Nursing 2 and the TV Nurse not working together in relation to VA 1's pressure ulcer management and all agencies not working together, prior to 31st March 2009 to safeguard VA 1.

6.5.3 The Panel was concerned about this important issue and the matter is addressed in a multi-agency recommendation of this report.

6.6 Did the staff involved with VA 1 receive adequate supervision and was there adequate management oversight of the case?

6.6.1 It was recognised by the Panel that supervision means different things to different agencies and expectations in relation to the oversight of practitioners' work vary also.

6.6.2 There was no evidence throughout the Review that any manager from any agency, (apart from the JCMT and Continuing Care Managers on 2nd April 2009) had taken action to intervene in this case and change the course of events for VA 1.

6.6.3 The Panel was of the view that it is not possible for practitioners at all levels to maintain high quality services for their clients/patients without the support and feedback that challenging supervision provides and without their work being appropriately directed by their managers.

6.7 How were the concerns expressed by VA 1's family managed and taken into account by agencies when providing services for VA 1?

6.7.1 There were three occasions when VA 1's daughter expressed concerns about her mother's care while she was resident at Care Home with Nursing 2. The first occasion was when VA 1 first moved from Care Home with Nursing 1 and she was placed within the dementia care unit at Care Home with Nursing 2. VA 1's daughter was concerned that other residents were more confused than her mother and that she would deteriorate more quickly without stimulating company. As a result, VA 1 was offered a trial placement on 4th November 2008 in a general nursing unit, but this quickly broke down due to VA 1's 'difficult to manage' behaviour. This appeared to the Panel to be an acceptable response to VA 1's daughter's concerns.

6.7.2 The second 'occasion' covered the period from 2nd to 12th February 2009. During this period VA 1's daughter began to express concern about her mother's care, particularly in relation to a number of safeguarding issues and the fact that she had had repeated falls, significant weight loss in a relatively short period of time and had developed a sacral pressure ulcer. All of these things were discussed at a strategy meeting on 12th February 2009. The outcome of the meeting was a decision that VA 1 did not require a protection plan. There is no record of any plan that was agreed in response to VA 1's daughter's other concerns and very little evidence of any action to address these issues thereafter, (save for the referral to the Tissue Viability Service on 14th March 2009). This response, both to VA 1's daughter's concerns and the decision not make any safeguarding plan did not meet the required standard of practice.

6.7.3 VA 1's daughter next expressed concerns about her mother's welfare in a telephone conversation with the JCMT Team Manager on 1st April 2009. In response the JCMT Team Manager raised a safeguarding alert and referred VA 1 to the CAPCC Service for short-term support while Care Home with Nursing 2 made appropriate arrangements to meet her needs. The response by the JCMT Team Manager and the CAPCC Service was of high quality.

6.8 From the information available, could the outcome for VA 1 have been predicted or prevented?

6.8.1 The Panel was informed that the deterioration in VA 1's condition to the point that she required palliative care, (leading ultimately to her death) was inevitable. As a consequence therefore, what happened was predictable and could not have been prevented.

6.8.2 The Panel noted however the improvement in VA 1's condition, (albeit briefly) following the intervention of the CAPCC Service between 4th and 6th April 2009. It was the view of the Panel that if VA 1 had been referred for Fast Track Continuing Care funding earlier and had received better care and attention thereafter, including proper ongoing assessments of her needs with appropriate interventions, that she would have enjoyed a better quality of life in her last few months.

6.9 Did the staff involved with VA 1 have the necessary training, skills and experience to discharge their duties to an acceptable standard?

6.9.1 Without exception, all the IMRs report that the practitioners involved with VA 1 had the necessary qualifications, skills and experience to discharge their professional duties. Some make reference to the need for additional safeguarding, mental capacity and 'end of life' care training and make appropriate recommendations to address these shortfalls.

6.10 Did those people involved in caring for and safeguarding VA 1 exercise their duty of care appropriately?

6.10.1 The Panel was of the view that there were issues and concerns about the practice of staff from all agencies that were involved with VA 1 up to the point that she was referred for Fast Track Continuing Care funding on the 30th March 2009. It was noted that while there were some examples of good practice, most IMRs identified examples of areas for improvement, omissions and missed opportunities that evidenced failures of staff to fully discharge their duty of care to VA 1.

6.10.2 It was the view of the Panel that ASC and Care Home with Nursing 2 staff did not discharge their duty of care to VA 1 to an acceptable standard. Neither agency responded appropriately to the several safeguarding concerns about VA 1 and did not take specific action in response to her daughter's expressions of concern about her mother. These represented a

number of missed opportunities to intervene on behalf of VA 1 and take action to improve her situation in the last few months of her life.

6.10.3 The Panel considered that VA 1's GP attended when requested but was not proactive in safeguarding VA 1's welfare and safety, nor in involving other specialists, such as a dietician when needed.

7. Conclusion

7.1 It was the view of the Panel that VA 1 received a variable level of service from the agencies with which she was involved and that while her death was predictable and could not have been prevented, it is possible that with better care the quality of her life in her last few months could have been improved.

7.2 The process of the Review has identified the following issues:

- Limited inter-agency communication and poor inter-agency working

The standard of effective communication and collaboration in this case was not of an acceptable standard and remedial action is required.

- Failure to recognise risk of harm

There were at least two occasions when VA 1 was assaulted or threatened by another resident and though there was a strategy meeting in response to these concerns, the conclusion that VA 1 was not in need of a protection plan was misguided and did not to recognise the likelihood of harm in future. In addition, there was clear evidence that VA 1 was not thriving at Care Home with Nursing 2 and there were direct allegations by VA 1's daughter that her mother was being neglected with no safeguarding action being taken until the JCMT was involved in April 2009.

The fact that no safeguarding action was taken would suggest that practitioners involved did not recognise the risk of harm to which VA 1 was exposed. This is a cause for concern and is reflected in the multi-agency recommendations.

- The expectation that agencies should take account of the wishes and feelings of individuals with impaired capacity.

The Panel was aware that VA 1 suffered from impaired capacity due to her cognitive condition but was concerned that there was no reference at all to any professional attempting to consider the requirements of the Mental Capacity Act (2005) or to engage with her and elicit her wishes and feelings about her situation and circumstances. The Panel identified this as unacceptable practice.

- The need for effective supervision of staff and adequate management oversight of their work.

It is not possible for practitioners to provide consistently high quality services to individuals without regular challenging feedback on performance and managerial direction. Equally, without proper oversight of practitioners' work, managers leave themselves vulnerable when there are complaints or there are issues of responsibility and accountability to be addressed.

- The need for practitioners to seek specialist assessments on clients when current arrangements leave needs unmet.

VA 1 was prone to falls, suffered from poor food intake and had difficulties in swallowing. Both of these issues would have benefitted from a specialist assessment, but no referral for such assessments was made. The Panel felt also that when the need for a specialist assessment had been identified, the practitioner involved should have taken personal responsibility to ensure the referral was made.

♦ The need for agencies to maintain 'fit for purpose' records.

The process of this SCR has been affected and the learning limited by the poor quality of record keeping reported by most IMR Authors. Fit for purpose records are important, both to provide an account of the sequence of events but also because they create an audit trail when there are issues of professional accountability.

7.3 Each agency has identified a range of single agency issues and learning points and has produced recommendations to address the particular issues within each service. All recommendations will be monitored and audited by the Serious Case Review (Professional Practice) Sub-group of the LSAPB.

8. Multi-Agency Recommendations

8.1 LSAPB to oversee the development of a multi-agency strategy on the discharge/ transfer of care arrangements for vulnerable adults in Leeds with associated policy, procedure and practice guidance.

Priority recommendation

8.2 LSAPB to ensure that NHS Leeds and Adult Social Care undertake work to improve guidance and processes that contribute to determination of Funded Nursing Care or Continuing healthcare eligibility.

Priority recommendation

8.3 LSAPB to ensure that all agencies have arrangements in place that provide 'fit for purpose' supervision and management oversight for staff at all levels.

Priority recommendation

8.4 LSAPB to remind all agencies of the expectations set out within the Mental Capacity Act (2005) in respect of people who are unable to make key decisions as a result of a cognitive impairment.

Priority recommendation

8.5 LSAPB to clarify its expectations that professionals who identify the need for a specialist service for a vulnerable adult in the course of their assessments should make the appropriate referral for that service. The fact that the service may not be available due to resource issues should not prevent the referral being made.

8.6 LSAPB to ensure that current multi-agency training strategies identify and reinforce the need for effective information sharing and collaborative working.

8.7 LSAPB should develop an information system that identifies and collates multiple safeguarding/quality of care concerns about all care providers to inform appropriate agency responses.

8.8 LSAPB should ensure that all key agencies have systems in place to provide 'fit for purpose' records of their involvement with vulnerable adults and these are subject to regular audit and review.

8.9 LSAPB should ensure that in addition to multi-agency safeguarding policy, all agencies have fit for purpose single agency procedures in place.

8.10 LSAPB should develop an audit tool to assess the standard of each agency's risk assessment and management processes to assure itself that they are fit for purpose.

Signed: .....

M Muir
Independent Author

Date: .....