Wolverhampton Safeguarding Adults Board

Safeguarding Adult Review

Alison

Died February 2015

Aged 50

Robert Lake Independent Author

1. Foreword by the Author

In late 2015, The Chair of the Wolverhampton Safeguarding Adult Board decided that the known circumstances of Alison's death in February 2015 met the Safeguarding Adults Review criteria as laid down in the Care Act 2014. It was decided that the Review would focus on the period of time from the 1st November 2014 to the date of Alison's death in February 2015.

I was subsequently appointed by the Board, in February 2016, to Chair a Safeguarding Adults Review Panel (SAR) and to author this Safeguarding Adult Review report. I am an independent social care consultant and a qualified social worker having previously been a Director of Social Services for fifteen years in large county local authorities. I have also held senior Board level positions in the NHS and the voluntary housing association sector and have chaired a local safeguarding children board.

At the outset, I wish to record my thanks to all those who have assisted with the preparation of this report: the authors of the Individual Management Reports, the members of the Safeguarding Adult Review Panel and especially to the Head of Safeguarding and her team at Wolverhampton City Council who have provided professional and administrative support.

The Terms of Reference for this Review are given at Appendix 1

2. Introduction

Alison was aged fifty at the time of her death. [Note: Alison is the name chosen by her relatives for the purpose of this anonymised report.] Alison had a learning disability, Down's syndrome, and in the latter years of her life, she suffered from dementia.

She was born in 1964 and had two elder brothers. The family encouraged Alison to participate in a wide range of social and educational activities, both as a child and into adulthood, and she established herself as a valued colleague and member of staff in a variety of roles with Wolverhampton City Council. Alison took ill-health retirement in October 2012 due to the rapid onset of dementia. Up until that time, Alison had the mental capacity to make informed choices in relation to most aspects of her life, albeit she required support with more complex life-changing decisions.

When Alison was in her mid-twenties, her parents had the foresight to think about what would be in her best interests in the longer term. Alison welcomed the idea of living independently but wished to do so in the then family home. Her parents therefore moved to another house themselves allowing Alison to stay in the house she knew, sharing the house with two other people with similar needs. The house was placed in Trust for Alison and daily living support was provided by care staff from a local Housing Association. The nature and level of this support

increased as Alison's independence lessened with the onset and development of dementia: in the months prior to her death Alison required constant 1:1 support.

Alison's father and eldest brother died some time ago. The younger of her two brothers (who was also representing Alison's mother) has made a very helpful contribution to this Review enabling me to gain an appreciation of the remarkable person Alison was.

3. A Summary Chronology of Key Events: November 2014 – February 2015.

Note: The SAR Panel received extensive and very helpful reports from each of the agencies involved in Alison's care. These included a copy of the Root Cause Analysis report prepared by the hospital Trust, in April 2015, which considered if there had been a delayed or missed diagnosis.

Of necessity, in the interests of brevity, the following section can only include key events.

3.1 Throughout **November 2014**, Alison suffered from frequent epileptic episodes, of varying degrees of seriousness. She received on-going and very regular medical support from a Consultant Psychiatrist and Community Nurse at a local Clinic and from her GP. On **14 November**, Alison was found on the kitchen floor having probably experienced some form of seizure. An Ambulance crew attended and no injuries or other causes for concern were found: transport to hospital was offered but the carers preferred to keep Alison at home and monitor her health there. There were no further immediate concerns arising from this incident.

3.2 On **1 December 2014**, Alison was seen, privately, by a Consultant Physician, who noted that there had been "significant deterioration in her abilities over the last year. She now has 24-hour care …. she continues to have black-outs or fits [which] continue to be a problem but [are] manageable".

For the remainder of **December 2014**, the epileptic episodes continued on a regular, sometimes daily, basis. The Community Learning Disability Service raised some concerns with the Housing Association Care Coordinator that the lack of monitoring charts must be addressed: it was agreed that this would be done.

3.3 In the early part of **January 2015**, it was noted that Alison was continuing to experience regular epileptic jerks and fits, sometimes daily. She was seen again by an Occupational Therapist, by her GP and by the Consultant Psychiatrist ND Community Learning Disability nurse. It was noted that Alison was reluctant to take some forms of medication (tablets): the medication was reviewed and alternative (liquid) forms prescribed.

Note: In the period from November to mid-January, Alison had continued to enjoy daily outings and social events on a regular basis. She had regular contacts with her mother and brother.

3.4 On **14 January 2015**, at 09.38 hours, Alison was admitted to hospital, by ambulance, having experienced three further fits/seizures/unresponsive episodes. The only information given to the hospital by the carer who accompanied Alison was that Alison was recovering from a seizure and that she had been found slumped on a sofa. (This conflicts with another report in the care record that the unresponsive episode occurred while Alison was sitting at the breakfast table.) An Accident and Emergency Department (A&E) Doctor contacted Alison's Consultant Psychiatrist for background information, and the two doctors discussed the possibility that the three episodes could be related to seizure activity or a cardiac event. Alison was walking to the side, showing a lack of co-ordination, shouting in pain and unsteady on her feet. On examination and with test results, it was found that Alison had a urinary tract infection and possible chest infection. It is reported that the A&E Doctor had suggested that the shoulder stiffness and neck pain was muscular. Antibiotics were prescribed and Alison was discharged home at 20.30 hours with a recommendation for cardiology follow up – an electrocardiogram (ECG) had shown some abnormality. The cervical spine had not been examined as it was not felt relevant to Alison's presenting complaint.

NB The events of 14 January are crucial to this Review: these are examined further below.

3.5 On **15 January 2015**, it was reported that Alison appeared tired and weak, stiff in the shoulders and in need of carer support to walk. She was experiencing some pain in her head and neck and swallowing difficulties. This was witnessed by the Community Learning Disability Nurse who visited that day – the nurse specifically asked if Alison had had a fall the previous day, prior to admission to hospital: the nurse was told that there had been no fall.

Also on 15 January, The Consultant Psychiatrist liaised with Alison's mother, by phone, and agreed that the GP would be requested to make a private referral for cardiology screening/ECG. The GP dictated a referral letter the same day. There are some reports in the care record that a GP visit was requested that day. GP records show that a return telephone call, rather than a visit, was requested and that, when this was done, the carer was not available to speak. Housing Association Care records do not record this telephone call having been received. There was no further follow-up action by the GP. It is known, however, that the Housing Association Carers did contact the out-of-hours 111 service later that day to query what was happening with the GP: the 111 clinician advised that the GP surgery should be contacted the following morning unless Alison were to deteriorate and, in which case, to call back.

3.6 On **16 January**, it is recorded by the Housing Association carers that they again requested a home visit by the GP and that this was refused: the GP had seen the hospital discharge notes, and the notes from the Psychiatrist and the 111 service, and did not consider it to be necessary to act further as Alison's condition was largely unchanged. The carers' manager then spoke to the GP by phone requesting a visit as Alison could not tolerate the medications prescribed by the hospital. The GP agreed to prescribe the medication in syrup form, and this was later collected from the dispensary. The manager was advised to contact the out of ours service if Alison's condition were to deteriorate over the weekend.

3.7 On Saturday **17 January**, at 13.49 hours, carers called for an ambulance as Alison had become very agitated, in a lot of pain, her right shoulder blade protruding and mobility significantly decreased. The ambulance rapid response vehicle attended at 13.54 hours. It was concluded that Alison's lack of coordination was due to the combination of known urine and chest infections. Carers state that it was clear how painful and difficult it was for Alison to mobilise. Alison was not taken to hospital: ambulance records state that Alison refused to go to hospital. Carers dispute this. In any event, the rapid response vehicle left at 14.57 hours: staff were advised to contact them again if necessary.
Note: The information provided in the ambulance service IMR about this visit was limited: as the ambulance service's representative explained, the records made on site are not comprehensive and can be difficult to read. We were told that a review of documentation is underway.

3.8 By **19 January**, Alison was reported to be much better in some respects but was unable to walk, requiring two staff to help her stand, and her neck was falling to the left. The GP visited and prescribed stronger painkillers and advised staff to support Alison to walk more. The GP was concerned that Alison was slumped in a chair. Staff were asked to place a towel under Alison's neck to relieve pressure and also place a towel underneath her to stop her slipping down the leather seat. Once Alison was sitting upright, the GP examined Alison's neck noting that she was tender over the muscle at the right side of her neck. It was concluded that this was due to her previous posture in the chair. Alison was able to move both arms feely. Later that same day, the new prescription was collected from the pharmacy.

3.9 On **20 January**, the Community Learning Disability nurse telephoned the carers and was told the Alison had been reviewed by the GP who had prescribed further antibiotics and stronger pain relief. Alison's neck was still stiff and she had reduced mobility.

3.10 By **21 January**, Alison appeared very distressed and her balance and mobility were still not improved. This was communicated by Alison's carers, in a phone conversation, to the Community Learning Disability Team who arranged for the Consultant Psychiatrist to visit the next day. Also on the 21 January, a urine sample was taken to the GP for analysis (later confirmed as normal) and contact was made with the Occupational Therapy Service by the Housing

Association Care staff requesting more carer support and a review of mobility equipment. The Community Learning Disability nurse visited in the late afternoon and again asked if there was any history of a fall. She found a record in the carers' notes (carers present at the time said that this was the first time they had seen this entry) that on the 14 January Alison had been found sitting on the floor. (It was known that during seizures Alison would often stoop or crouch down onto the floor in a cross legged position.) The nurse questioned the carers if there had been a seizure or a fall on this occasion but the carers had no further information - they said they were not aware of any reports of a fall.

3.11 On the **22 January**, the Consultant Psychiatrist and the Learning Disability nurse made a home visit to Alison. She was unable to bear weight or move her neck. Enquiries were again made by the Learning Disability nurse about a possible fall on the 14 January and again it was stated that there was no record of a fall – Alison would have seated herself on the floor when she experienced the upper body jerk. The admission to hospital had followed an incident at the breakfast table when Alison was seen to sway to the side and slump while seated. The Consultant undertook a very thorough examination of Alison and concluded that she presented with torticollis (a wry neck), had difficulty weight-bearing and tenderness in the cervical region. "There was no history of injury or fall to consider any fracture/dislocation at this stage." The Consultant advised the staff to continue with current management. If any further deterioration, to call 999. Carers to contact the Consultant at lunchtime the next day with latest symptoms. The Consultant also arranged for a letter to be made available for staff to take to A&E for neck x-ray should Alison's condition worsen and she would ensure that the GP was updated.

It should also be noted that on the 22 January a Safeguarding referral was raised, by the Ambulance Service (the then providers of the out-of-hours service): a call had been made by a support worker to the 111 telephone service, at 09.23 hours on the 20 January to seek advice about a medication error – a double dose of epilepsy medication. No serious harm was caused. Alison's GP had been notified of the medication error on the evening of the 20 January and had been asked for further advice.

3.12 On the **23 January**, the Occupational Therapist delivered additional aids for Alison. The carers contacted the Consultant Psychiatrist, as arranged, reporting that there had been a mild improvement in Alison's condition: she was not as distressed and was more tolerant of neck touch, albeit her neck was still turned to the left and she could not weight bear. Consultant advised continued monitoring and reporting.

Later that day the Consultant Psychiatrist spoke to the GP and discussed the known increased risk of atlantoaxial dislocation/subluxation [a condition in which the head and spine may become misaligned] in individuals with Down's syndrome but excluded this given that no trauma had been reported by Alison's carers. It was agreed that the Consultant Psychiatrist would review Alison in two days' time.

3.13 On the **24 and 25 January**, Alison's condition continued much as before.

3.14 On the **26 January**, the Consultant Psychiatrist again visited Alison. As Alison's condition had not improved, the Consultant decided, in consultation with the GP, that Alison should be re-admitted to Hospital, by ambulance, for further investigation: "need to rule out any injury to the cervicalis [nerves in the neck]. Also any infection/inflammatory and vascular event". Alison's carer(s) went with her and her mother also attended. Alison was admitted, via A&E, to the Medical Admissions Unit at 13.19 hours. It was noted by both the ambulance crew and medical staff that Alison was leaning to the left side and swaying and that her head was falling forward.

3.15 Over the next three days, Alison's condition was monitored by hospital staff. On the **27 January**, Alison was transferred to the gastroenterology ward and a septic screen and a CT scan of the head and neck was requested by the doctor. On the **28 January**, the CT scan was attempted but as Alison "tried to jump off bed" the scan was abandoned. At this stage, clinicians were of the view that Alison's difficulties could have a septic source rather than injury.

3.16 On 29 January, the City Council Adult Social Care Team decided that, as Alison was in hospital, funding for the continued presence of the Housing Association care support workers, at the hospital, should be withdrawn. However, following representations from Alison's brother, with the support of Alison's Consultant Psychiatrist, funding was continued.

3.17 On **30 January**, it was decided that Alison should be treated for encephalitis and infection. A CT scan and lumbar puncture (there was a query about possible viral meningitis) were successfully completed, with anaesthetic assistance, and an unstable C2 fracture of the spine, with dilation of the third and fourth vertebrae, was diagnosed. A cervical collar was fitted and it was decided that Alison should be transferred to a hospital in Birmingham for an MRI scan and specialist treatment. According to hospital records, it was not until after the fracture was diagnosed that medical staff were informed, by Alison's carers, that she had experienced a fall on the 14 January.

3.18 On **31 January**, Alison was found to be febrile (feverish), hypotensive (low blood pressure), hypoxic (low oxygen levels) and unresponsive. She was transferred to the Intensive Care Unit in the early hours of the **1 February**. She continued to receive treatment for a chest infection. Her tongue had swollen and she was at increased risk of her airway being compromised.

3.19 On **2 February,** Alison was transferred to the orthopaedic ward from ICU – Hospital staff continued to care for Alison while awaiting her transfer to the Birmingham hospital. The transfer was effected late on **5 February**.

3.20 <u>Alison's care at the Birmingham hospital **5 February to 16 February.**</u>

On arrival, Alison was seen by a Doctor who advised that she be nursed flat, with collar and allowed to eat. She was seen by a Consultant on the 6 February. She was noted to have upper airway noise. She continued to be seen by medical, nursing, physiotherapy, speech and language therapy, intensive care, and acute pain teams regularly over the course of her stay (including night attendances) with a view to having surgery (fixation of neck) once her chest infection improved. She started intravenous antibiotics on the 10 February. It is recorded in her notes for 14 February, by the neurosurgery registrar that "if chest clear for surgery this would take place on 16 February". However, Alison's condition deteriorated later on the 14 February, respiratory failure, and the prognosis and a likely decision to provide only palliative care was discussed with her brother. Alison was placed on the supportive care pathway on the 14 February at 17.30 hours. She continued to be reviewed by doctors, nurses and physiotherapy until her death at 00.10 hours on the **16 February 2015.**

4. Analysis and Comment.

4.1 There were a number of examples of best practice:

- It is to the credit of the care staff that between the 14 and 26 January they persistently brought Alison's neck pain and loss of mobility to the attention of relevant professionals, albeit some have commented that they did not feel they were listened to by some of the medical and other professionals involved;
- The care and attention shown by the Consultant Psychiatrist and the Learning Disability Nurse, both before and especially during the events under consideration in this report, were of a very high order. An example (one among many) would be the Consultant's specific request, on 26 January, that consideration should be given to the possibility that Alison was suffering from cervical subluxation. Their interventions meant that Alison received the care and acute medical assessment she needed, albeit it was to prove to be too late;
- The fact that Housing Association care staff (familiar faces to Alison) were able to accompany and stay with Alison in Hospital. (However, there is a need for greater clarity, supported by policy and guidance, in relation to funding support, insurance issues etc. in extenuating circumstance where there are benefits to a service user during a hospital stay);
- There was clearly good communication and understanding of the need to contact other agencies shown by many of those involved in Alison's care. This extended to communication with Alison's mother and brother;
- The high standard of record keeping at the GP surgery and in the Community Learning Disability Team;

- Although not apparent from the written reports, it is known from conversations with Alison's brother that the standard of care provided to Alison by the ICU at the Hospital was exemplary;
- Alison's brother would also point to the generally excellent daily care afforded to Alison by the Housing Association carers over a considerable period of time.

4.2 But, the standards of care staff record keeping, arising from the events of the morning of the 14 January, was grossly unsatisfactory. Some of the key information was not recorded until well after the event and what was eventually recorded would not appear to be comprehensive. As stated in paragraph 3.4 above, the events of the 14 January are crucial in gaining an understanding in this tragic case. From all the reports received by the SAR Panel, it would appear that the first time that medical, nursing and other professional staff were informed that Alison had had a fall on the 14 January was after the neck fracture was diagnosed on the 30 January although we cannot be certain that it was on 14 January that Alison sustained the injury to her neck. Despite various professionals asking, between the 14 and 30 January, if Alison had had a fall, injury or trauma on 14 January or thereafter, no information had been forthcoming. It is still not clear how the report of the fall finally emerged. Suffice it to say that this was after the fractured neck was medically diagnosed.

Two further comments are necessary:

- It should have been clear to the Housing Association care staff that the sudden onset of symptoms on the morning of the 14 January was suggestive of the fact that Alison had sustained some form of injury overnight or that morning.
- It is possible that some confusion may have been caused by the fact that the term "fall" would not necessarily be used by care staff in respect of Alison's seizures.

4.3 Information received from the Birmingham hospital states that an MRI scan was undertaken on 8 February and that the fracture was described as "recent". The reporting Doctor confirmed that "recent" is not a definitive term and he cannot be specific about when the fracture occurred.

4.4 Having said that, information available to the SAR Panel enables us to be reasonably sure that Alison did have a fall on the 14 January and that this was the cause of her fractured neck. We have been told that the carer records, of unknown origin and timing, show that between 07.30 and 09.00 hours that day, in the presence of a permanent member of care staff, Alison suffered a seizure, with jerky movements, resulting in her falling back against/onto the sofa and to the side. In addition, the earlier incident, at 07.00 hours, witnessed by an agency

carer, when Alison dropped to the floor during an epileptic episode, may have considerable and equal significance.

4.5 It is not unreasonable to conclude that had ambulance, hospital and other medical, nursing and professional staff been informed of the fall sooner, and on the assumption that those professional staff would have responded by undertaking fuller investigations, then the outcome for Alison may well have been different.

[It should be noted that a full investigation of these issues was undertaken by the Housing Association resulting in formal and appropriate disciplinary action being taken against permanent staff who failed to report the full events of the 14 January in a timely manner. Actions in relation to the agency member of staff were taken by the Recruitment Agency concerned.]

4.6 There are some other matters of concern:

- The fact that on admission to A&E on the 14 January little note seems to have been taken of the pain in Alison's neck nor the fact that she was holding her head to one side. According to hospital records, it was not possible to carry out a full neurological examination and there was no cervical examination as it was not felt to be relevant to Alison's presenting complaint. [The events at A&E on the 14 January were subject to a Root Cause Analysis investigation in April 2015 by the Hospital Trust. A copy of the report and findings from that investigation were made available to the SAR Panel.]
- The fact that on the 17 January, the Ambulance Rapid Responder recorded that Alison refused to be taken to hospital. Alison lacked the mental capacity to give, or refuse, informed consent; therefore, this was clearly in error;
- The medication error on the 20 January, albeit this had no significance in the larger picture;
- The fact that the transfer to the Birmingham hospital took some six days to effect. It is clear from reports received that the Birmingham hospital did all it could to facilitate the transfer as soon as possible.
- The fact that throughout the key period, beginning with the events of the 14 January, there appears to be a repeated theme of medical staff not intervening because Alison 's condition "was largely unchanged". With hindsight, it can be dangerous to assume that a previous diagnosis/treatment can be relied on.

4.7 There is a further matter which needs consideration: whether or not Alison received a lesser service because of her learning disability and dementia. I found little evidence to suggest that this was the case albeit the hospital report notes that Alison's pre-existing conditions of Down's syndrome and dementia may have led to "diagnostic overshadowing" – the initial diagnosis on Alison's re-admission

to hospital on the 26 January was “global deterioration due to progression of cognitive decline”. The apparent lack of a full medical history and/or Hospital Passport meant that the speed of the deterioration was not appreciated. In addition, and as pointed out by the Advanced Social Work Professional from the City Council, in the Individual Management Review, Alison could have been provided with an Independent Advocate well before the events under consideration here. That person could have played a key and positive role in the events of January and February 2015.

4.8 In Paragraph 3.11 above, reference is made to a Safeguarding Referral raised on the 22 January in relation to the medication error on 20 January. There were two additional Safeguarding Referrals raised as a result of Alison’s case: On 4 February a referral was raised alleging neglect by the A&E Department and the Ambulance Service by failing to respond effectively to Alison’s deteriorating condition. (As mentioned earlier, the hospital subsequently undertook a Root Cause Analysis into these matters.) The third referral, raised on the 6 February, related to the failure by Housing Association carers to disclose the full details of what took place on the 14th January and that neglect was occasioned.

It is reported that all these Safeguarding Referrals were completed in a timely manner and the outcomes reported to the Care Quality Commission (CQC). CQC followed up the first and third of these referrals with the provider, but there is no evidence that the CQC inspector passed this information on to the hospitals team within CQC which held regulatory responsibility for these services when the concerns were received.

4.9 During the SAR Panel deliberations, and as drawn to our attention by Alison’s family with photographic evidence, it came to our notice that the neck-brace provided to Alison, while in Hospital, appeared to fit badly and be very uncomfortable. The Panel would suggest that the

Hospital Trust gives consideration to the provision of neck braces: how a correct fit and comfort can best be achieved.

5. Recommendations for the Future

5.1 One of the main purposes of a SAR is to seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and to ensure that those lessons are applied in practice to prevent similar harm occurring again. As part of the Individual Management Review process, some of the agencies involved here made recommendations for actions within their own work setting. These have been reviewed by the SAR Panel and can be summarised as follows:

The Hospital Trust.

- To explore options for improving awareness and management of patients with communication or learning difficulties, e.g. having Learning Disability 'champions' within emergency care settings (A&E, AMU) to enable a better understanding of the current problem affecting the individual and how this has impacted on their normal level of function.
- To raise staff awareness of the Mental Health Capacity Act.
- To review their procedures relating to Health Records

The Housing Association

- The organisation to adopt their parent body's safeguarding procedures (which are more robust).
- The service to continue to embed their parent body's auditing procedures and ensure all relevant staff are trained in their use.
- To ensure greater scrutiny from management using clear and robust auditing processes
- The service and senior managers to increase number of spot checks related to all aspects of the service.
- Record keeping procedure to be reviewed to include staff agreement to ensure notes are completed, at least daily, either personally or handed over to manager if possible (even when going off sick)
- Regular safeguarding training to be provided, reviewed and maintained: content of safeguarding training to ensure staff understand what potential safeguarding is and how they should respond
- To review and maintain a record of attendance at safeguarding training to ensure staff are compliant.
- To ensure that concerns are reported and escalated in line with statutory and contractual obligations (as evidence of excellent person centred care)
- To undertake a review of the security of care records
- To develop and adhere to joint working agreements as outlined above.
- The service to undertake a work force development plan to meet the current service demands and allow for this to grow safely.
- To review recruitment protocols to reduce reliance on agency staff
- The service to set targets for agency use and ensure these are not exceeded

All Age Disability Service (The City Council)

- To ensure that adults with a learning disability or whom lack mental capacity have access to an independent advocate where there is no-one appropriate or available to act on their behalf. (It is acknowledged that Alison had excellent family advocates).
- To develop a policy that clearly identifies the limits of social care support in health and hospital settings".

Clinical Commissioning Group

- Each GP practice to have an adult safeguarding policy and a lead GP for adult safeguarding. [Note: There is no statutory role (and therefore no funding) for a named GP for adult safeguarding, but this may change in the future. This is a national rather than a local decision.]
- To use this case as an exemplar when teaching primary care staff about adult safeguarding

Care Quality Commission

- To continue to build effective information sharing systems between CQC local teams, the local authority and other relevant authorities so collaborative working can be developed using the scheduled bi-monthly information sharing meetings and the existing links between commissioners, safeguarding officers and inspectors.
- CQC to strengthen its systems for cross-directorate working, ensuring information which relates to other directorates is disseminated and shared appropriately.

In accepting these recommendations, the SAR Panel has asked each of the agencies concerned to provide the Wolverhampton Safeguarding Adults Board (WSAB) with an Action Plan detailing how these recommendations will be put into effect. Copies of these Action Plans are given at Appendix 2 – to follow.

5.2 I would **recommend** that the WSAB endorses the recommendations made by the agencies involved, as detailed above, and requires them to report regularly on progress made on their action plans until such time as evidence shows that all actions have been undertaken/completed to the satisfaction of WSAB. In addition, WSAB will wish to be satisfied that the recommendations made in the Wolverhampton hospital's Root Cause Analysis have been fully implemented.

5.3 I would add four **further recommendations** for the WSAB to consider:

For the Ambulance Service

- That the WSAB requires the ambulance service to ensure that all their staff, especially the Paramedics and Technicians who attend emergency and other call-outs, are fully trained in the Mental Capacity Act.
- That the Wolverhampton SAB requests the ambulance service to expedite its review of documentation used by staff when attending patients to make these more informative and legible.

For the Hospital Trust

- That the WSAB requests the Royal Wolverhampton Hospital Trust to review protocols regarding the use of medical equipment to support treatment.

For all the medical agencies

- That the WSAB request that all the medical agencies involved remind medical staff of their responsibility to reassess patients on each new presentation and not to rely on previous diagnosis/ treatment

5.4 I have not found it necessary to make any recommendations to the WSAB itself: the Board's procedures and practice appear robust and fit for purpose.

6. Closing Remarks

6.1 The SAR Panel was unable to establish exactly when Alison may have suffered a fall which could have given rise to the fracture in her neck. However, as stated earlier, we can be reasonably sure that one or other of the two reported incidents in the morning of the 14 January were the cause. These incidents should have been recorded and reported, at the time, by care staff. Ambulance and medical professionals should have taken more note of the neck pain which Alison then experienced, with a loss of mobility and the fact that she was holding her head in an unaccustomed way, much sooner. As also stated earlier, if these things had happened, then the outcome for Alison could have been very different.

6.2 The Aims for this Review, as detailed in the terms of reference, can be summarised as:

To review the background and circumstances leading to the death of [Alison] and ascertain whether there are lessons to be learnt for:

- Effective inter-agency working
- Effective intra-agency working
- Effective communication and information sharing

In terms of effective inter-agency working and effective communication and information sharing, with the critical exception of the non-reporting of the fall(s) experienced by Alison, until very late, and the possible 'diagnostic overshadowing' identified in the Hospital's Root Cause Analysis, practice by all concerned was good.

In terms of intra-agency working, each of the agencies has made recommendations for actions which will improve their practice. I have added

three further recommendations for additional actions in two of the agencies. As detailed earlier, the WSAB should accept all these.

6.3 It is to be hoped that the lessons to be learned from this review, as defined in the recommendations and action plans contained in this report, once fully taken on board by all concerned, will prevent the same set of events and the tragic outcome occurring again.

Robert Lake
Independent Chair
July 2016

APPENDIX 1

Wolverhampton Safeguarding Adult Board

Terms of Reference: Safe Adult Review for Alison

1. Family Details and period of time to be covered.

Family comprises: Alison, Alison's Brother and Mother.

Review period: 1st November 2014 to 16th February 2015.

2. Safe Adult Review process:

2.1 On 30 November 2015 the Chair of Wolverhampton Safeguarding Adult Board agreed that the known circumstances of Alison's death met the Safe Adult Review criteria as reflected in Care Act 2015 legislation and guidance.

This decision followed a Safe Adult Review Committee Meeting held on 28 September 2015.

On the 25 February 2016 the WSAB contracted with the Independent SAR Panel Chair and SAR Author, Robert Lake who has extensive experience as an independent management consultant specialising in adult social care practice and management.

2.2 A preliminary meeting was held on 21st March 2016 of the Safe Adult Review Panel. This meeting agreed the processes to be applied within the review.

2.3 Provisional SAR Panel membership has been agreed and scoping identified. Terms of reference have been discussed and the draft copy circulated for amendment to the SAR Panel.

2.4 The SAR panel will include representatives from:

Head of Safeguarding; Hospital
Quality and Patient Safety Manager; CCG
Head of Safeguarding and Quality
West Midlands Police

Service Manager (Adult Disability); WCC
SAR Panel Adminstrator

2.5 The following agencies have agreed to complete IMR Reports

- CCG
- Adult Services
- Hospital
- Housing Association
- Recruitment Agency
- Community Learning Disability Service
    - Nurse
    - Psychiatrist
- West Midlands Ambulance
- Care Quality Commission

2.6 IMR reports will be requested from all agencies in the city having had contact as specified below. They will be expected to provide a comprehensive detailed chronology in line with WSAB guidance and templates. Any documents not completed in the required format will be rejected with requirements to complete on the agreed templates. It is proposed that all IMR authors will be invited to attend a briefing session scheduled to take place at 9.00 a.m. on 7th April 2016, although comprehensive written guidance will be provided as part of the request to complete the IMR template and chronology. Furthermore Authors are required to attend an all day meeting 9.30 a.m. to 4.30 p.m. on 6th June 2016 for discussion with the SAR Panel members. All meetings will be held at Priory Green.

2.7 A detailed timeline will be constructed to assist the SAR process, identifying the dates and progress points for the review is available at section 6.

2.8 It is likely that a considerable volume of information will emerge from the IMR reports and chronologies. The SAR Panel may need to amend and adjust the Terms of Reference. Should this happen this will be in the interests of focussing on specific issues rather than any broader enquiry.

2.9 The review will focus on the period of time from 1st November 2014 to 16th February 2015.

3. Background

3.1 Alison had a learning disability, down syndrome, and as well as dementia, she lacked capacity and was reliant on 1:1 care through Housing Association for all of her

everyday care needs and welfare. She shared her house with two other people who also had learning disabilities.

3.2 Alison was admitted into Hospital on the 26/01/2015 for further investigations, following a period of ill health from the 14/01/2015.

3.3 Alison was diagnosed with a C2 fracture on the 28/01/2015, cause not known, but there was a query as to whether she had a fall or suffered a seizure whilst at home. She was then transferred to Critical Care at Hospital before being transferred to The Queen Elizabeth Medical Centre in Birmingham on the 09/02/2015.

3.4 Alison passed away on 16/02/15 at Queen Elizabeth Medical Centre, Birmingham

Previous Safeguarding History

3.5 There were three safeguarding referrals raised and investigated:

3.5.1 22/01/2015 – Investigated by Disability Team, 2nd medication error in six months – poor communication, reporting, procedures by service provider, Housing Association. *Allegation of neglect substantiated. Future actions were recommended.*

3.5.2 04/02/2015 – Investigated by Hospital Social Work Team and Root Cause Analysis completed – Concerns raised around GP, A&E, and Ambulance Service not acting in 's best interests regarding treatment and misdiagnosis after patient came into A&E on the 14/01/15 after query having a seizure and ambulance called on the 17/01 after was still displaying pain and symptoms and was not readmitted into hospital. *Allegation of neglect substantiated. Future actions were recommended.*

3.5.3 06/02/2015 – Investigated by Disability Team – allegation on the 14/01/2014 that agency worker from Recruitment Agency was found standing over who was crossed legged on the floor and was struggling to get up. It was observed that 's neck was bent to the side. It took a staff member until the 05/02/15 to disclose their concerns to a manager. Entry found on 14/01/15 in notes that there had been an incident estimated between 07:30 and 09:00 as time was not recorded where had a seizure with jerky movements, resulting in falling back against the sofa. The staff member had not informed the manager on the 14/01 or subsequently after. *Allegation of neglect substantiated. Future actions were recommended.*

4. Terms of Reference:

4.1 **Aims**- to review the background and circumstances leading to the death of and ascertain whether there are lessons to be learnt for:

- Individual agencies working
- Effective inter-agency working

- Effective communication and information sharing
- Improve intra- and interagency working to better safeguard and promote the welfare of adults

A Safeguarding Adults Review is a learning activity and does not seek to apportion blame.

4.2 Involvement of relevant family members:

The family will be informed that a SAR is to be undertaken and they will be invited to contribute to the review process.

4.3 Some historical information may be critical to this review in line with National studies. Therefore, if agencies feel there is pertinent information available prior to the scoping period for this review, then they should include this in the chronology. It is hoped this will shed some light on whether the circumstances leading to ’s death could have been predicted or prevented.

4.4 Safe Adult Reviews and other case reviews should be conducted in a way in which :

- an adult* in its area dies of abuse or neglect, whether known or suspected

  AND

- there is concern that partner agencies could have worked more effectively to protect the adult*.

  They must also arrange a SAR if:

- an adult* in its area has not died, but the SAB knows or suspects that the adult has experienced serious** abuse or neglect.

  They may also

- commission a SAR in other circumstances where it feels it would be useful, including learning from “near misses” and situations where the arrangements worked especially well.

* adult must be in the SABs area and has needs for care and support (whether or not the local authority has been meeting any of those needs).

** something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered

permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

4.5 Purpose

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

The purpose of the reviews are not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

4.6 Principles

The following principles will apply to the review:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- the individual (where able) and their families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
- the Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;

- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed and

- professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.

5. Media Strategy:

5.1. Any media interest will be responded to via Wolverhampton City Council Communications Team on behalf of the Wolverhampton Safeguarding Adult Board. Any planned media statements will be managed through the Wolverhampton City Council Press Office/ Communications Team. Any statement will be agreed with all relevant agencies. There will be a strict embargo on any press activity until the conclusion of the SAR

6. SAR Timetable:

Meeting	Date
Panel Meeting 1	**21st March 2016**
Training\ Briefing Session	**7th April 2016** *9.00 a.m. to 11.30 a.m.*
Chronology returns	**29th April 2016**
IMR returns	**20th May 2016**
Panel Meeting 2 – Review of reports received. **Whole day event to include SAR Panel members and named IMR authors**	**6th June 2016** *9.30 a.m. to 4.30 p.m.*
Panel Meeting 3 **Draft report and findings**	**13th July 2016** *10.00 a.m. to 1.00 p.m.*
Submit SAR Overview Report and action plan to the SAR Committee	**25th July 2016** *10.00 a.m. to 11.30 a.m.*

Extra-ordinary meeting of WSAB	**tba**