SERIOUS CASE REVIEW

Executive Summary
in relation to:

0001

June 2010

Contents of Executive Summary

1. Introduction

1.1 This Serious Case Review relates to the circumstances of a 'near miss' event in March 2008 within a supported living environment when A was stabbed by 0001 in what appeared to be an unprovoked attack. The report has used elements of the Department of Health Research report: Serious Case Reviews in Adult Safeguarding (March 2009) to assist in its examination and findings.

1.2 It was agreed by the Surrey Safeguarding Adults Board that this case should be reviewed in line with the Surrey Serious Case Review Protocol because:

- There was evidence of a risk of significant harm that appeared not to have been recognised by agencies or professionals, not shared with others and not acted upon appropriately
- Abuse or neglect was suspected to be a factor in the incident
- The incident happened when 0001 was being supported by a range of agencies
- The incident had implications for a range of agencies and professionals
- The incident suggested that protocols and procedures were not being adequately implemented, understood or acted upon.

1.3 The final overview report was presented to the Safeguarding Adults Board in February 2010 and there is an expectation that learning will be cascaded by the appropriate Board members to their Scrutiny Committees and Executive Boards. The recommendations arising from the report will be monitored and reviewed by the SSAB and it will be shared with the Safer and Stronger Partnership Board.

1.4 The Serious Case Review Panel was chaired by a senior manager from Adult Social Care

Chair - Craig Chalmers (Surrey County Council)
Facilitator - Linda Stewart (Surrey County Council)
Administrator - Vikki Kitcat (Surrey County Council)
Surrey Police - Alan Robson
Surrey Primary Care Trust - Antony McCallum
Surrey & Borders NHS Foundation Trust - Graham Wilkin
Surrey County Council – Learning Disabilities - Mary Hendrick
Parent/Carer of Service User with Learning Disability – Caroline Farnes
Surrey County Council Adult Social Care (Best Practice) - Andy Butler

None of the panel had previously been involved with 0001 or A or their families

Reports and information that contributed to the Serious Case Review were from:

- The Safeguarding Adults Team
- Surrey and Borders Partnership NHS Foundation Trust
- Surrey Police
- Adult Social Care

- Surrey County Council Emergency Response Team
- Surrey Primary Care Trust
- The Independent Housing Support Agency
- Independent Report writer

1.5. The Chair of the Serious Case Review panel visited the families of both 0001 and A and their views and information were considered as part of this report

2. The facts/summary of events:

2.1. 0001 is diagnosed with diagnosed with autistic spectrum disorder and mild to moderate learning disability, with temporal lobe abnormality. He has a history of severely challenging behaviour and psychotic episodes. He was an in-patient in a long stay hospital from 1991 until his discharge in 1996 to a registered care home. He remained at the registered care home, attending Day Services (NHS resource), until moving to supported housing in 2008. After the stabbing incident he was detained under Section 2 of the Mental Health Act and is now living elsewhere in a specialist establishment.

His family have always remained in regular contact with him.

2.2. A has a diagnosis of severe mental impairment and autism, with temporal lobe epilepsy as well as a history of challenging behaviour. He was an inpatient in the same long stay hospital as 0001 from 1990 until his discharge in 1996 to the same registered care home as 0001. He remained at the registered care home, attending the same Day Services (NHS resource) as 0001 until moving to supported housing with 0001. After the serious assault he was admitted to hospital and underwent surgery for his injuries, and he returned to supported housing where he currently resides. He is in regular contact with his father.

2.3. **Key events**

2.3.1. **February 1996**. 0001 and A are placed at the registered care home together with other service users from the hospital

2.3.2. **March 1997 – May 2001**. Incidents recorded when 0001 threatened to hit A on two occasions, threatened to set fire to workshops and threatened to kill a staff member with a knife. Several recorded incidents of assaults by 0001 on staff members at the day centre and the care home.

2.3.3. **2002**. No record of care management contacts during a 2-year period from May 2001 to May 2003.

2.3.4. **2003 – 2007.** Concerns recorded about 0001 absconding and incidents when he had pushed or kicked other residents including A.

2.3.5. **September 2007.** Call received alleging serious safeguarding issues within the registered care home including lack of reporting of incidents, no updated care plans, assaults by residents unreported, staff 'bullied' by the proprietor and assaults on

staff unreported.

2.3.6. **November 2007.** Initial Safeguarding Senior Strategy meeting held which highlighted incidents when 0001 assaulted other residents including A that had not been recorded. Police agreed to lead the safeguarding investigation.

2.3.7. **December 2007.** Safeguarding Senior Strategy meeting confirmed a number of the serious concerns raised in relation to poor care standards and financial control.

2.3.8. **Further Senior Strategy meetings held in December and January 2008.** Interim management arrangements put into the care home. Report presented by care manager detailing the risk from 0001's behaviour if there are any unplanned changes and recommending a structured environment with robust boundaries to ensure the safety of other service users and staff.

2.3.9. **February 2008.** Care Manager informed that 0001 and A would have to move that week, as the proprietor was to resume control of the care home.

2.3.10 **March 2008.** 0001 and A moved in together to supported living.

2.3.11 **March 2008.** Sleep-in staff sees 0001 walking away from A's door and find A bleeding from a wound. Ambulance called and A is taken to hospital. 0001 is taken to the police station at 12.30am but an assessment is not undertaken until 12.25 the following day when 0001's father acts as the appropriate adult.

3. Key issues or themes arising from the case:

3.1 There was a lack of awareness about the history relating to 0001 and A that meant that the risks inherent in placing 0001 and A together in a supported housing setting were not fully appreciated.

3.2 There was an inherent weakness around collective decision-making particularly when a person is deemed to lack mental capacity in a specific area.

3.3. There was a lack of any recorded mental capacity assessments in relation to specific issues and risk management tools do not appear to have been in place at key times.

3.4 Consultation with the families or the appointment of advocates does not seem to have been considered at key times.

3.5 A serious lack of communication and sharing of information between some agencies is apparent.

3.6 There was a lack of integrated working between Adult Social Care Services and the health teams which contributed to a diffusion of responsibility and a lack of a 'joined up' approach between the involved professionals.

3.7 The pressures created by the safeguarding concerns and the risks within the registered care home meant that concerted attention had to be given to high level planning to address the complex issues involved for a number of service users. That focus, and the urgency of the situation, may have detracted from the necessary attention to individual needs and risk assessment.

3.8 The Safeguarding process required a greater emphasis on the individuals and need for advocates.

4. Recommendations and action plan:

1. Serious Case Review Process and Procedures

SC1.1 Consider appointing an independent chair and overview writer for Serious Case Reviews

SC1.2 Consider using Children's Board Serious Case review format for Adults Serious Case Reviews

2. Joint Working Arrangements

SC 2.1 Review joint working arrangements and protocols for cases being managed through both care management and the Care Programme Approach (CPA) processes. Learning and action from this review to be shared with other agencies.

SC2.2 Identify which agency and which staff member holds case accountability where two or more agencies are involved in the case management process. The identified agency will lead on the review process. These changes should be reflected in revised joint working protocols

3. A Chronology of significant events

SC 3 Review the policy on recording chronologies and significant events for learning disabilities cases

4. Reviews

SC 4.1 Face-to-face reviews involving service users and carers should take place unless there are "exceptional circumstances" as noted in Fair Access to Care Services guidance

SC 4.2 Reviews should focus on the service users needs and should be inclusive and cover all services being provided within a single comprehensive review

SC 4.3 Review and revise guidance on telephone reviews to include 'a requirement' to ensure that the responsible professional records the telephone review in the case file

SC 4.4 Case reviews to be revised to include developing a review template, which ensures that there are clear actions and timescales for all agencies. All reviews must be user/client centred.

5. Overall monitoring of policies and procedures

SC 75 Systems to be developed for monitoring the implementation of policies and procedures**.**

6. Mental Capacity checklist

SC 6.1 Develop and introduce a mental capacity checklist and assessment tool**.**

SC 6.2 Ensure systems in place for monitoring that learning disabilities staff have completed Mental Capacity Act training

7. Risk assessment

SC 7 Develop a joint risk assessment tool and guidance for using this. This should be compatible with the principles of personalisation

8. Senior Strategy Meetings

SC 8.1 Review procedures for Senior Strategy meetings to ensure needs of service users and user views are central

SC 8.2 Review procedures for Senior Strategy Meetings to ensure that they include reference to the need to record information on risk and capacity

9. Carers assessments

SC 9 Ensure Carer's assessments are routinely offered and recorded and appropriate action plans developed

10. Section 117 arrangement

SC10 Review processes for ensuring Adult Services staff are aware whether Section 117 applies

11. Emergency Duty Team

SC11 Develop systems for monitoring that the Emergency Duty Team has responded in a timely manner when there has been a request for a Mental Health Act assessment

12. Quality assurance of the SCR process

SC12 Quality assures the Serious Case Review process in relation to the 0001 case. To include whether Safeguarding Board SCR procedures were followed and the quality of the individual management reviews and the overview report

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