Surrey Safeguarding Adults Board

SUMMARY OF SERIOUS CASE REVIEW

In respect of HL

September 2008

Report by Bill Robbins, Independent Chair of the Serious Case Review on behalf of Surrey Safeguarding Adult Board

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Background

1. HL was born in 1949 and at the age of two years diagnosed as suffering from profound mental retardation. In 1956 he was further diagnosed with, “autism” and “psychosis”. As a result his communication skills are extremely limited and he has a history of severe challenging behaviour and self-harming.

2. In 1962, at the age of 13 years, HL was admitted informally to Botley’s Park Hospital in Surrey (later renamed “Homewood Trust” and then “Bournewood Community and Mental Health Trust”). The reason recorded for the admission was ‘HL has become too big and strong for his mother to control, he needs training and discipline’. His mother and father subsequently died.

3. Bournewood contracted with a private agency, Mentor Community Care (later renamed Lifeways Community Care) to recruit and supply adult placements for some individuals. In 1993/94 they provided nine placements. One of them was Mrs. E who was contracted in October 1993 and agreed to provide care and accommodation for HL in her own home and he moved there on the 13th March 1994 with a care plan produced by Lifeways. This placement was considered successful.

4. On 22 July 1997, following an incident of self-injurious behaviour at a Day Centre, HL was attending, he was re-admitted to Hospital. HL returned home on 5th December 1997 on section 17 leave and he was discharged from his section 3 order at a Hospital Managers Review meeting on 12th December 1997.The legal issues surrounding his period resident in hospital at this time, have been extensively considered in the British Courts and the European Court of Human Rights.

5. The judgments in these cases, and the deprivation of liberty safeguards introduced by the Mental Health Act 2007, have achieved much to provide additional safeguards for people who lack capacity and who might be deprived of their liberty. However in 2005, HL’s paid carers Mr. & Mrs. E, felt that his situation in 1997 raised some issues that could be investigated under the Multi-Agency Safeguarding Procedures. As a result of their referral, an Adult Protection Interagency Planning Meeting was held in January 2006

which initiated various internal actions by the partner agencies and led to an Adult Protection Case Conference in October 2006 at which HL's paid carers indicated that there was a list of things for an independent person to look at; nobody had looked at the social care records, the NHS Ombudsman did not investigate the way in which HL was treated, only whether he should have been admitted and the clinical management of his stay and the Court processes only looked at the legality of his detention and whether his Human Rights had been breached.

6. A review was commissioned by the Surrey Safeguarding Adults Board (SSAB) in line with the Procedure for Review of Serious Adult Protection Cases (revised August 2004).

7. The terms of reference for the Serious Case Review were agreed by the Surrey Safeguarding Adults Board as follows:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies currently work together to safeguard vulnerable adults
- To review the effectiveness of Surrey's present procedures (both multi-agency and those of individual organisations)

- To establish what those lessons are, how they will be acted upon and what is expected to change as a result

- To improve inter-agency working and better safeguarding of vulnerable adults

- To prepare an overview report bringing together and analysing the findings of the various reports from the key partner agencies, in order to make recommendations for future action.

8. The methodology to be used was:

a) To establish the chronology of the care received in relation to HL's placement at Bournewood Hospital (Villa 1B) from 22nd July until 5th December 1997 – when HL was discharged into the care of Mr. & Mrs. E.

b) To examine the adequacy of the collaboration and communication between all the agencies involved in the care of HL or in the provision of services to HL between 22nd July 1997 and 5th December 1997

c) To carry out a review of all investigations and reviews undertaken by the Surrey Safeguarding Adults partner agencies whether those were undertaken during HL's admission to Villa 1B or subsequently

d) To prepare an independent report based on the findings and make recommendations to the Surrey Safeguarding Adults Board in respect of Surrey's current Safeguarding Adults Procedures.

9. The Procedure adopted by the Review was as follows:

a) Key people representing the agencies participating in the Review who were still employed by the participating agencies, received a letter before providing information to the Serious Case Review Group which informed them of the terms of reference and procedure to be adopted by the review, requested a report and set out the areas and matters to be covered by them in their report. Former employees were not contacted because the Review Group believed sufficient documentation and correspondence existed available to the Review Group to consider. A safeguard was identified that if, having reviewed the paperwork and other information gathered e.g. from interviews with those who were still current employees, there appeared to be points of potential criticism of former or current members of staff, those persons would be sent the relevant extracts and asked for their comments;
b) Any points of potential criticism were put in writing to those providing information either in writing or by interview, and they were given a full opportunity to amend those accounts or make any further response which was recorded;
c) All sittings of the review were held in private;

d) The Draft report was made available to the Safeguarding Board and other agencies asking for comments as to point of fact;
e) The summary of the review and any recommendations are to be made public;
f) The information submitted to the review either orally or in writing was not made public by the review, except insofar as it is disclosed within the body of the review's final report;
g) Findings of fact were made on the basis of the written and oral information received by the review. The standard of proof applied was the balance of probabilities. Corroboration was sought through examining the documentation available and submitting relevant extracts of that documentation to named individuals, seeking their comments on those points whilst acknowledging they concern events of ten years ago. Comments within the narrative of the report and any recommendations were based on those findings, and took into account issues relevant under the Freedom of Information Act 2000.

10. The Membership of the Serious Case Review Group was drawn from the agencies involved in the case but with no personal involvement in the matters under review. They are:

- Craig Chalmers, Service Manager Older People/Disabled Peoples Services, Surrey Families Directorate (Adults);
- Detective Inspector, Paul Noke, Surrey Police;
- Cynthia Dwyer, Lead for Specialist Services, Surrey Primary Care Trust;
- Dr. Karen Dodd, Associate Director for Specialist Therapies – Learning Disabilities, Surrey & Borders Partnership NHS Trust
- Cliff Bush, Chair of North West Surrey Association of Disabled People;
- John Bale, Chair of Action for Carers Surrey;
- Bill Robbins, Social Care Consultant (Independent Chair).

Nominees all have appropriate knowledge and experience of Safeguarding Adults and interagency work, and have suitable qualifications and seniority within their agencies.

The Group has had access to legal and safeguarding advice as necessary throughout from Surrey County Council staff.

11. The Methodology used by the Serious Case Review Group (SCRG):

11.1 An initial meeting was held to: confirm and accept the terms of reference; identify the 'evidence' required from each participating agency; set the time scales within which the review process should be completed; agree the dates, times and venues of meetings; and establish the nature and extent of legal advice required.

11.2 The Independent Chair sought access to appropriate and identified files and records which were either, in the case of the majority of the documents, copied in advance of SCRG meetings to the members or, with regard to a small number or follow up documents, circulated for inspection, interrogation, cross-referencing and discussion at the SCRG meetings themselves.

11.3 The Independent Chair has carried out interviews with: Mr. & Mrs. E, who supplied a number of background documents in support of their concerns; and staff in the various agencies still in employment of that agency who were involved in the case in 1997, other than those who declined to be involved. All interviews with such staff were written down and ratified by them and are included in the background documents used by the SCR Group. Given that this was to be a review of joint working and the procedures and systems used in 1997, not an investigation or inquiry, it was not considered necessary to trace and seek interviews with all former employees of the relevant agencies, as there is sufficient available written evidence. All former employees were treated equally in this regard. This latter point applied to Drs. M, D, G, and the Approved Social Worker.

11.4. Using the correspondence provided to the Review, a chronology was then compiled outlining the key events from all the participants and agencies' perspectives.

11.5. Using this chronology to consider and deliberate on all of the documentation available to them, the Group then agreed the key points to be included in the report and the recommendations for further action.

12. Findings and recommendations of the Review

12.1 The placement of HL with Mr. and Mrs. E from 1994 was described by Mentor/Lifeways Community Care, as highly successful in coping with both his needs and outbursts of disturbed behaviour. From reports by the care manager and community staff at care reviews, he thrived there. It is to be noted that this was and is the only successful placement of an individual with complex needs out of the nine similar situations the Bournewood resettlement programme attempted. Medical treatment for HL was provided by Mr. & Mrs. E's local GP practice and he seems not to have required nor received any clinical input from the Surrey and Borders Partnership NHS Trust (or predecessor NHS Trusts) since leaving hospital in 1994.

There are positive comments as to the care provided to HL by Mr. & Mrs. E. The NHS Ombudsman's findings **(A16/C15 para. 27)** confirmed "Mr. & Mrs. E as being highly committed to Mr.L's care and were able to provide him with a significantly better quality of life than he had before." The NHS Ombudsman's report **(A16 para 31)** goes on to say "As it turned out, an atmosphere of mistrust developed; and there were disputes over matters such as access to diaries kept by Mr. and Mrs. E, and visiting arrangements. Mr. and Mrs. E were also convinced that Trust staff were attempting to discredit them in order to justify their actions."

Tensions were ongoing for several years and eventually, in August 2005, Mr. & Mrs. E made a formal complaint regarding alleged defamatory statements made about them and recorded,

to the now Surrey and Borders Partnership NHS Trust, which was upheld **(C17,C18,C19,C20).**

The Day Centre, at that time in 1997, was poorly prepared, under resourced, and not capable of effectively meeting HL's needs and behaviours. On the day of the incident, unknown to Mr. & Mrs. E, the transport arrangements had been substantially changed which could have been a significant cause of HL's disturbed behaviour. The staff could not cope with HL's behaviour on 22nd July and they were unable to contact Mr. & Mrs. E for assistance or to take him home. The Manager called for medical help both from a local GP and an ambulance. Hospital admission was inevitable to safeguard HL and others in the circumstances. Consideration was given as to whether HL should be admitted under section 2 or 3 of the Mental Health Act 1983. However as he was compliant this was not considered appropriate, as was common practice at that time.

12.2 Following a formal complaint by Mr. & Mrs. E, the practice and procedures at Day Services have been improved appropriately.

12.3 HL was initially placed in the position he was in July 1997, by the failure of Health and Social Services to agree the resettlement and discharge process and for responsibility and funding to have passed to Social Services under a Section 28A agreement from April 1994 onwards.

This meant, in the view of Dr. M at that time in July 1997, that HL could be readmitted at any time without recourse to the Mental Health Act 1983. This approach was widely practiced at the time and was described in the Judgement of the House of Lords which cited the pragmatic advice set out in the 1978 Review of the Mental Health Act 1959, paragraph 1.8.

Recommendation 1

Surrey Safeguarding Board should consider within its proposed definition of institutional abuse, the potential for individual's rights and needs to be ignored, as agencies fail to agree roles and responsibilities in a timely way.

12.4 The pace of the hospital closure and resettlement was swift considering the numbers of patients involved and the considerable cultural change that was required of all staff working in an institutional setting. It was challenging for all concerned and stretched or changed many long operated systems and ways of working. In the context of custom and practice at that time, clinicians with responsibilities for someone who was still technically an “inpatient”, would have been accustomed to having authority as well as accountability and might not have accepted any challenge to that position.

12.5 A lengthy period of in patient observation, assessment, treatment and behavioural therapy was embarked upon without there being any acceptance of a community based alternative for almost 5 months, probably due to the poor relationship between clinicians and Mr. & Mrs. E, with the former perhaps feeling besieged by Mr. & Mrs. E ‘s challenge.

12.6 The diagnosis of cyclical mood swings and the treatment regime was, eighteen months later, discounted for HL’s needs by clinicians specialising in autistic spectrum disorders. Indeed they cite that the admission to hospital episode would have triggered more disturbed behaviour by him and that there were no drug treatments that would have been effective.

12.7 The delays in providing behavioural guidelines were unacceptable and contributed to extending HL’s stay in hospital unnecessarily.

12.8 This in-patient period appears to have had no beneficial effect on HL’s overall disturbed behaviour and resulted in an adverse effect upon his physical condition. Both his behaviour and physical condition are reported to have improved upon his release in December 1997 and have been maintained to the present day.

12.9 Save by way of seeking a second opinion, which Mr. & Mrs. E did do but, which in the event was supportive of Dr.M, her decision in this matter was not able to be effectively challenged at the time by Mr. & Mrs. E, the Hospital General

Manager, or any other agency. The system did not allow for such challenge as it was designed around a long stay institution rather than a community based approach with the need for greater flexibility and risk taking. Today such decisions could be amenable to challenge within the professional supervision arrangements for clinicians or potentially be the subject of an adult safeguarding investigation in respect of professional abuse as described in the joint agency procedures on the grounds of the alleged misuse of therapeutic powers. However given the widespread practice at the time, applying today's criteria to what happened then, it is unlikely it would have been found to have been professional abuse or misuse of therapeutic powers.

12.10 The Mental Capacity Act 2005 introduction of Independent Mental Capacity Advocates and the Department of Health guidance on implementing the Bournewood safeguards also provide a further way of ensuring an individual lacking capacity to consent is protected, however further legislation is to be implemented in 2009 which might provide for this issue.

12.11 The improvements in clinical governance are noted which should prevent such episodes from either recurring or continuing for any length of time without proper challenge. It is noted the Surrey and Borders Partnership NHS Trust now has provision for the calling in of an external mediator in such matters concerning doctors' performance.

Recommendation 2
The Surrey and Borders Partnership NHS Trust is recommended to consider all the National guidance on the supervision of doctors and review its policies and procedures for clinical supervision accordingly. This review should include scrutiny and follow up by senior managers where concerns are raised.

12.12 The Surrey and Borders Partnership NHS Trust's report in response to the care manager's formal complaint of HL's care whilst admitted in 1997, finds that whilst a number of concerns were satisfactorily answered there appears to have been shortcomings in respect of:

- Basic Nursing Care
- Record keeping
- Follow-up appointments
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A number of improvements were recommended which were then implemented by the Surrey and Borders Partnership NHS Trust and monitoring arrangements put in place to see that they would be maintained. The replacement service at Bramdean displays evidence of a satisfactory range of Quality Assurance systems that have been or are now in place for that facility. However the recent (2006) Safeguarding Adults' investigation at another facility, albeit with a different care group, indicates a lack of consistency across all of the Surrey and Borders Partnership NHS Trust provision. The current capability to monitor training has been hampered by the need to merge the training records of the three former NHS Trusts but this should now be a priority as the nationally required electronic staff records are implemented.

Recommendation 3
Surrey and Borders Partnership NHS Trust's full Trust Board receives annual reports from their nominated Director to monitor the Trust's Safeguarding Policy, Procedures & Training Strategy and overall performance in this area.

12.13 The care manager acted as a strong advocate for HL and Mr. & Mrs. E throughout the period in question, challenging the clinicians, with some support from her Team Manager. It is clear that given the lack of awareness of safeguarding issues at that time, nationally and locally, the care manager acted in a highly professional and progressive manner.

Joint working with Health managers in relation to the resettlement programme seems to have been left to first line managers. A case file audit was undertaken in June 1998 which identified the need for more intervention by senior managers in cases such as HL's. Senior Managers at the time have no detailed recall of events in this case.

Following management restructuring in both Health and Social Services there now exists regular and frequent joint senior management team meetings, which can deal with issues regarding individuals as well as matters of overall policy and strategy.

Recommendation 4
The Families Services Directorate (Adults) can and should, have appropriate influence over the care of individuals in health settings, including secondary care. All Managers, especially care managers, need to act assertively and proactively to ensure this happens and alert senior management swiftly if serious concerns remain unresolved. Equally senior managers should take prompt and appropriate action to support front line staff where issues arise. Where this does not happen, or where care managers continue to have concerns regarding potential institutional or professional abuse, they should contact the Safeguarding Team for further advice. There may be a training need in order to ensure all relevant staff feel confident in such situations.

12.14 When completing the reports for Section 3 compulsory detention for treatment, there appears to have been a lack of effective joint working between the Approved Social Worker and the Care Manager (as reported by the Care Manager and Mr. & Mrs. E) This could be improved by the inclusion of an accredited ASW in each Community Learning Disabilities Team as part of their care manager resource.

Recommendation 5
Surrey County Families Directorate are recommended to complete their proposals over the next 3 years, to have at least one Care Manager/Social Worker in each integrated Community Team for People with Learning Difficulties, qualified as an Approved Social Worker (ASW) and to maintain this accredited capability by the individuals participating on the County ASW duty rota. ASW on going training should include information on the issues of people with learning disabilities so that all ASWs have some insight into their needs and likely behaviours. This provision will need to be revised following enactment of the new Mental Health Act and the replacement of

the Approved Social Worker role with that of an Approved Mental Health Practitioner.

12.15 No referral regarding the alleged physical assault and neglect of HL during this period of hospital admission, was made to the Police in December 1997 by either Mr. & Mrs. E, the care manager, or any other health or social care professional. Mr. E eventually made a referral to the Police in August 1998 following dissatisfaction with the Surrey and Borders Partnership NHS Trust's response to the care manager's official complaint in February 1998.The referral should have been made in 1997 at the time of the alleged assault or on HL's discharge in December, when there would have been more opportunity to collect forensic evidence and the recall of staff may have provided more detailed statements which would have greatly assisted the investigation. The Police were left with no opportunity to gather forensic evidence, which might have supported any possible prosecution.

In 1997, no statutory agency, including the Police, would have had guidance or procedures in place to investigate allegations of general neglect by Long Stay Hospitals. The latest version of Surrey's Safeguarding Procedures includes 'Institutional Abuse' as grounds for implementing the Safeguarding Procedures and routinely includes the Police.

All multi-agency staff must have an understanding of the Police role and need for forensic evidence, built into their training.

Recommendation 6
Allegations of any potential abuse committed against a vulnerable adult, resident in any form of provision, must be reported using the Safeguarding Procedures. This may be to the Surrey County Council Contact Centre or to the Police.

12.16. The legal responsibility for the provision of care to some ex hospital patients and those funding their own care has continued to be unclear, e.g. those accommodated in Housing Association homes, as are the arrangements for coordinating their care management.

Recommendation 7

The Surrey Primary Care Trust and Surrey County Council are recommended to fully implement their agreement in principle, regarding care management arrangements for the group of people whose care is currently fully funded by Health or who are self funding.

When any service user is admitted for Assessment and Treatment to either an NHS or a private unit commissioned by the NHS, arrangements for them to receive care management services need to be maintained, unless the individual is already receiving NHS Continuing Care.

It should be noted that being eligible to receive assistance in line with the Safeguarding Adults Procedure is not dependent on how or if a service user is receiving a service. If a service user in Surrey is funded by social care, health care, or is self funded, they will still be assessed using the Thresholds of Intervention and Assessment of Seriousness in relation to a Safeguarding allegation or concern. A decision will then be taken as to whether this meets the Safeguarding criteria.

12.17 Surrey County Council and its partner agencies is committed to a multi agency approach in relation to safeguarding adults as well as the involvement of service users and carers within the process. The Surrey Safeguarding Team has been acknowledged in the past as an example of good practice nationally, and continues to strive to ensure that there is a consistent and timely response to safeguarding issues across the county. Independent Chairs chair all Case Conferences across the County and there is an expectation that service users and/or their representative are in attendance.

The Safeguarding Team is available to give advice and support to front line practitioners and this helps to ensure a consistent and effective response to safeguarding concerns and allegations. Given the quantity and range of care providers in Surrey, it will be important to ensure that awareness of safeguarding adult's policies and procedures are included in staff induction processes and awareness training.

Recommendation 8

The Surrey Safeguarding Board is recommended to receive an annual report from all partner agencies setting out their performance in managing the Safeguarding Agenda, including the monitoring of staff induction and training in safeguarding adults issues.

13. Conclusions:

13.1 If available in 1997, the current Surrey Multi-Agency Procedures for protecting vulnerable adults definition of professional abuse could have been invoked by Mr. & Mrs. E. They would have been able to make a referral to consider whether it met the threshold for investigation into whether professional abuse was taking place, i.e.
"Professional abuse is the misuse of therapeutic power and abuse of trust by professionals, the failure of professionals to act on suspected abuse/crimes, poor care practice or neglect in services, resource shortfalls or service pressures that lead to system failure and culpability as a result of poor management systems/structures."

13.2 Surrey Safeguarding Adults Board has recently revised the Multi Agency Procedures to include a definition of institutional abuse/restrictive practice. If this Multi-Agency Procedure had been available prior to 1997 it could have been pursued in HL's case in respect of the care management arrangements and may have prevented the admission to hospital for assessment.

13.3 The Surrey and Borders Partnership NHS Trust now have governance processes in place which enable individual doctor's performance to be effectively monitored and if appropriate, challenged.

13.4 Effective co-working policies and practice are being implemented between Families Services Directorate (Adults) Mental Health and Learning Disabilities Services when providing services to people with learning disabilities who also have a mental health issue.

13.5 There are still a number of ex hospital patients for whom clear care management arrangements are being agreed and implemented between Surrey Primary Care Trust and Surrey County Council.

13.6 The Surrey Multi-Agency Safeguarding Partnerships continue to learn from events and evolve accordingly. An additional strength would be the annual monitoring of staff training in the participating agencies to ensure practice keeps pace with this learning.

13.7 Given all of these conclusions and the introduction of the 'Bournewood Safeguards' themselves after the Court proceedings in this matter, we believe that it would be highly improbable now, and in the future, for any individual to be subject to the circumstances that HL experienced from 22nd July to 5th December 1997 by being unlawfully detained in hospital.

Serious Case Review Group
September 2008