Coventry Safeguarding Adults' Board Serious Case Review
Executive Summary of Case No: CSAB/SCR/2015/9

1. Reason for establishing the Serious Case Review (SCR)

1.1 The SCR was established by the Coventry Adult Safeguarding Board (CSAB) to review the circumstances leading to the death of Mrs E on 24th May 2013 who was 66 years of age. The SCR criteria was met because Mrs E was an adult at risk, and neglect may have been a contributory factor.

2. BACKGROUND AND PERSONAL HISTORY

2.1 CSAB has sought to ensure that Mrs E remains at the forefront of this Review and therefore, it is important to provide some brief biographical detail provided by the family, while ensuring the anonymity of the family is protected.

2.2 Mrs E led a busy and fulfilling life, and she and her husband were a devoted couple who liked spending time together, and with their family. Church also formed an important part of her life. Mrs E's intelligence and skills shone through in many different ways – not least in one of her favourite pastimes in solving complex crosswords. She was a talented musician, giving lessons privately after working as a secretary for many years. From 1996 onwards, Mrs E became her husband's main carer after he suffered several serious illnesses. They moved to a Housing with Care Scheme so that Mrs E's husband could receive additional support with some of the more physical aspects of his personal care.

2.3 Mrs E was described as thoughtful, considerate and always putting everyone else first. She never wanted to be any bother, never made a fuss about any health or other problems and was appreciative of any help or thoughtful behaviour shown towards her. These aspects of Mrs E's personality were to play a key part in the chain of events which led to her tragic and untimely death. The extent to which Mrs E was popular and well respected was reflected in the high turn-out at her funeral.

3. SUMMARY OF KEY EVENTS AND MAIN FINDINGS

3.1 This section provides a chronological summary of events, followed by an overview of actions taken by professionals in respect of some key issues.

Fall and Admission to Hospital

3.2 On 23rd March 2013, Mrs E fell on the ice when visiting a local shop, but for several days declined to act on advice to seek medical attention. Subsequently, she was taken by ambulance on 1st April to the University Hospital Coventry and Warwickshire (UHCW) where she was assessed as having a small crack in one of her vertebrae. This diagnosis was reached without the usual radiological investigations being carried out. Mrs E re-attended A&E 2 days later because of increasing pain and being unable to move, and X-rays and a CT scan revealed a compression wedge fracture of the lumbar spine. She was fitted with a back brace, and remained in hospital until 15th April. Mrs E was severely constipated for 10 days, and when this did not respond to oral laxatives, the condition finally resolved after being given an enema. Mrs E found this painful and experienced abdominal pain afterwards.

3.4 Mrs E displayed considerable anxiety when engaging in physiotherapy because of the pain in her back, leg and abdomen, but progressed to walking with the aid of a stick. Although the therapists noted how the pain from the fracture was affecting her ability to

mobilise, AB, Mrs E's daughter, felt that some nursing staff displayed a lack of person centred care - underestimating the pain and difficulties Mrs E was experiencing.

Hospital Discharge Issues

3.5 Mrs E was discharged on 15th April at short notice, and a day earlier than planned, probably because her bed was required. No screening took place to establish if Mrs E would require additional support on returning home, and there was no liaison with the Housing with Care Scheme which may have enabled them to plan for Mrs E's return. It must be noted that Mrs E did not receive significant support from the Housing with Care scheme herself, their residing there was primarily for support to Mrs E's husband.

3.6 There remains some uncertainty as to whether Mrs E was medically fit for discharge, which stems from the different conclusions reached in 2 reports on the significance of the abnormal blood test results of 09.04.13 which showed a raised C reactive protein (CRP). The interpretation reached by the internal Mortality Review (MR) was that this result suggested that Mrs E was probably becoming unwell, and therefore the discharge was not well thought through. The Individual Management Review (IMR) for this SCR arrived at a different conclusion that this high figure was to be expected because of inflammation after a fracture. This view was reinforced by the lower CRP figure when blood tests were carried out on her readmission in May.

3.7 Irrespective of these different findings, the SCR established that the blood test results were not looked at prior to discharge, and therefore the opportunity was missed to carry out repeat tests to see if the position had improved. The discharge decision was also taken without knowing the result of the abdominal x-ray carried out on the day of discharge which subsequently confirmed that there was no blockage in the bowel. Given that Mrs E was never weighed during her stay, this meant that the decision to discharge Mrs E was made without taking account of 3 important pieces of information. There were some gaps in the discharge summary as this did not include an explicit alert for the GP to check these results, nor did it include any information about the severe constipation problems and how these were resolved.

Care after Return Home / Discovery of Pressure Sores

3.8 On return home, Housing with Care staff immediately made referrals to the Fast Response Team (FRT), and Adult Social Care, because of concerns about Mrs E's reduced mobility, and the likely impact on her ability to care for her husband. The response to these was slow. A social work assessment visit was not planned until 2nd May, and 11 days elapsed before Mrs E was visited on 26th April by a community physiotherapist (CP1) because at that time, the 48 hour response service for priority referrals, which was introduced subsequently, had not been established. She and the Housing with Care scheme felt that the discharge had been "unsafe" due to the lack of advance planning. The community physio quickly secured all the necessary equipment but did not consider whether further physiotherapy would be helpful given Mrs E's continuing difficulties in mobilising.

3.9 On discovering that Mrs E had broken skin on her buttocks area, the physio made an immediate referral to the fast response team. She also arranged for a twice daily intermediate support service to augment the care being provided to Mr E by the Housing with Care Scheme. A District Nurse examined Mrs E the following day and found 3 grade 2 breaks in her skin and 2 small sores on her buttocks area. A Pro Pad pressure relieving cushion and single mattress was ordered and advice given on diet and regular repositioning. A safeguarding referral was also made to the Social Care Older Adult &

Physical Impairment Team in line with the CAB's safeguarding procedures, and a social worker visited on 30th April 2013, and organised additional domiciliary support.

3.10 The panel considered that although the District Nurses were diligent in providing care and monitoring the pressure sores, they did not consult Mrs E about her preferences when ordering a single mattress, which resulted in this being rejected when it was delivered because it was important to Mrs E to continue sharing the double bed with her husband. Their approach showed a lack of flexibility, and the panel concluded that they could have explored things in a more person centred way to find a practical solution which would be acceptable to Mrs E.

3.11 Mrs E continually declined the help offered with her personal care, which together with the rejection of the mattress, led to health and social care professionals sharing their concerns that Mrs E might be suffering cognitive impairment and might lack mental capacity. Given their concerns about the risk of the tissue damage worsening, on 2nd May, a short term admission to a Nursing Home was identified as the best way forward. This option was put to Mrs E by the GP, and there is some evidence that Mrs E felt pressured by the GP into agreeing to the admission.

Response to Constipation Problem

3.12 During the period at home, Mrs E's nursing care was provided by 5 district nurses (DNs) because of the way the service is organised. They became aware that Mrs E was again suffering with severe constipation, but the number of nurses involved resulted in duplicated activity and conflicting conclusions about the extent of the problem. Their assessments at times lacked the necessary depth, and they continued to request prescriptions from the GP for stronger oral laxatives rather than considering whether there was a need for treatment such as administering an enema. Their response may have been different had they been aware of the recent history in hospital and how the problem had been resolved. Equally, the GP at this point did not review Mrs E's changed circumstances, health needs and medication following her return home, and could have been more proactive given the increasing evidence of the continuing constipation. At the point of admission to local Nursing Home, Mrs E had probably been constipated for the last 12 days.

Admission and Care at local Nursing Home

3.13 On 4th May, Mrs E was admitted to a local registered nursing home. The rapid implementation of this plan, due to the impending bank holiday, created two problems. It resulted in a poor admission experience because the nurse on duty claimed to be unaware that the admission had been agreed, and also full information was not provided to the nursing home in advance about all Mrs E's circumstances and health needs to help them plan their care.

3.14 At the nursing home, Mrs E continued to suffer pain and discomfort from the back pain, tissue damage, constipation and a urine infection, There were serious deficits in the level of care and speed of response to these issues, which in part was due to there never being an over-arching care plan to address Mrs E's identified health needs. Instead, individual plans were drawn up piecemeal to address each health issue in isolation, and often there were delays before these were done. No active work was carried out in helping Mrs E improve her mobility, and the deterioration resulted in her using a walking frame and wheelchair for longer distances.

3.15 When Mrs E's overall physical condition worsened, diet and fluid charts were commenced, but these were only completed on 3 of the 9 days during the remainder of her stay. In the meantime, according to the family, Mrs E continued to lose weight noticeably. The evidence points to Mrs E having remained constipated throughout her stay, and by 11th May, Mrs E was reporting severe abdominal pain, and subsequently there were several recorded instances of other symptoms that may indicate serious constipation such as faecal impaction and leakage. From 15th May, Mrs E had episodes of vomiting.

3.16 Following plans drawn up at the first safeguarding case conference on 15th May for further investigations and blood tests, Mrs E's family raised their concerns on 18th May that Mrs E was looking profoundly unwell, and pressed for the bloods to be taken urgently - offering to take these to hospital to speed the process up. Later that evening, Mrs E fell in the bathroom and hit her head. No medical assistance was sought, and family were only informed on their visit the next day when her daughter also pressed for an ambulance to be called as she was worried about Mrs E's grossly distended stomach, and because Mrs E had not been drinking and eating for several days. The nurse on duty did not immediately act on this request as she was busy dispensing medication, but after a short delay the paramedics were called.

3.18 The failure to seek immediate medical attention on 18th May 2013, either when the grossly distended abdomen was first observed, or following the fall, was negligent, and resulted in a delay before Mrs E's serious condition was assessed. Staff should have sought immediate medical help given Mrs E's existing back injury, the fact that the fall may have involved a possible head injury, and because Mrs E was vomiting and complaining of acute abdominal pain. Mrs E's family should also have been informed. The seriousness of this inaction was recognised by the provider's management given their subsequent disciplinary action and reporting of the outcomes to the relevant national bodies.

Second Admission to UHCW

3.19 On 19th May, following the attendance of paramedics, Mrs E was admitted to UHCW. On examination, Mrs E was found to have severe sepsis, a perforated diverticulum, and a large pelvic abscess. X-rays showed that the original wedge fracture in her spine remained unchanged but also revealed the existence of a second wedge fracture. Although it has not been possible to establish when the second fracture occurred, it was confirmed that the consequence would be that Mrs E would have been suffering considerably more pain in the same area. Mrs E was vomiting brown liquid, had a urine infection and was doubly incontinent. Mrs E also had multiple pressure sores – 1 at grade 3. She was found to be dehydrated and had suffered significant weight loss.

3.20 It was concluded that Mrs E was too unwell for surgical intervention and she was transferred to the Critical Care Unit for guided percutaneous drainage to be carried out as soon as possible. However, there was a delay of around 36 hours before this was carried out which was in part due to problems in arranging radiologist support.

3.21 Mrs E died on 24th May 2013. The cause of death was recorded as pelvic abscess, sigmoid perforation, and fracture of the L1 vertebrae.

Overview of Professionals' Response to Mrs E's Constipation

3.22 The analysis of professionals' actions has led to the conclusion that after her discharge from hospital, there were several missed opportunities both during her time at home, and at the nursing home, to assess fully Mrs E's constipation and to escalate the treatment when the problem persisted. The decision to continue with laxatives appears misplaced

when the problem persisted for so long and the symptoms were becoming more extreme. The analysis indicates that there was insufficient note taken by professionals of the guidance issued by the National Institute of Clinical Excellence (NICE) as Mrs E displayed several of the symptoms / factors listed as potential indicators of a serious problem. Although it will never be known when the perforation of the bowel occurred, Mrs E's bowel pathology was clearly worsening by 15th May 2013 by the increasing severity of symptoms. It is possible that had alternative action been taken by clinicians in the community at this time, a different outcome may have occurred. It must be emphasised however, that this suggestion is clearly speculative.

Overview of Professionals' Response to Mrs E's Pain and Symptoms

3.23 A major challenge for professionals was that there was often a marked difference between what information Mrs E shared with family about her symptoms, and what she shared with professionals. The earlier profile of Mrs E provides some helpful insights as to why this might have been, with Mrs E's desire not to be a burden or make a fuss. However, notwithstanding this, professionals were not sufficiently pro-active in checking these out with Mrs E, and there was a lack of depth to many of their assessments, for example in respect of the degree of pain Mrs E was experiencing and how this was impacting on her life. Professionals rarely established a full picture, and although Mrs E contributed to this in not sharing full information, there were missed opportunities by some professionals to adopt a more pro-active and structured approach to assessments. More probing may have uncovered the extent of her problems sooner and triggered further medical assessments and treatment. When Mrs E did disclose the extent of pain and problems, there were many instances where insufficient consideration was given to her accounts.

Overview of Mental Capacity Issues

3.24 It proved difficult to get a sense of what changes were observed in Mrs E's cognitive functioning which led to some professionals assessing whether Mrs E's cognitive functioning was impaired, and whether she lacked mental capacity, in the light of what were perceived as Mrs E's potentially unwise decisions. Assessments that were carried out concluded that Mrs E had mental capacity but was experiencing some confusion and impaired memory. The panel agreed that there was considerable uncertainty and ambiguity in this case, and where this exists, it is difficult for professionals to know when to act, and how to evaluate someone's behaviour and responses. Where assessments were initiated, the panel agreed that they were acting in accordance with the Mental Capacity Act which requires assessments to be decision specific at the time that decision needs to be made.

First Safeguarding Processes

3.25 Mrs E's case was not well considered through either of the two safeguarding processes. The conclusion of the first process that the pressure sores were due to self-neglect and Mrs E's "non-compliance", stemmed from professionals' lack of knowledge and understanding about Mrs E's personality and values. The panel found no evidence or indication of self-neglected – she was a proud and previously independent person, who was reluctant to accept help through a combination of not wanting to make a fuss, and wanting to maintain control of her life and privacy.

Second Safeguarding Process

3.26 A second safeguarding investigation was commenced after AB raised a safeguarding alert with the Social Care Team on 21st May, once the seriousness of Mrs E's condition had been established, raising her concerns about the care provided during Mrs E's stay at the

Nursing Home. This second process was poorly managed. The decision not to hold a strategy meeting in line with approved procedures, not only resulted in no consideration being given to notifying the police, but meant that there was inadequate planning of the investigation. This, and the weak chairing at the three case conferences, resulted in drift in gathering answers on several key issues, and a shift away from the original focus of the second alert. The fact that the UHCW Root Cause Analysis Report, and Mortality Review were not shared also impacted on the effectiveness of the safeguarding process. Ultimately, the process ran out of steam which was shown by the lack of reasons recorded for the conclusion that Mrs E had suffered neglect during her time at the nursing home.

Post Mortem Issues

3.27 A post mortem was not held which may have provided answers to the unresolved questions of when the second fracture occurred, and the cause of the perforated diverticulum and abscess. While the panel could see why this decision was made, it was concerned that the checks and balances built into the referral system did not work in this case. The decision not to inform the police about the first safeguarding alert, and the long delay before notifying them of the second alert, proved significant as this meant that there was no "flag" in the Coroner's office systems about the previous or current safeguarding issues which might have triggered further enquiries. The sudden death notification form sent to the Coroner's Office by UHCW did not identify any safeguarding issues even though by the time Mrs E died, agencies had been informed of the second alert made by family, and the further alert raised by UHCW because of the pressure sores. As there was a doctor willing to sign the death certificate, the Coroner made a decision not to request a post mortem.

3.28 The panel considered the issue as to whether Mrs E's death should be viewed as "expected" or "not expected". One view was that this was expected death given the seriousness of Mrs E's condition when she was re-admitted. Some other panel members took the view that looking at the whole time period covered by the SCR, and Mrs E's generally good health prior to the fall, her death could be viewed as "unexpected".

4. KEY LEARNING

4.1 The key learning covers a number of issues within the following themes:-

- Clinical Assessments
- Hospital Discharge
- Case Planning and Continuity of Care
- Person Centred Practice
- Risk Management
- Mental Capacity
- Safeguarding Processes

Clinical Assessment of Back Injuries

4.2 It is important that when patients present at A&E with back injuries, doctors should ensure assessments are in line with national guidelines. Where there are reasons for departing from these, for example not calling for an X-ray or other scans, the reasons should be documented along with whether the patient was given a choice or declined these. In addition, the patient's previous level of mobility should be established to provide a benchmark for assessing the impact of the injury on the ability to carry out basic daily activities, and whether there is a need for further support to aid rehabilitation.

Assessing Pain

4.3 The analysis has identified the importance of professionals adopting a more pro-active approach in carrying out holistic pain assessments, making full use of national guidelines and checklists such as those issued by the Royal Society of Physicians and the British Pain Society in 2007. To help professionals gain greater understanding of how patients may experience pain, training should make use of Help the Aged studies which include patients' descriptions of their experiences.

Assessment and treatment of constipation

4.4 Agencies need to ensure that staff have received training which covers the NICE guidance, and apply this in their assessments.

Diagnosis and Treatment of Sepsis

4.5 Given the delays that occurred in treating Mrs E's sepsis, it will be important for CSAB to agree how professionals' awareness can be increased on recognising the possible signs and symptoms, and the importance of rapid diagnosis and treatment to improve the chances of survival. CSAB should also require assurances from local agencies that staff have been reminded that emergency medical help must be sought immediately when patients vomit brown, or coffee grained, liquid.

Hospital Discharge

4.6 A number of actions have been agreed to improve hospital discharge planning. The term "now medically ready for discharge" should be recorded in the medical notes and discharge summary. A patient's home circumstances must be explored in sufficient depth to ascertain what support will be available post discharge, and whether this appears sufficient. When there is an indication that the patient, or anyone living with her, has carers, this must always act as a trigger to probe further. A protocol should be drawn up for liaison between hospitals and Housing with Care schemes to facilitate smooth transition from hospital to home with all necessary support and equipment in place prior to discharge.

4.7 Discharge summaries must comply with national guidance to include a brief summary of all relevant information covering all investigations, new diagnoses, and why medications have been started or stopped including constipation. Clear instructions must be given as to whether the provision of a back brace is essential to aid recovery, or is optional to provide comfort and support. Patients' needs for ongoing physiotherapy post discharge will also be included when there has been an injury affecting mobility or dexterity.

Care Planning and Continuity of Care

4.8 A key recommendation from this review is that health and social care organisations implement an integrated assessment process so that care planning is person-centred, effective and coordinated. This requires full sharing of information, trusting other professionals' judgements, reducing duplication, so that the range and complexity of an older person's needs are properly identified and addressed in accordance with their wishes and preferences. As part of these developments, the pro-active contribution of GPs will be crucial in ensuring continuity of care, particularly when patients are discharged from hospital or residential settings. A key element for ensuring effective planning will be agreement at all stages of involvement as to which professional / agency is to be the lead professional to co-ordinate services. Similarly, there should always be a key worker within residential settings.

Person Centred Practice

4.9 This SCR has highlighted that in any professional involvement, the needs, views and choices of the individual takes centre stage at all times, and that they are fully involved in decisions about the support they need. Decisions need to take account of all relevant factors including age, gender, living arrangements, personal relationships, lifestyle, and culture - as well as their illness or disability. When dealing with pressure sores, professionals need to look for creative solutions in negotiation with service users where standard service options are not acceptable.

4.10 Although guidance states that information gathering should be of a depth and detail "proportionate to the person's needs", a recurring theme within this SCR, was the lack of knowledge about Mrs E's background, attitudes, values and use of language which would have helped inform assessments and decisions. Agencies therefore need to ensure that professionals bring to their work the necessary level of "professional curiosity" to probe issues - particularly where patients and service users do not share information, and are reluctant to accept help or act on advice.

Risk Management within Housing with Care Settings

4.11 The SCR has identified the need for further guidance for Housing with Care staff on their roles and responsibilities in approaching situations where there may be a tension between respecting tenants' rights to independence in decision-making, and the need to safeguard tenants who are perceived to be placing their welfare at risk.

Mental Capacity

4.12 All agencies have identified the need for more training around assessing mental capacity. Within this, it will be important to include a reminder of the possible causes of short term impaired cognitive ability which was not apparent in this case.

Safeguarding Process

4.13 This SCR has identified the need for additional training on all aspects of the safeguarding arrangements and formal processes, including the importance of strategy discussions to scope the investigation, and the organisation and conduct of case conferences. In addition, more detailed guidance should be provided on the type of situations where the police should be notified. Where professionals are uncertain how to proceed, advice should be sought from their safeguarding lead at an early stage, who may assist in discussions with their counterparts, when necessary, to agree a way forward.

Post Mortem Issues - Liaison with the Coroner's Office

4.14 To ensure due consideration is given to the need for a post mortem in circumstances such as this case, CSAB should make an approach to the Coroner to seek agreement to the drawing up of a formal protocol to establish a two way liaison process. The protocol would specify the circumstances where relevant information will be shared about cases or services where there is a known, or potential, safeguarding issue, and during the conduct of a Safeguarding Adults Review (SAR). Alongside this initiative, the format of the hospital sudden death notification form should be revised to make it clear when there has been a safeguarding issue.

Safeguarding Adults Reviews (SARs) Methodology

4.15 The future conduct of Safeguarding Adults Reviews (SARs) has now been placed on a statutory footing through implementation of the Care Act 2014 from 1st April 2015. Key learning from this SCR is that the model adopted for future SARs should involve managers and practitioners as this will enable more direct exploration of key events, how their view of the case at the time shaped their actions, and identify any organisational or "system" issues which affected their approach. It will also be essential for CSAB to agree a protocol to cover how any parallel investigations will feed into the SAR and those reports are shared.

5. MULTI-AGENCY RECOMMENDATIONS

5.1 The multi-agency recommendations are organised around the 3 key themes underpinning the learning from this SCR.

Safeguarding Processes

1. CSAB should assure itself that there is a clear framework and methodology for conduct of SARs, including a protocol for agreeing how any parallel investigations and reports will be shared during the SAR process.

2. CSAB should implement a quality assurance system to check the effectiveness of its safeguarding procedures, with a particular focus on the use of strategy discussions, quality of investigation reports, skills in chairing case conferences, and time-limits for distributing case conference minutes.

3. CSAB should be assured that either through the revised Pan West Midlands Procedures, or additional local practice guidance, there is detailed guidance on the circumstances when the police should be notified of safeguarding alerts including a requirement that if a vulnerable adult, who is the subject of a safeguarding alert, dies in hospital, an automatic referral will be made to the police to explore whether neglect or mistreatment contributed to their admission, or to their death.

4. CSAB should be assured that a protocol has been established with the Coventry and North Warwickshire Coroner for sharing information in cases where there is a safeguarding issue which may require a post-mortem, or an investigation through the safeguarding procedures.

Assessment and Treatment Issues

5. CSAB Members should develop a protocol on how agencies will work together in cases where multiple agencies are involved including agreement on which professional will take the lead.

6. CSAB Members should assure themselves that their staff have received appropriate training, and are working to national guidance issued by Department of Health, NICE, and professional bodies to implement the learning from this SCR on the identification, assessment and treatment of pain, constipation, back injuries, sepsis and mental capacity.

7. CSAB Members should assure themselves through supervision and case audits that staff have sufficient skills to engage effectively with persons in a personalised way, in gathering relevant information to guide assessments and care planning, particularly in risky situations when patients and service users are reluctant to accept help or act on advice.

Continuity of Care, including Hospital Discharge Arrangements

8. CSAB Members assure themselves that when patients / service users are moving to a different environment, their organisation shares all relevant information, and contributes fully to multi-agency planning.

9. CSAB request an update report from NHS England on progress on ensuring the pro-active contribution of GPs in the development of multi-agency care plans and review of patients discharged from hospital.

10. CSAB should be assured that hospital discharge procedures include guidance on:-

- factors which should trigger screening for post discharge support;

- the inclusion of all relevant information in discharge summaries, including clear prompts for community professionals on follow up action where there are any outstanding test results;

- the importance of pro-active liaison between the hospital, community services and housing with care schemes.