Northamptonshire
SAFEGUARDING ADULTS

Serious Case Review

Overview Report

Alice Porter (Pseudonym)

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Executive Summary

Alice Porter was born and bred in Kingsthorpe, Northampton. She loved the area, the cafes and shops. It was also close to the cemetery where her Mum's grave was and she liked to visit and take flowers.

Alice described herself as affectionate and she loved visits from her family. She liked to have a laugh, a chat and enjoyed singing and dancing.

Alice enjoyed drama, musicals and any kind of dancing. She loved to socialise. She liked to keep active and enjoyed swimming.

Alice attended the local Methodist Church and enjoyed the tea events that took place there.

On 20th April 2011 Alice was being accompanied by Mencap staff to attend church when she fell. The Mencap staff called an ambulance and, despite some initial discussions about whether to take Alice home, the ambulance crew took her to hospital for assessment.

Alice was admitted to Northampton General Hospital on 20th April 2011, where she died on 26th May 2011. Alice was 54 when she died.

Serious concerns were raised about the care and attention Alice received from both East Midlands Ambulance Service and Northampton General Hospital in the time between her fall and her death.

Northamptonshire County Council received three safeguarding alerts regarding Alice's care while Alice was in hospital.

Northampton General Hospital undertook a serious incident investigation and the findings from this and from the safeguarding investigation were considered by an Adult Safeguarding Case Conference on 27th July 2011. EMAS also undertook a serious incident investigation and the case conference found neglect in respect of both East Midlands Ambulance Service and Northampton General Hospital.

The circumstances of Alice's care were escalated to the Northamptonshire Safeguarding of Vulnerable Adults Board who decided that a serious case review should be undertaken, to understand the reasons behind a failure to meet Alice's care and clinical needs and to learn lessons to improve services going forward.

1 Introduction

1.1

This Serious Case Review (SCR) has been commissioned in relation to Alice Porter (pseudonym).

1.2

Alice was a lady with a learning disability who was 54 when she died in hospital on 26th May 2011. She lived in a small care home, which was operated by Mencap.

1.3

The safeguarding of vulnerable adults is a function of the Local Authority and, in this case, is overseen by Northamptonshire Safeguarding of Vulnerable Adults (SOVA) Board. Under the terms of the Northamptonshire SOVA procedures, the decision as to whether or not to hold a serious case review of any particular case is the responsibility of Northamptonshire SOVA Board and is exercised through their Serious Case Review (SCR) sub-group.

1.4

Following Alice's death a decision was taken by Northamptonshire General Hospital (NGH) and East Midlands Ambulance Service (EMAS) to instigate an investigation under their serious incident (SI) procedures. This followed a review of an early management report, which confirmed that Alice's death presented significant care/service delivery failures, which met the criteria for a serious incident.

1.5

At the same time, Northamptonshire County Council (NCC) safeguarding team received three safeguarding notifications. Two concerned the care that Alice had received from NGH and EMAS. The third notification was in respect of Mencap and an allegation that they had failed to provide information to hospital staff that would have enabled NGH to make "reasonable adjustments" for Alice in terms of her learning disability.

1.6

"Reasonable adjustments" should be made as required by the Disability Discrimination Act 1995, Equality Act 2010 to support the delivery of equal treatment. For an individual with a learning disability in a hospital setting this may mean making adjustments to enable them to understand the treatment or pathways required to address their medical condition, making allowances for communication difficulties and the anxieties of being in an unfamiliar setting.

1.7

The circumstances surrounding Alice's death were considered by the Serious Case Review sub-group on 7th February 2012 and again on 28th June 2012. Members concluded that this case met the requirements for a SCR to be commissioned. The request was ratified by the SOVA Board in July 2012.

1.8

The purpose of the SCR is to identify whether agencies that were involved with Alice acted appropriately and whether any lessons can be learnt.

1.9

Unlike Children's Services, there is, at present, no clear statutory framework providing duties and responsibilities in relation to the protection of vulnerable adults. There is government guidance in place, however, which requires Local Authorities to ensure that arrangements are made to provide for good and effective inter-agency procedures and protocols to improve the protection of vulnerable adults.[1]

[1] No Secrets, Department of Health 2000

2 Terms of Reference

2.1

It is important to understand that the purpose of a Serious Case Review is not to re-investigate or to apportion blame.

It is:

- *To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults*
- *To review the effectiveness of procedures (both multi-agency and those of individual agencies)*
- *To inform and improve local inter-agency practice*
- *To improve practice by acting on learning*
- *To prepare or commission an overview report which brings together and analyses the findings of various reports from agencies in order to make recommendations for future actions* [2]

2.2

The focus of this review is to consider the level of intervention, care and support provided to Alice Porter from 1st April 2011 until her death on 26thMay 2011.

2.3

The Terms of Reference for each Serious Case Review are agreed by the SOVA Board.

2.4

The specific issues to be addressed by this SCR are:

- Whether agencies acted effectively in preventing injury occurring
- Whether agencies made effective responses in the care and treatment of Alice Porter, according to individual agencies policies and SOVA inter-agency procedures
- Given Alice Porter's learning disability, what consideration was given to mental capacity and best interest decision-making in responding to Alice Porter and whether expected standards were followed
- Whether reasonable adjustments were made for Alice Porter's learning disability by individual agencies
- To seek to understand if these events could have been avoided and what lessons have been learnt as a result of the Serious Incident Process and Safeguarding investigation
- To consider the overall effectiveness of inter-agency and intra-agency working at that time. Were agencies working within the framework of safeguarding procedures and guidelines?

[2] Northamptonshire Safeguarding Vulnerable Adults Board Serious Case Review Guidance July 2009

3 Methodology

3.1

The overview report and analysis are based on Independent Management Reviews (IMR) and chronologies submitted by the following key agencies:

- Northampton General Hospital (NGH)
- East Midlands Ambulance Service NHS Trust (EMAS)
- Northamptonshire County Council (NCC)
- Mencap

3.2

Alice Porter's GP also responded to a request to provide details of the GP practice's involvement and met with the independent chair of the panel.

3.3

These agency reports are written by individuals who have had no role in the conduct of the cases and as such are independent of the process. The reports are presented to the multi agency SCR Panel where they are effectively challenged and points of clarification are raised.

3.4

A meeting was held on 9th August 2013 with the independent author to brief the IMR authors on their role. This was attended by NGH, EMAS and NCC. Mencap was unable to attend. This was disappointing as MENCAP had to be asked to re submit their IMR as it did not address the Terms of Reference. The IMR was defensive in tone and the ability to assist the Panel and develop their own learning was compromised.

3.5

The SCR Panel has met on 3 occasions and the challenge and clarification resulted in further information being provided by Mencap, NCC, and the decision made that Alice's GP be asked to provide information for consideration.

3.6

While the focus of the Panel was Alice, the panel was clear, when becoming aware of issues which may have impacted on other service users, that the matters be escalated for appropriate action to be taken, rather than await the recommendations of the SCR Report.

3.7

The family of Alice Porter were informed of the Serious Case Review and declined to be involved. This was largely due to the lapse of time since Alice's death and the SCR commencing, as well as the fact that it would be painful for them.

4 The Review Panel Members

Independent Chair

- Clare Enfield — MAPPA Coordinator
Northamptonshire Police Probation and Prisons

Panel Members

- Steve Lingley — Head of Protecting Vulnerable Persons
Crime and Justice Command
Northamptonshire Police
- Clare Culpin — Director of Nursing and Quality
Kettering General Hospital
NHS Foundation Trust
- Carolyn Kus — Director of Adult Social Care
Northamptonshire County Council
- Mark Ainge — Head of Community Services
Fire and Rescue Service
Northamptonshire County Council

4.1

The SCR Panel Chair and the Overview Author are independent, appropriately qualified and experienced professionals.

4.2

The Chair is a qualified social worker with 30 years experience in the Probation Service both in operational and senior roles. The majority of this time has been working with, and managing services for, high-risk offenders.

4.3

The independent author has over 35 years experience of adult social care at operational and strategic levels, in particular at the interface with health. This has included 5 years with national inspectorates, assessing the performance of councils and as a regulator of care services.

5. Chronology of events.

5.1

Alice Porter resided in a care home in Northamptonshire, which was operated by Mencap.

5.2

Mencap describes their organisation as 'working with people with a learning disability to change laws, challenging prejudice and supporting people with a learning disability to live their lives as they choose'.

5.3

Alice had a learning disability, which meant that she required support with personal care, managing her finances, going out in the community and medical care. Alice was placed in the Mencap care home following the death of her mother. Northamptonshire County Council (NCC) funded her care.

5.4

Alice had family who were involved in her life and visited her in the care home, which was a small establishment with only two further residents. There was normally one staff member on duty to support all three individuals. The house also had a small team of support workers.

5.5

On 24th January 2011 Alice fell down stairs at the care home and was admitted to Northampton General Hospital by ambulance. Alice had various bruising and required stitches to her head. It would also appear that Alice had had another fall earlier in January 2011.

5.6

Alice had high blood pressure and diabetes. Prior to her death she had been attending her GP with stomach problems relating to constipation and, in March 2011, had been referred to NGH for investigation of this. Alice attended her appointment at NGH on 6th April 2011.

5.7

On 20th April 2011 Alice was accompanied, along with two other residents, by two Mencap care staff to attend church. She had a fall, which was not witnessed, but it appeared to the staff that were with her that she had fallen backwards and possibly hit her head on a parked car. The care staff heard a bang and said that Alice lost consciousness for 20 – 30 seconds.

5.8

The care staff-members called 999 and when the paramedics arrived Alice was conscious.

5.9

On arriving, the ambulance crew were met by a care staff-member who explained what had happened, that Alice had learning disabilities and lived in a care home. The paramedics saw that Alice was rolling around on the floor. The paramedics completed their visual observations of Alice and, following assessment, decided to move her to the ambulance. Alice, who usually walked unaided, was unable to get to her feet. The ambulance crew were assisted by a member of the public in moving Alice onto a stretcher.

5.10

Observations were completed in the ambulance and it would appear that there then was discussion about what to do next. The Mencap staff felt that Alice would not do well in a hospital environment and Alice herself was keen to go to a tea party that day. Alice appeared to be unable to stand unaided but the paramedics, based on the history given, the mechanism of her fall and their observations, were happy to take Alice home if she could stand.

5.11

The paramedics described Alice as a reluctant patient who was distressed by observations and wanted to go home. En route to hospital Alice began to engage with the ambulance crew and was able to stand without assistance so the ambulance took her home. However, on arrival at the care home, when helping Alice out of the ambulance, it appeared that she was unable to stand (it is not clear whether this was due to Alice declining to stand or if she was in fact unable to stand) and therefore the paramedics decided to take Alice to hospital for further assessment.

5.12

On arrival at Northamptonshire General Hospital (NGH) on 20th April 2011, Alice's blood pressure was low and she was moved to the resuscitation area.

5.13

When examined, weakness was shown in Alice's left leg and her right leg showed significant weakness. There was concern about a possible spinal injury and an MRI scan was requested. Alice was admitted to an orthopaedic ward and a spinal x-ray was undertaken.

5.14

On 21st April, Alice was taken for an MRI scan but she refused to have it done. The plan was to mobilise Alice, but Alice didn't "cooperate" with the physiotherapist, shouting when her legs were moved. Throughout the 21st April, Alice's blood pressure was low. The MRI scan was not undertaken.

5.15

On 22nd April Alice's blood pressure continued to be low and she appeared to have a fit. Alice again refused physiotherapy. The recommendation was to keep Alice as mobile as possible. No MRI had been taken at this point.

5.16

On 23rd April Alice had signs of pressure sores.

5.17

Alice was seen again by a physiotherapist on 25th April and struggled to maintain a standing position. No MRI had been taken at this point.

5.18

On 26th April Alice declined physiotherapy and was unable to stand. No MRI had been taken at this point.

5.19

On 28th April the decision, following the ward round, was to continue with physiotherapy. It was also noted that Alice had developed a pressure sore.

5.20

On 28th April, visiting Mencap staff noted deterioration in the grip of both of Alice's hands. This was discussed with the doctor and, in light of this neurological deterioration, a head CT and spinal MRI were planned.

5.21

The MRI, which took place in the afternoon of 28th April, confirmed that Alice had compression of her spinal cord – a serious neck injury.

5.22

The neurosurgery unit at John Radcliffe Hospital in Oxford was contacted and it was decided that Alice should be transferred urgently. Alice was transferred by "blue light" ambulance to Oxford on 28th April.

5.23

On 29th April it was recorded by John Radcliffe Hospital that there was very little chance that surgery would improve Alice's neurological condition. On 29th April it was also noted that Alice was unable to move her arms below the shoulder and that surgery would not resolve the paralysis. The decision was taken in agreement with the family to keep Alice comfortable – palliative care.

5.24

On 11th May, as there was no change in Alice's condition, a case conference decision was made by John Radcliffe Hospital to transfer her back to NGH.

5.25

Alice was transferred back to NGH on 19th May 2011. The transfer letter from Oxford stated "no action or surgery advised" and in agreement with Alice's family, a decision was made to keep her comfortable. Alice was on an orthopaedic ward. She was assessed by the Learning Disability Nurse at NGH on 20th May 2011 and a plan was put in place to support her while in hospital.

5.26

Alice's condition deteriorated further and on 24th May she was transferred to the High Dependency Unit at NGH. While on the High Dependency Unit (HDU), Alice suffered a cardio-respiratory arrest and was successfully resuscitated.

5.27

Discussions took place with Alice's family and it was decided that in the event of a further arrest, resuscitation would not be appropriate.

5.28

Alice was transferred from HDU back to the ward on 25th May 2011 and died in the early hours of 26th May 2011.

6 The Agencies

The following provides a summary of the individual agencies' contributions to the Serious Case Review Process.

6.1 Mencap

6.1.1

Mencap was the provider of the care home service in which Alice lived: a small home with only two other residents.

6.1.2

Following the first submission of the Mencap IMR, the Panel was of the view that Mencap had not addressed the terms of reference and that it was difficult to get a sense of Alice, given that Mencap care staff were likely to be the people who would know her best. This was discussed with the Mencap IMR author at the first panel meeting and Mencap were given the opportunity to re-submit their IMR to ensure the terms of reference were addressed. Mencap were also asked to provide further information for the panel on staff training records, the day centre that Alice attended, to record medical episodes leading up to the fatal fall, and for their view of the term "uncooperative", which other agencies had suggested Mencap staff had used to describe Alice.

6.1.3

The ensuing Mencap report mainly focussed on the role of the care staff in respect of Alice's fall and subsequent stay in both NGH and John Radcliffe hospitals. It is reported that on the day of Alice's fall, staff followed procedure by calling an ambulance, giving clear information to the paramedics that Alice had fallen backwards and possibly banged her head on a parked car, and that a member of staff had accompanied Alice to hospital.

6.1.4

Staff visited Alice every day apart from one and communicated with Alice's family and with hospital staff on her needs.

6.1.5

Mencap explained that while they would attempt to ensure that any of their residents received support when settling in at the hospital, they are unable to provide full support, as they still have to provide support for other residents at the home.

6.1.6

Mencap was not funded by Northamptonshire County Council to provide additional specific one to one support hours for Alice.

6.1.7

There is a record in the Mencap chronology of the manager of the service Alice received contacting NCC Learning Disability Team on 22nd April to see what

support and help was available for Alice whilst she was in hospital, and being informed of the Learning Disability nurse based at the hospital.

6.1.8

The IMR reports this as the manager raising her concerns with the local learning disability team about the support Alice was receiving “but no additional funding was allocated”.

6.1.9

Mencap staff explained to NGH several times that Alice would not have the capacity to make or understand decisions regarding her health or treatment and also tried to contact the LD liaison nurse at NGH but unfortunately the nurse was on annual leave.

6.1.10

At the SCR panel meeting on 27/1/14 Mencap also provided a copy of the Health Action Plan that was in place for Alice. Health Action Plans for people with a learning disability were recommended by Department of Health in their white paper Valuing People (2001). The purpose is to identify health actions that will make a positive difference to the health and well being of the individual. Health Action Plans were expected to be in place from 2005.

6.2 East Midlands Ambulance Service (EMAS)

6.2.1

East Midlands Ambulance Service (EMAS) responded to the 999 call made by Mencap staff on the 20th April 2011, following Alice’s fall. Of the two staff-members who attended the incident, one has left the Trust and was unavailable for interview. The author of the IMR interviewed the other staff-member. Statements, however, were available from the earlier Serious Investigation and Safeguarding Investigation, which took place in 2011 following Alice’s death.

6.2.2

The Patient Record Form (PRF) was, at the time of the accident, the means of recording used by EMAS. This records that Alice had learning disabilities and was diabetic – this was information provided by the carers who are described as being helpful. The PRF did not, as would be expected, provide a clear time line of events although the interview with the paramedic who attended Alice helped to provide further information.

6.2.3

When the ambulance crew arrived there was a large group of people around Alice and a carer informed the paramedic about the incident, that Alice had fallen and may have hit a parked car. There is no record that the carers informed the ambulance crew of Alice's loss of consciousness. The paramedic recalled, in interview, wanting to get Alice into the ambulance as soon as possible as she was concerned about her privacy and dignity. Alice had been incontinent, was wearing a dress and the scene was described as being chaotic.

6.2.4

It is also reported that the carers advised the attending crew that Alice could be "uncooperative". The paramedic recalls being told by the carers that Alice was a "difficult lady" with a learning disability and may be difficult to deal with.

6.2.5

The ambulance crew completed visual observations and assessed Alice for injuries. There were no obvious signs of injury and they decided to move her to the ambulance. Alice, at this stage, was not following prompts and was anxious about a tea party she was due to attend that afternoon. The statement records "she was indeed uncooperative and in fact resisted our assistance" in relation to moving her onto a stretcher. A member of the public assisted the crew to get Alice onto the stretcher.

6.2.6

The PRF records that Alice*"? Tripped on the kerb –banged head"*. The PRF contains boxes for ticking in relation to being knocked unconscious and the "query" box had been ticked on the PRF. In the statement for the SI, the crew stated Alice had tripped and had fallen with no apparent injuries. On discussion with the paramedic she stated that Alice was not knocked unconscious and that they also checked the car and that there was no mark or damage on it. The paramedic also stated that the fall was not observed so it was not clear if Alice had tripped up or put herself on the floor. This is at odds with information given by Mencap staff that Alice had fallen backwards and had lost consciousness for 20 – 30 seconds.

6.2.7

The statement records that the crew carried out a full examination and clinical observations as per the PRF and that there was no injury sustained. On discussion with the paramedic, she stated that Alice didn't like being touched and found observations distressing.

6.2.8

The PRF has one set of observations completed and no evidence that the head injury was assessed or Alice's spine cleared. The paramedic view was that the mechanism of fall was low and that a C-spine fracture would not have been suspected as there were no signs of injury. Although it is not documented, the paramedic said that she would not have moved Alice without checking her spine. The paramedic also stated that she would not have attempted to board and collar (the procedure if a spinal injury is suspected) Alice if she had identified a possible C-spine fracture; this due to Alice's temperament and the additional stress this would have caused, as placing a patient on a board who is distressed and struggling may have then caused further issues in relation to the C-spine.

6.2.9

It appears that once in the ambulance there was a group discussion about what to do, with the ambulance crew wanting to use the Mencap staff-knowledge of Alice to inform decision-making. It is reported that Mencap staff said they would rather take Alice home as she wouldn't do well in a hospital environment and it was also reported that Alice was quite difficult to engage with. Alice wanted to go to a tea party that afternoon. The paramedic reported that they had no clinical reason to take Alice to hospital based on history given, mechanism of fall and the observations. The crew were happy to take Alice home if she would stand. A second set of observations should have been completed. The reason given for non-completion was that Alice was a reluctant patient who was distressed by observations and wanted to go to home.

6.2.10

En route to hospital Alice's behaviour changed, she started to cooperate and she stood up with no assistance. The PRF also records that the carer stated her behaviour was now back to normal and they would prefer to take Alice home. The crew reported in the statement that they made a joint decision with the carer to, at this point, return Alice to the care home as they were concerned she would find the hospital experience stressful. Once at the care home they started to help Alice out of the ambulance. The paramedic remembers that on arrival at the care home Alice refused to stand. Then, on standing, it had appeared to the crew that she had decided to sit down and they helped her back onto the trolley. Alice would not try and stand again and the paramedic remembers at that point being concerned about leaving Alice at the care home and they took her to hospital for further assessment.

6.2.11

There is a consent section on the PRF form and this was not completed. There is no evidence that a mental capacity assessment was completed. The PRF did not provide clarification as to whether or not Alice was consulted. The paramedic said that Alice was consulted and informed of decisions being made throughout the assessment. Alice was also asked questions about what had happened and her pain levels, as well as what she wanted to do. On discussing Alice's capacity with the paramedic she stated that she did an informal capacity assessment and that it was clear from Alice's behaviour and the information provided by the carers that Alice did not have capacity to make decisions about the care she required. That was why the initial decision was made with the carers to take her home.

6.2.12

The "non-conveyance" box has been completed and the PRF states that advice was given to call the ambulance service back if needed although this was crossed out as Alice was conveyed, i.e. taken to hospital. There is no information provided on the PRF around the decision-making process, regarding whether to take Alice to hospital or not. All the information available was provided by the crew-statement and the interview with the paramedic.

6.2.13

The PRF provides additional information that Alice refused to stand and that she reported no pain or discomfort. It was also recorded that she was incontinent and that this was normal behaviour. The paramedic recalled being told by the carers that this was normal.

6.3 Northampton General Hospital

6.3.1

Following the death of Alice, NGH completed an early management report. It was decided that there were significant care/service delivery failures that fulfilled the criteria for a serious incident. A serious incident (SI) investigation took place and a report was completed in September 2011.

6.3.2

The serious incident report has been shared with the SCR Panel and the statements and information provided for the serious incident report have informed the NGH IMR.

6.3.3

Alice was admitted to Accident and Emergency (A&E) at NGH on 20th April 2011, having been transported there by the ambulance crew who attended the 999 call.

6.3.4

The period Alice was an in-patient at NGH included Easter Bank Holiday weekend. The SI recognises that reduced medical cover over a long bank holiday weekend added to problems with support and supervision of junior medical staff.

6.3.5

There appears to be discrepancy as to “loss of consciousness” in the SI report, the EMAS IMR and the Mencap IMR, which will be explored further in the analysis section. Similarly, the serious incident report notes that there was “no documentation to suggest that the hospital staff were made aware by the ambulance service that the carer had stated that the patient had suffered some “sort of seizure””. Neither the Mencap IMR nor EMAS IMR make mention of a seizure.

6.3.6

Upon admission to A&E Alice was conscious and alert although described as “uncooperative”. Initial examination indicated reduced tone and power in her lower limbs and it was thought that she may have sustained a spinal injury. While Alice was “log-rolled” to protect her spine during examination, no other form of spinal protection was put in place.

6.3.7

In the NGH IMR there is mention that the carers had stated that Alice had lost consciousness, but there is no record that a head injury was considered, or guidelines regarding head injury followed.

6.3.8

An MRI scan was requested and discussed with the radiologist on call and it is recorded that the scan could not be performed that evening – MRI scans are not undertaken out of hours. The decision was taken to transfer Alice to the care of the orthopaedic team and an x-ray of her lumbar spine was requested. It is stated that as Alice did not complain of pain it was not considered necessary to undertake neck and skull X-rays.

6.3.9

There was no record on the admission/discharge documentation that there was a possibility that Alice had suffered a spinal injury. The reason for admission to the ward was given as “head injury”.

It is recorded

(1) head injury

(2) ??spinal

(3) …history explained, unlikely spinal injury. Advised observe overnight

6.3.10

Alice was reviewed in the morning of 21st April 2011. She was moving her legs and the plan was to mobilise her. She was taken for her MRI scan but did not agree to the scan taking place. It was not possible to determine whether the ward staff were informed that the scan had not taken place at that time.

6.3.11

Consideration does not seem to have been given of Alice’s capacity to consent to the scan or of any discussion of alternatives when she refused. The Mencap IMR states that their staff were surprised that the MRI was going ahead without any support for Alice being present, as they had been very clear with hospital staff that

Alice did not have the capacity for any procedure, including x-rays, to be undertaken unsupported. Alice's sister had also been clear with the hospital that Alice did not have the capacity to make decisions.

6.3.12

Attempts continued to mobilise Alice. Alice refused physiotherapy and "shouted out when attempting to move her lower limbs" on 21st April, refused physiotherapy on 22nd April and "struggled to maintain standing position due to generalised weakness" on 25th April 2011.

6.3.13

Throughout this period Alice, who usually had high blood pressure, had persistently low blood pressure. This was highlighted using appropriate documentation on four separate occasions, with no documentation in the medical notes on two of these occasions. There was no referral, as would be expected, to the Critical Care Outreach Team (CCOT) at any point. This team is available to provide advice and support to ward staff regarding any patient about whom they are concerned. There was no documentation to show that possible reasons for the low blood pressure were considered. This could have been due to a spinal injury.

6.3.14

During her stay in hospital Alice developed pressure sores. There was no record of a referral to the Tissue Viability Nurse and it is considered that the pressure area risk-assessment undertaken on the day of admission underestimated the risk to Alice.

6.3.15

There was also no risk-assessment undertaken for Venous thrombo-embolism (VTE) which would indicate the level of risk to Alice of developing a blood-clotting complication.

6.3.16

On 28th April 2011 at 08.00 hours, Alice was reviewed on the ward round and it is documented that *"she has really not been mobile"*. This was the first documentation by medical staff since 22nd April 2011.

6.3.17

Alice was seen by a doctor at 14.00 hours on the 28th April and it was noted that she was no longer moving her arms and legs. An MRI scan was successfully completed and confirmed a traumatic injury to her cervical spine with cord-compression. There was still no spinal protection in place at this time.

6.3.18

The results of the scan were communicated to the orthopaedic team at 18.30 hours and attempts were made to put spinal protection in place but Alice was "non-compliant".

6.3.19

Following the result of the MRI scan, contact was made with the neurological unit at John Radcliffe Hospital in Oxford and Alice was transferred there for assessment. Spinal protection was eventually put in place prior to Alice's transfer to John Radcliffe Hospital at 21.15 hours on 28th April 2011.

6.3.20

Alice was transferred back from Oxford on 18th May 2011. The transfer letter states "no action or surgery advised" and, with Alice's family's agreement, a decision was made to keep her comfortable. It is clear from notes of a meeting with NCC and Mencap that Alice's family were not happy about a return to NGH and were asking questions about transfer to a different hospital.

6.3.21

Alice remained on the orthopaedic ward until she became unwell on 24th May 2011 at 08.45 hours. Later that day Alice was transferred to the High Dependency Unit. She suffered a cardio-respiratory arrest and was successfully resuscitated. The notes from John Radcliffe Hospital record DNAR – do not attempt resuscitation. Discussions took place with Alice's family at NGH and it was decided, in the event of a further arrest, that resuscitation would not be appropriate.

6.3.22

Alice was transferred back to the ward at 19.35 hours on 25th May 2011. Her condition deteriorated rapidly and she passed away at 01.15 hours on 26th May 2011.

6.4 Northamptonshire County Council

NCC fulfils a number of roles and in relation to this SCR there are three areas of responsibility, namely:

- Care-management and assessment
- Safeguarding
- Commissioning and contract-monitoring

The initial IMR submitted by NCC focussed mainly on the safeguarding aspect and touched on case-management. Following the SCR panel meeting on 6/12/13 further information was requested on the commissioning and contract-monitoring role and this was provided for the panel meeting on 27/1/14.

6.4.1 Care management and assessment

6.4.1.1

NCC was the funding authority for Alice's placement at the Mencap care home. Alice did not appear to have a named social worker and it was assumed that she would only have been subject to reviews. At the first panel meeting it was clarified that Alice had been known to the local authority since 1994 and accommodated as a younger adult since 2001. The last formal review had taken place in May 2009. It was explained that, as was the practice at the time, Alice was not allocated to a team or worker due to having a long-standing package of care.

6.4.1.2

Alice appears to have been appropriately placed with Mencap and upon admission to hospital NCC report that she was well supported by both her family and staff from the home who made a total of 11 visits to see Alice in hospital, three of them in Oxford.

6.4.1.3

It is not clear on what date NCC staff were aware that Alice was in hospital having suffered a fall. It is however recorded in the Mencap IMR that the manager of the care home contacted the Learning Disability Team on 22nd April 2011 to see what support was available for Alice whilst she was in hospital.

6.4.2 Safeguarding

6.4.2.1

On the 10th and 13th May two meetings were held, chaired by NCC. The first meeting was attended by NCC staff, NGH staff and the Community Learning Disability team. The focus was what had occurred since Alice's fall and the proposal that Alice should return to NGH from John Radcliffe Hospital. The meeting discussed applying for Continuing Health Care funding to fund a Mencap carer to support Alice while in hospital. Alice's family were not happy about a return to NGH.

6.4.2.2

Alice's sister attended the meeting on 13th May 2011. This meeting was concerned with looking at future care options for Alice. Before decisions could be made, further information was needed from John Radcliffe Hospital about levels of nursing care required. Alice's family were to be given information about nursing

homes, as it was evident that Alice could not return to the Mencap home. Alice's family were not happy about the proposed return to NGH.

6.4.2.3

On the 12th May 2011 the NCC Safeguarding Team received a safeguarding notification from Mencap containing the outline story of Alice's treatment by EMAS staff, admission to NGH and subsequent care.

6.4.2.4

On 14th June 2011 a second safeguarding notification was received by NCC. On this occasion it was raised by the safeguarding lead at NGH raising concerns about Alice's treatment in hospital.

6.4.2.5

On 24th June 2011 a third notification was received. This was sent by the safeguarding lead at NGH raising concerns that Mencap had failed to provide information to hospital staff that would have enabled NGH to make "reasonable adjustments" for Alice in terms of her learning disability.

6.4.2.6

Given that at this stage NGH and EMAS were moving towards the serious incident investigation, there was communication in May 2011 about how the health service Serious Incident procedure and the SOVA procedure linked together.

6.4.2.7

On the 25th May 2011 NCC chaired a safeguarding strategy meeting attended by the Advocacy Service, Care Quality Commission (CQC), members of Alice's family and NCC safeguarding team staff. No representatives from either NGH or EMAS attended although apologies were sent. At this point it was known that Alice had only a very limited life expectancy and the focus of the meeting was mainly exchanging information and considering how the safeguarding concerns were to be investigated.

6.4.2.8

Following Alice's death on the 26th May 2011, NCC proceeded with their investigation into whether Mencap had failed to provide adequate information to NGH about Alice's learning disability and consequent capacity. At the same time there was liaison with the Alice's family.

6.4.2.9

The safeguarding issues regarding Alice's treatment at NGH and by EMAS were being considered through the serious incident investigation.

6.4.2.10

On the 9th June 2011 the terms of reference for the serious incident investigation were sent to NCC for their comment. Further contact with NGH indicated that the deadline for the SI completion was the 24th August 2011. At this time NCC were also informed by EMAS that they were investigating the incident as part of the NGH SI and had appointed their own investigating officer.

6.4.2.11

On the 22nd August 2011, NCC received a draft copy of the joint NGH/EMAS SI action plan to which they responded on the 18th October.

6.4.2.12

EMAS were contacted by NCC in December 2011 to ask if they had any further feedback in respect of the SI report. NCC was informed that EMAS had only just received the report and that there were some issues that they needed to consider.

6.4.2.13

On the 11th January 2012 NCC again contacted EMAS to find out when the EMAS report would be ready. The response from EMAS was that they had been unhappy with the report and had written to NGH to ask that it be corrected.

6.4.2.14

On the 7th February 2012 the circumstances of Alice's death was subject of a preliminary discussion at the SCR sub-group at which it was agreed that contact would again be made with EMAS to ask for the report and that, following the concluding safeguarding case conference, there would be a formal referral for a SCR to be carried out. The request to EMAS was made on the 9th February.

6.4.2.15

The SCR sub-group met again in late February or March 2012 at which point they had received the supplementary report from EMAS. However no one from EMAS was at the meeting and there were concerns about the quality of the report. It was agreed that the matter would be discussed with the NCC lead officer for the investigation to see whether she thought there was sufficient information to move to a case conference and meeting with the family to feed back findings.

6.4.2.16

The final case conference took place on 27th July 2012.This resulted in findings of neglect in respect of NGH and EMAS but no finding in respect of Mencap.

6.4.3 Commissioning and Contracting

6.4.3.1

NCC had a contractual arrangement with Mencap for the provision of residential care services. While this was a block purchase contract, the contractual arrangements were in line with the Council's Framework Agreement for Younger Adults Care Home Services that was signed-up to by all care home-providers that provide services for NCC.

6.4.3.2

These arrangements continue to be negotiated as Mencap adapt their model of service-provision to reflect the change of focus to community-based support.

6.4.3.3

There were no compliance issues in respect of the service where Alice lived. There had however been a number of safeguarding notifications, which concerned service-user-to-service-user abuse during April and May 2010.

6.4.3.4

Contract-monitoring arrangements usually meant that a full contract-monitoring visit would occur annually, although the period between visits would be extended where no concerns were highlighted.

6.4.3.5

The service where Alice lived had had a contract-monitoring visit on 4th December 2008 and no major concerns were raised in relation to the service. The SCR Panel did however note that there were comments in the contract-monitoring report that the residents at the care home did not respond to fire alarms when they sounded. The manager of the NCC contracting service was asked to take urgent steps to ensure that subsequent action had been taken to ensure the safety of residents.

6.4.3.6

The Panel was informed that further measures had been put in place. A Care Home Review Team is in place and there is an electronic recording system also in place, which records contract-monitoring information and safeguarding information so that full details of care-provision are held on a single site.

6.4.3.7

During this period, there were significant levels of activity in relation to the re-configuration of the Mencap Care Home services, resulting in consultation exercises with service-users and relatives.

7 Analysis

7.1 The SOVA Process

7.1.1

From the outset, there have been delays that have impacted on the length of time to complete this review, given that Alice died in May 2011.

7.1.2

It is evident that there were complexities in terms of the roles and relationship between the agencies involved in the serious investigation, and the interface with safeguarding. These resulted in the case conference to conclude the safeguarding investigation into allegations made in May 2011 not taking place until 27th July 2012. The detail of this process is outlined in paragraphs 6.4.2.8 to 6.4.2.16.

7.1.3

The inter-agency working between EMAS and NGH at the time of the Serious Incident Report preparation does appear to have been less than satisfactory and is likely to have contributed to the delays in getting the investigations finalised.

7.1.4

The issue of the relationship between the SI process and the Safeguarding process could have caused difficulties but appears to have been managed satisfactorily between NCC and NGH. A new joint procedure was introduced in March 2012, which appears to have clarified and consolidated how the agencies work together. This is an effective piece of inter-agency collaboration.

7.1.5

When the decision was taken to proceed with a serious case review in July 2012 there were pressures and capacity issues for Northamptonshire's SOVA Board business unit. Two other SCR's were being progressed at this time, one being published in October 2012, the second being published in May 2013. There was also concern about the ability of multi agency partners to engage with a third SCR. Some agencies had involvement in all three SCR's. The initial meeting to agree the terms of reference took place on 12th July 2013. There was then a further delay that could not have been anticipated or planned for. This resulted in a decision being taken at the November 2013 SOVA Board meeting to appoint a new Chair for this SCR. The first SCR Panel meeting took place on 6th December 2013.

7.1.6

Nevertheless this has resulted in unacceptable delay. The panel did acknowledge that agencies involved have already implemented recommendations. It did mean, however, that the IMR's were being written from previous statements and members of staff involved at the time of Alice's fall and subsequent period in hospital in some cases had left organisations.

7.1.7

The expectation in Children's Services is that serious case reviews should be completed within 6 months from notification to Ofsted and, if there are reasons for delay, this should be reported and any early lessons implemented without waiting for the overview report. In this case NGH and EMAS have gone on to implement the recommendations from their Serious Incident recommendations, but Alice's family have had a long time to wait for the review.

7.1.8

The SCR Panel recognises that, unlike Children's safeguarding, Adult safeguarding is not yet on a statutory footing, however good practice would dictate that SCR's should be completed in a timely fashion.

7.1.9

On 12th May 2011, NCC received a safeguarding notification from Mencap raising serious concerns about the care that Alice was receiving in hospital. Following an internal strategy discussion, agencies were contacted for information. NCC also received a safeguarding notification about the care Alice received from EMAS and NGH raised a notification about Mencap. At this time NGH had instigated a serious incident investigation and there was conversation between NCC and NGH about how the serious incident procedure and the SOVA process linked together.

7.1.10

There was, however, no evidence that consideration had been given by the NCC safeguarding team to visit Alice and ascertain her safety. It is suggested that it may have been assumed that while in hospital she would have been well looked-after.

7.1.11

The Panel clarified that the usual process would be for concerns in a hospital setting to be referred back to the hospital safeguarding lead and the expectation would be that they would report back to NCC. The Panel was informed that NCC would now involve the Clinical Commissioning Group (CCG) when serious issues were raised to identify whether the issues were institutional or quality concerns.

7.1.12

This does raise a question for the SOVA Board in terms of the involvement of the Local Authority Safeguarding team in instances when abuse is alleged in a hospital setting.

7.2 Health Conditions

7.2.1

Although outside the scope of the original terms of reference, the Panel was concerned that Alice had been having falls prior to the fall that resulted in her admission to hospital. Additional information was sought from Mencap and Alice's GP to see if there was any information that could highlight anything that may have contributed to her death. It was evident that Alice had been having some additional health problems during this period. The Panel was not given assurance that the history of falls, which appeared to be a new health concern, was adequately addressed.

7.2.2

The Panel was concerned by the content of the health action plan submitted by Mencap at SCR Panel meeting on 27/1/14.

7.2.3

The panel already knew that Alice suffered from high blood pressure (hypertension). Alice's health action plan referred to Alice receiving medication for hypotension – low blood pressure. The entries on the plan were dated December 2006. The health action plan also noted that Alice was receiving medication for her diabetes when the Panel had been informed that her diabetes was diet controlled.

7.2.4

This information was escalated to the Director of Adult Social Services for assurance that the plans of the other service users in the service were accurate.

7.2.5

A copy of the Health Action Plan was shared with Alice's GP who confirmed that this had not been seen previously, was out of date in respect of medication for diabetes and the error of hypotension instead of hypertension.

7.2.6

Alice had attended her GP eight times from November 2010 for abdominal problems diagnosed as constipation. Her GP referred her on 24th March 2011 for a general surgery consultation.

7.2.7

During this period Alice had had two falls prior to the fall that resulted in her being admitted to hospital. Mencap acknowledge that a falls risk-assessment should have been completed with input from other professionals.

7.2.8

The Panel noted that Alice was described as having fallen backwards on the 20th April. It was also noted that the Northampton General Hospital Serious Incident Investigation (NGH SI) reported that one of the carers had reported that Alice was "lying slumped against the car with her head pushed as far forward as possible on to her chest". The panel questioned whether Alice's fall on 20th April had had a physiological reason. The meeting with Alice's GP, however, clarified that while

Alice had ongoing health conditions which were managed, the referral that was made to a general surgeon had provided reassurance that there was no serious problem.

7.3 Care-Management

7.3.1

The Panel was informed that, at the time of the incident, Alice, whose placement at Mencap was funded by NCC, did not have an allocated social worker and it was presumed she would only have reviews. The Panel clarified that Alice's last formal review was May 2009 and that the practice at that time was not to have an allocated worker due to having a long-standing care package. This practice has now changed and every service-user has a named team and worker.

7.3.2

It is expected that people in receipt of Adult Social Care services should receive a review at least annually, or earlier if needs change significantly, from the Local Authority.

7.4 The fall and Alice's journey to hospital

7.4.1

Following Alice's fall, the Mencap staff acted appropriately by calling 999.

7.4.2

There is, however, discrepancy in the IMR's on the information that was given to the ambulance crew when they arrived. Although reportedly not observed, Mencap states that their staff gave clear advice to the paramedics that Alice had fallen backwards, had banged her head on a car and had been unconscious. EMAS, however, recorded a query as to whether Alice had been knocked unconscious and in interview for the IMR, the paramedic stated that Alice had not been knocked unconscious. It is, however, recorded by NGH that Alice was reported to have lost consciousness for approximately 20 seconds. The source of this information is not given but it does record that the carer was present on admission.

7.4.3

This is also discussed in the NGH SI report. Statements provided at this time indicate that the ambulance crew were informed that Alice had lost consciousness but their view was that there was doubt about the loss of consciousness given the way in which Alice fell, as described by the carers.

7.4.4

It is reported that the ambulance crew were informed by the carers that Alice could be "uncooperative". In a statement for the SI the crew stated "she was indeed uncooperative and in fact resisted our assistance"

7.4.5

Mencap clarified for the Panel that their view was that at no point during any medical appointments would Alice have been "uncooperative". The Panel was informed that Alice could feel frightened if she did not understand any procedure.

7.4.6

Alice's GP said that Alice was a "happy girl". She regularly attended the surgery in the company of her carer. Alice was described as not initiating conversation but she would answer direct and simple questions. She could make herself understood and was able to say if something hurt.

7.4.7

EMAS accepts that there is no evidence that the ambulance crew attempted to find out why Alice was being "uncooperative" or indeed what the ambulance crew considered as "uncooperative". There is nothing documented that the crew considered that Alice may have been uncooperative due to being in pain or due to her head injury. The PRF does, however, document that she was not in pain.

7.4.8

The Panel were of the view that reasonable adjustment had not been made for Alice's learning disability and she was seen as being a patient who would not cooperate. What could have been signs of a clinical need were ascribed to behaviour that could have been as a result of her learning disability

7.4.9

It is also of concern that the terms "uncooperative" and "non-compliant" are also to be found in the NGH recordings of Alice's stay in hospital.

7.4.10

It would appear that the ambulance crew did try to be sensitive to Alice's dignity in wanting to get her into the ambulance as soon as possible.

7.4.11

EMAS accepts that there is poor recording of their contact with Alice on the day of her fall. The record-keeping around clinical care and decision-making is limited and, as a result, the decision-making does not appear to have been made in an informed manner. There is a lack of narrative and holistic assessment and limited evidence of engagement and communication with Alice.

7.4.12

There is no evidence that a Mental Capacity Assessment was carried out. Whilst capacity is referred to there is no documentation of the assessment and best interest decision.

7.4.13

The Mental Capacity Act 2005 provides a statutory framework for assessing whether an individual has capacity to make certain decisions and addresses the issue of providing care and treatment for people who lack capacity to consent to it.

7.4.14

It is recognised that the ambulance crew was keen to include the carers in the decision-making. EMAS is clear however, that if the ambulance crew felt that Alice did not have capacity and could not make a pathway decision, a full capacity-assessment should have been completed and documented and a decision made in Alice's best interest.

7.4.15

The Panel was concerned that the ambulance crew took a lot of information from the carers and that evidence of clinical-assessment was limited.

7.4.16

EMAS acknowledged that the crew should have consulted the carer to support a best-interest decision for Alice, but, as the attending emergency services, the final decision should have been made by the ambulance crew to support Alice's clinical needs. The Panel concurred with this view.

7.5 Alice's periods in Northampton General Hospital

7.5.1

NGH acknowledges in their review that NGH failed to respond to adverse clinical signs and symptoms and instigate prompt and appropriate treatment from Alice's admission until her transfer to Oxford.

7.5.2

The review also found that there was an inability of all staff involved in Alice's care to take into account her learning disability and to assess the impact that this had on her capacity to both communicate effectively and refuse or consent to investigation and treatment.

7.5.3

There was no assessment of Alice's capacity to consent to or refuse treatment – this is of particular relevance in relation to her refusal of the first MRI scan. At the time, NGH considered that this could have been due to lack of training in the Mental Capacity Act that medical staff received, but despite training in capacity being available for other disciplines, there was no documented evidence that anyone considered undertaking a formal assessment of Alice's capacity. This appears to be despite Alice's family and the Mencap staff informing hospital staff that Alice did not have capacity to make decisions. No alternative diagnostic plan to the MRI appears to have been put in place and it is unclear how the team assessed the associated risk.

7.5.4

The SI confirms that there was poor documented communication with Alice's family and her carers and this resulted in information not being relayed between the many different staff groups involved in her care.

7.5.5

While staff were aware of Alice's learning disability, there was no documentation to indicate that Alice's communication needs were considered when carrying out care. Indeed, The Panel noted that the label of "uncooperative" was used in terms of her reluctance to mobilise, and when spinal protection was being introduced after the second MRI scan, the term "non-compliant" was used. This is previously referred-to in this analysis and of concern is that these terms appear to be have followed Alice from the initial contact with the ambulance crew through her hospital journey until her spine compression was diagnosed.

7.5.6

Mencap staff did visit often while Alice was in hospital, as did her family, but there did not appear to be any formal arrangements in place to allow the carers and relatives to spend time with Alice or to be available for reassurance, for example with the MRI scan. The Panel was concerned that Alice's family and the carers were Alice's biggest advocates and that the voice of Alice's family and her carers were not heard. The Panel was also concerned that no additional support arrangements had been put in place while Alice was in hospital.

7.5.7

To assist people with a learning disability with emergency hospital admissions which can cause distress, there are tools in place: one is the Accident and Emergency "grab" sheet. This holds information not only on vital medical matters but also on how the individual communicates and how they express pain. As described by the name it is intended to be kept up-to-date and "grabbed" to accompany the individual in the case of an emergency admission. The A&E grab sheet did not accompany Alice to hospital on this occasion and it is apparent that her "hospital book" was not supplied until her transfer to Oxford. There was therefore a lack of written communication, which would have impacted on how the clinical team managed her care.

7.5.8

The Panel was informed that both Mencap staff and Alice's family had raised concerns with hospital staff about Alice's care. There was no record about this in the nursing or medical notes and, indeed, the failure of NGH to respond resulted in Mencap submitting a safeguarding notification to NCC.

7.5.9

NGH did have a specialist Learning Disability Nurse in post at the time of Alice's admission. At that time this post was part-time and the person in post was on annual leave. There was, however, no record to indicate that hospital staff had at any time considered referring Alice to the Learning Disability Nurse or the NGH Safeguarding Lead for advice. From August 2011 the Learning Disability Liaison Nurse post is now full time resulting in access to expert advice and to strategic development. It was clarified for the Panel that the Learning Disability Nurse is still only available during office hours and covers the whole hospital. NGH acknowledged that the knowledge about learning disability should not rely on one person and needs to be with the whole workforce. The Panel was informed that a significant amount of work has been undertaken to raise awareness of learning disabilities and there is an elective planned pathway in place.

7.5.10

The SI reports that there was a failure to recognise physiological changes and to provide appropriate investigations and treatment. This was exacerbated by a lack of senior overview and reduced medical cover over the Easter Bank holiday weekend.

7.5.11

The SI states that Alice's learning disability clearly affected the care and treatment she received, as there was no formal attempt made to assess her mental capacity

and no communication between key staff about how Alice's learning disability affected her ability to communicate. No reasonable adjustments appear to have been made to her care and management to accommodate this.

7.5.12

On Alice's return to NGH from Oxford the lead nurse for learning disability became involved in her care and there was facilitation of an appropriate care plan.

7.5.13

The NGH IMR highlighted areas of practice that required further development.

- Lack of communication between and within staff groups and between NGH staff and outside agencies
- No assessment of Alice's capacity
- Poor documentation of diagnosis, care given and communication with Alice's family and carers
- Failure to identify Alice's symptoms as an indication of possible spinal shock or cerebral involvement, despite being told she had hit her head and lost consciousness when she initially fell.

7.5.14

It is acknowledged that appropriate referral was made to the learning disability nurse for support for Alice's family and carers on her second admission to NGH. In addition there was good liaison with her carers from Mencap.

7.5.15

The Panel acknowledged the honesty and transparency in the information NGH submitted for this serious case review.

8 Recommendations

8.1 Multi-agency recommendations

8.1.1

SOVA Board should consider implementing timescales for completion of and procedures for reporting delay in the completion of SCRs.

8.1.2

SOVA board to develop an escalation procedure for information of concern that comes to the attention of SCR Panels, to ensure timely action is taken to assure the appropriate care and safety of service-users.

8.1.3

SOVA Board to consider the role of the Local Authority safeguarding team in respect of safeguarding notifications of care failings in hospitals'.

8.2 Mencap

The following are the recommendations from the Mencap IMR.

8.2.1

The Hospital Book of the individual who is receiving treatment should be taken to the hospital immediately an admission has taken place.

8.2.2

Anyone who has any indication of a potential head injury should be taken to A&E without delay to be checked out. In the case of Alice Porter, as the paramedics were called, they made the decision regarding Alice's care needs and therefore overruled the Mencap staff team.8.2.3

Mencap have implemented the above lessons learnt in their services within Northamptonshire as a local procedure.

8.2.4

SCR PANEL recommendation: That Mencap regularly review Health Action plans to ensure medical information is accurate and up to date.

8.3 Northampton General Hospital

There are no new recommendations arising from the IMR. A comprehensive action plan was developed following the recommendations of the SI demonstrating that improvements have been made. This Action Plan is attached at Appendix 1.

8.4 EMAS

It has already been noted that there has been a significant period of time from the day of Alice's fall to the completion of the SCR. It is acknowledged that EMAS has not waited for the SCR and has implemented its own recommendations. There are no new recommendations arising from the EMAS IMR but the detail of the lessons learnt included in the IMR is contained in Appendix 2.

8.5 Northamptonshire County Council

8.5.1

That the SCR Review Panel should consider whether this case raises an issue about the direct involvement of the NCC Safeguarding Team in situations where they receive reports of neglect in NHS hospital settings. If so it should look at what protocols and agreements should be in place so that the role of the Safeguarding Team is known and understood by all parties.

8.5.2

That action should be taken by the Safeguarding Team to ensure that notifications are always clear about exactly what the concerns are and whether these are historical or ongoing. Where notifications are not clear this should be followed up straightaway and a record of the follow-up discussion made.

8.5.3

Given the considerable delays in this case, consideration might also be given to a mechanism whereby some sort of review meeting is triggered by cases where it has not been possible to complete investigations within a certain period (say six months). There may also be a benefit in having a requirement that all such meetings are monitored and reported to the SOVA Board. Such a system would help to prevent families having to wait for an unacceptably long time to find out the results of investigations into what has happened to their family members.

8.5.4

SCR Panel Recommendation: That NCC and the Fire Service share information and intelligence on Fire Risk Assessments to identify care premises which can be visited jointly.

9 CONCLUSION

All of the agencies involved in the care of Alice have cooperated with the serious case review process and have responded to the Panel's challenges and requests for clarification.

The terms of reference for this review were set out in 2.4. These are:

- Whether agencies acted effectively in preventing injury occurring

  The view of the Panel was that it was unlikely that Alice's fall could have been prevented. It would appear that there was no underlying physiological reason for the fall. Mencap did have risk-assessments in place for their service-users, although they acknowledged that a falls risk-assessment should have been completed for Alice. The Panel recognised that while risk could be minimised it was not possible to prevent all eventualities.

- Whether agencies made effective responses in the care and treatment of Alice Porter, according to individual agencies policies and SOVA inter-agency procedures.

  The Panel view was that the responses to Alice – and to her family – were not effective.

  Policies and procedures in respect of mental capacity and best interests were not followed. There was no referral to the Safeguarding Lead at NGH for advice and support, nor, during Alice's initial admission, to the Learning Disability nurse. There is no evidence of effective communication with Alice and her family.

  When safeguarding referrals were received in respect of Alice's care and support, consideration does not appear to have been given to visiting Alice in hospital to seek assurance of her safety and welfare.

- Given Alice Porter's learning disability, what consideration was given to Mental Capacity and Best Interest decision making in responding to Alice Porter and whether expected standards were followed.

  Both EMAS and NGH recognise that Mental Capacity Assessments should have been completed.

  While the interview with the paramedic suggests that an "informal capacity assessment" was undertaken, the process was not completed appropriately or recorded adequately. It was not completed in line with agency standards and did not adhere to the principles of the Mental Capacity Act 2005.

  It is accepted that the ambulance crew did engage Alice's carers in decision-making but again there is no recorded documentation that any best interests decision was taken with regard to the appropriate pathway for Alice.

There is no evidence during Alice's first admission to NGH that her mental capacity was considered or best interest decisions made. The principles of the Mental Capacity Act 2005 were not adhered to.

- Whether reasonable adjustments were made for Alice Porter's learning disability by individual agencies

  The view of the Panel was that reasonable adjustments were not made for Alice's learning disability.

  While it is recorded that the ambulance crew were informed that Alice could be "uncooperative", there is no evidence that the crew attempted to ascertain why she was being uncooperative or what they considered uncooperative. There is no documented consideration that Alice may have been uncooperative due to being in pain or due to a head injury.

  Similarly, NGH did not make reasonable adjustments to ensure diagnostic investigations were undertaken. There was no communication between key staff about how Alice's learning disability affected her ability to communicate. It was assumed that Alice was uncooperative and non compliant rather than ensuring that diagnostic tests were undertaken in a timely manner.

  The Panel ascertained from Alice's GP that Alice regularly attended the surgery in the company of her carer. The GP described Alice as not initiating conversation but she could answer direct and simple questions. She could make herself understood and was able to say if something hurt.

- To seek to understand if these events could have been avoided and what lessons have been learnt as a result of the Serious Incident Process and Safeguarding investigation.

  The Panel is not in a position to form a view as to whether the outcome for Alice would have been different if appropriate clinical procedures care and support had been in place.

  It is likely, however, that the experience for Alice and her family would have been very different if reasonable adjustments for Alice's learning disability had been made, mental capacity assessments undertaken and best interest decisions taken.

  There have been significant improvements in training, education and processes, both intra and inter-agency, since 2011 and these are outlined in the Appendices.

- To consider the overall effectiveness of inter-agency and intra-agency workings at that time. Were agencies working within the framework of safeguarding procedures and guidelines?

  Northamptonshire Safeguarding Adults Board inter-agency procedures include in their requirements for inter-agency working that agencies will

"Actively work together within an identifiable inter-agency procedural framework encompassing effective communication, an appropriate risk-management framework and clarity about agency and professional responsibility, authority and accountability"

While there is evidence of communication and cooperation between Mencap and the ambulance crew, at the time of Alice's fall, there was a lack of clarity about who were the professional decision makers in relation to Alice's pathway.

During the initial period at NGH there is no evidence that these inter agency requirements were adhered to, and of particular concern, is the lack of documented evidence that effective communication was taking place with Alice, her family and her carers.

There was also evidence of a failure in inter-agency communication. In particular, between EMAS and NGH at the time of the serious incident investigation which, in all likelihood, resulted in the protracted timescales for this serious case review.

The key themes that run through the period from Alice's fall and her first stay at NGH are:

- Communication – both internal communication and with Alice and her family and carers
- Failure to make reasonable adjustments which negatively impacted on the diagnosis and treatment plan for Alice.
- Failure to properly apply the Mental Capacity Act and make best interest decisions.

These are the same themes that run through the plethora of research documents and inquiries into the health care of people with learning disabilities that have been published over recent years.

While it is recognised that these publications have largely been in respect of the ongoing health care needs of people with a learning disability and access to services, it is suggested that the findings could also be applied to emergency interventions.

There is resonance with Alice's experience in particular findings of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD), March 2013.

These can be summarised as:

- Delays or problems with diagnosis or treatment; problems with identifying needs and providing appropriate care in response to changing needs
- The lack of reasonable adjustments to facilitate healthcare of people with a learning disability, particularly attendance at clinic appointments and investigations
- GP referrals commonly did not mention learning disabilities and hospital "flagging" systems to identify people with learning disabilities who needed reasonable adjustments were limited
- Professionals in both health and social care commonly showed a lack of adherence to and understanding of the Mental Capacity Act 2005, in particular regarding assessments of capacity, the process of making "best interest" decisions and when an Independent Mental Capacity Advocate (IMCA) should be appointed
- Despite numerous previous investigations and reports, many professionals are either not aware of, or do not include in their usual practice, approaches that adapt services to meet the needs of people with a learning disability
- There is a continuing need to identify people with learning disabilities in health care settings and to record, implement and audit the provision of "reasonable adjustments" to avoid serious disadvantage
- Communications within and between agencies need to be improved

It is evident, and it is acknowledged, by those involved in Alice's treatment that they failed her and her family and that Alice's learning disability clearly affected the care and treatment she received.

The Panel wishes to acknowledge the role of Alice's family in her life and their attempts to raise issues about her care while she was in hospital. It is recognised that their voice was not heard.

It is almost three years since Alice's death and in this period the agencies involved have not waited for the serious case review, but have undertaken their own investigation(s) and have implemented the learning from the findings to improve the service to people with learning difficulties and ensure appropriate care and support.

10 References

1. No Secrets, Department of Health 2000
2. Disability Discrimination Act 1995
3. Equality Act 2010
4. The Mental Capacity Act 2005
5. Six Lives Progress Report on Health Care for people with Learning Disabilities, Department of Health 2013
6. Death by Indifference, Mencap 2007
7. Healthcare for All, Sir Jonathan Michael 2008
8. Confidential Inquiry into Premature Deaths of People with a Learning Disability 2013

Appendix 1

Serious Case Review: Alice Porter

Action	Deficits Identified	Actions required to address deficits	Actions already in place to address deficits	Timescale	Progress Update	RAG Rating
Improve awareness of how to use the Mental Capacity Act in practice.	Inconsistent awareness of: What to do if someone without capacity refuses treatment How to make reasonable adjustments and how to ensure the person's best interests are met.	Mandatory Mental Capacity Act training in place SOVA lead in place LD Strategic Liaison Nurse in post (2.5 days) Information readily available on the intranet	Undertake programme of awareness raising of using the MCA in practice and triggers for escalation. Target priority groups (on call Sisters, on call Senior Nurses and Bed Managers, Senior Staff Nurses, On call Managers, Junior Doctors, Consultants, Directors) Follow up individually those staff involved in the incident. Screensavers and emails reminding staff to go to the intranet for further details or contact the Leads if unsure. Undertake a full review of current Safeguarding adults and MCA training including means of evaluating effectiveness. Develop information for each ward and department which includes contact details for the LD and SOVA lead. Integrate MCA and SOVA raising awareness into HCA Development Programme AP Programme and Preceptorship Programme.	Priority groups complete by end June 2011 Screensavers June 2011 14 June September 2011	Training figures to July 2013 Safeguarding Adults: Level 1 – 69.8% Level 2 – 57% Mental Capacity: 72.2% E Learning Packages are also available for both topics.	**Complete**

Improve the care given to patients with complex needs where there is a potential for patients behaviours to mask physical symptoms	Inconsistent approach to care planning; reviews by medical team; Involvement of carers in recognising symptoms and using clinical review meetings to plan care going forward	Carer's Policy in place Clinical Review meetings working well in some areas of the hospital.	Develop a checklist for people with complex needs which includes; consideration of pain, psychological impact and involving carers in recognising symptoms. Introduce Clinical Review meetings as standard through the core care plans. Remind consultants to document reviews by their medical team and if necessary to review patients daily. Ensure that any non-compliance with procedures is documented and alternatives considered. Improve handovers to include the patient's communication needs and reasonable adjustments that are put in place.	Checklist to be introduced by end June 2011 End August 2011 September 2011	Carers policy re-launched in May 2013 Evidence of clinical review/multidisciplinary/Best Interest meets for individuals where applicable. Evidence of 'reasonable adjustments' made in numerous cases. Creative and supportive examples of care where non-appliance issues raised and evidence of 'best interest' decision making in accordance with MCA.	

Improve practitioners communication skills with PWLD	Communication isn't always appropriate for PWLD	Help me in Hospital booklets are in operation to inform staff of the needs of PWLD	Run a communication skill straining programme. Develop a communication passport that will focus staff on key communication needs.	Passports to be implemented by end September 2011	Communication training is part of the LD awareness training. In the past 12 months LD awareness training. HCA Induction – 169 Preceptorship – 109 Volunteers – 48 In September 2012 60 healthcare staff from across the Trust attended a hospital 'Getting it Right' road show facilitated by Mencap including individuals with LD. Use of Hospital Passport is embedded in the Trust	
Implement easy-read leaflets for PWLD who	Easy read leaflets are not in place for scans	Other easy read leaflets and communication folders are present on every ward	Develop new leaflets and implement across in-patient areas: A: MRI Scan B: CT Scan	September 2011	Leaflets developed and in use. Links for accessible	

need to have an MRI scan or a CT scan			C: X-Ray D: Endoscopy		materials available on LD page of Trust Intranet.	
Ensure that people with learning disabilities are easily identified in their records	Documentation of assessment is within the nursing records and is not clearly identifiable to all staff involved in care of patient	Several assessments are currently used: A&E Grab sheet; A&E pathway; The LD nurse is able to support staff to ensure that all patients with LD have a care plan that meets their needs.	Safeguarding Dividers are now in all new medical records. Dividers are being added to existing patients as they are re-admitted to NGH. Chronology Events Sheets need to be introduced as currently used effectively for Safeguarding Children. (Further work underway to combine safeguarding children sheet and safeguarding adults sheet)	Ongoing By end August 2011	Flagging system in place to alert the LD Nurse when LD patient attends via A&E.	
Ensure that staff understand their responsibilities under the Mental Capacity Act. There should be policies on the Mental Capacity Act readily available to NHS staff.	Some staff not confident to carry out capacity assessments despite having undergone training. MCA Policy is currently under review	MCA training is mandatory for all clinical staff. Compliance statistics monitored via CQEG	Undertake a review of and ratify MCA Policy. Raise awareness of MCA policy. Review MCA training to ensure fit for purpose – to include evaluation of effectiveness.	July 2011 Procedural Document Group August and on-going November 2011	MCA Audits undertaken January 2013 50% compliance August 2013 60% compliance The Trust developed a competency framework to ensure staff knowledge of MCA is reflected in practice.	

Appendix 1

Ensure Processes and timeframes for the reporting, investigation and feedback for all incidents, complaints or claims involving a safeguarding vulnerable adult element have a governance framework to provide assurance.	Monitoring of Safeguarding issues is not robust. Compliance with timeframes not always evident. Roles and responsibilities of need to be made explicit.	Safeguarding Policy reviewed October 2009 – Due for review October 2011. Development of database to provide ease of monitoring and assurance of timeframes met. Confirm and Challenge meetings. Clinical Governance Review Scheme. Monitoring via CQEG. Development of Trust Safeguarding Adults Steering Group.	Full review of Safeguarding Adults processes to include the development of a Safeguarding Assurance Group (SAG). Review of Safeguarding Policy to reflect above. Monitoring of compliance with Safeguarding Policy including timeframes. Any deficiencies identified to be reported in CQEG quarterly report.	14 June 2011 November 2011 Quarterly	SAG TOR reviewed to ensure process reports to the serious incident group. Reflecting an intergraded governance structure regarding adults incidents.	

Ensure lessons learnt from Safeguarding Adults incidents, complaints and claims are disseminated within the organisation and changes made as appropriate	Processes in place to learn lessons from incidents, complaints and claims but Safeguarding Adults themes not always identified unless SOVA reported.	SOVA Lead provides monthly report to SOVA Steering Group Patient Safety Learning Forum in place.	Lessons learnt from Safeguarding Adults issues reported on incidents, complaints and claims as well as SOVA's need to be triangulated to ensure trends are identified and learning is disseminated throughout the organisation . SOVA Steering Group representative to attend the Patient Safety Learning Forum. Discuss aggregated learning from each directorate at Patient Safety Learning forum. Identify Medical Lead for Safeguarding.		SOVA Lead Nurse and LD Nurse attend Patient Safety learning Forum.	

Appendix 2

EMAS - Lessons Learnt

Documentation

The gaps in the documentation by the crew has been identified as an issue; in particular a second set of observations and lack of narrative of the process of decision making, mental capacity and best interests. The Incidents took place in 2011 and the incident was recorded on a paper PRF, which offers limited space for narrative and no prompts around social history or activities of daily living. The consent section is limited to a choice of three tick boxes and the crews are relied on to provide the additional information. EMAS crews now mostly use the Toughbook and complete an electronic PRF, which supports better documentation.

Within EMAS there is on-going work monitoring the standard of PRFs, and education is provided yearly to all staff on information-governance. The Toughbook electronic patient records are standardised across six ambulance services nationally and are continually being adapted to gather relevant information, improve patient experience and safety and support better information-sharing and record-keeping. The utilisation of tough books has improved and at present the trust is 62% compliant with the benefit that the electronic patient records provide staff with a free text box enabling staff to record a larger narrative and a more informed assessment including information around MCA and best interest decisions. 100% compliance is not achievable at present due to the areas that EMAS deliver care in not always having network access and some hospitals within the region not having equipment that supports the system. In this case, the standard paper PRF is utilised however this is recognised nationally as adequate for the role.

Since 2010 there has been a focus through Essential Education (mandatory) and Clinical Bulletins on the importance of routine observations and documentation, for example, temperature should be recorded for all patients. Essential Education in 2011-12, attended by 90% of staff, included a module on documentation. PRFs are routinely audited and findings reported to crews. The recordings of Clinical Observations are CPIs for ambulance staff (Clinical Performance Indicators) and compliance with taking and recording these observations is regularly monitored. Essential Education for 2012-13 for front-line staff includes information on CPIs in the Resource Book given to front line staff.

The trust are currently working with the company that develop the electronic patient record form for the Toughbook to incorporate specific capacity assessment sections and this is planned to be released in the next upgrade. At present there is no timescale for this.

The attending crew received additional training around documentation after completion of the SI and the author has confirmed that the paramedic has also attended all other essential education that has been delivered since the incident.

Mental capacity

The EMAS Consent Policy which incorporates principles from the MCA Code of Practice was not developed until the last quarter of 2010. It has since been reviewed and revised on a number of occasions to provide practical guidance to staff, including emergency treatment and restraint under the MCA, and a flow chart mapping the process for a capacity-assessment.
Education with regard to the Mental Capacity Act had been delivered by 2010 but was done in stand-alone modules supported by the dissemination of station posters and pocket prompt cards. There was not the same level of integration of MCA awareness and education into every aspect of clinical care as there is within the agency now. During Essential education from November 2011, a flowchart to assess capacity was issued to staff during essential education and provided to those staff that had already attended. Education for 2012-2013 also included a workbook for all staff on capacity-assessment and best interest decision. Education for 2013-2014 includes a face-to-face session for all frontline staff, which incorporates mental capacity-assessment and responsibilities under the MCA.
The new JRCALC handbook that was released in April 2013 and is carried by every staff member contains information on safeguarding, Mental Capacity Act and best interest decisions, ensuring all staff have clinical guidelines on hand at all times.
The safeguarding team have produced a supportive tool that all staff can utilise when completing the two stage best (sic) for assessment, which is available via the Toughbooks, and have incorporated a questions around mental capacity with their specialist face to face audit to assure compliance. Additionally, safeguarding referrals are also being audited to look at capacity and consent.
Clinical bulletins on consent and capacity have been developed and disseminated to staff through their payslips and via email newsletter since the incident to ensure that they are receiving regular messages around its importance, including identifying how to do a capacity-assessment and that it should be decision-specific.
The safeguarding team continue to work with staff to support them to utilise the MCA appropriately and engage regularly with the Regional MCA and DOLs forum to ensure that best practice is identified and shared. The safeguarding team are available during office hours to provide expert advice around best interest decisions, and during out of hours, all staff have access to the clinical assessment team within the EOC and to on-call line managers.

Communication

In 2011-12, Safeguarding Education was delivered to 90% of staff using a ‘Think Family’ model which encouraged crews to look holistically at the situation and not just focus on the patient and their presenting clinical problem. It specifically included information about the important role of carers, carers own needs for support and of the possibility that family or professional carers may be involved in abuse or neglect of the patient. Based on the interview gained from Para 1 it

should be recognised that the attending crew recognised the importance of the information that the carers provided and spent time with the carers to gather that information.

Learning Disability Education has been developed and delivered to raise awareness of the particular needs of this vulnerable group of people in line with 'Six Lives' recommendations and this was delivered during 2011-2012 as a face-to-face education module as part of 'Think Family'. This included information on how to communicate and engage with individuals with learning disabilities and the importance of engaging directly with an individual and not just with the carer. All vehicles were initially provided with an A4 symbols card to support communication. Since this, the trust have invested in a 60 page communication book that is on all ambulance with easy-read symbols covering all essential topics including falls and hospital-attendance.

The knowledge of frontline crews regarding learning disabilities as part of the safeguarding agenda is tested through routine audit by their own managers, and through a separate audit of a small percentage of staff in each division by the Safeguarding Team, in order to provide additional quality-assurance. Referrals and the referral process are also audited routinely by the Safeguarding Team. Questions that are currently asked check staff awareness of the categories of and indicators of abuse, and on their response to a range of scenario-based questions about different situations, these involving safeguarding issues (including situations involving carers and people with learning disability for example). Results are analysed by the Safeguarding Team, reported-on and used to inform future safeguarding education and communications. Staff are aware of the importance of engaging with individuals with learning disabilities and the trust are assured that the staff are compliant through this audit process.

It should be recognised that whilst the statement and the PRF provide little information on the level of communication that took place during the attendance, the crew were on scene with AP for over an hour, gathering information from AP and the carers and attempting to provide a patient-centred service. Additionally the information gathered from Para 1 during interview demonstrates that the attending crew communicated with both AP and her carers in attempt to provide her with the care she required.

<u>C-Spine</u>

Since this incident EMAS has reviewed the protocol and guidelines with regards to C-spine injuries and there are guidelines and a flow-chart readily available to all staff.

A face-to-face module on assessment of spinal injuries was delivered during 2012/2013 for all frontline staff as learning identified from SI and SCRs.

EMAS continues to provide staff with clinical bulletins via email newsletter and payslip to update staff on changes and to keep staff engaged with the mechanism for this type of injury.

Investigation process

Systems have been amended so that it is possible to identify incidents or complaints involving people with a learning disability, to try to ensure issues are effectively and appropriately responded-to, including Safeguarding team sign-off on the ToR for any investigation.

Information on Adult Safeguarding and on how to complain has been provided in an easy-read format. A workbook has been developed in easy-read format to support investigation officers, to engage with individuals with learning disabilities during a complaint or a serious investigation.

Since the time of the attendance in 2011, the agency has strengthened and developed its knowledge around mental capacity and learning disabilities and continues to do so through engagement, best practice and lessons learned.

The agency recognises that the attendance was poorly recorded and that AP's experience needs to be learnt from, however, it should be recognised that the crew had attempted to utilise the knowledge of the carer and to make decisions that would prevent additional stress to AP.

Since this attendance EMAS have provided additional MCA training both face-to-face and via communication and have produced supportive tools for frontline staff to utilise in an informative flow chart. They all have access to and an online, two-stage test tool.

All frontline staff have received face-to-face learning disabilities training and there are specially-developed communication booklets being provided on all ambulances. The trust continues to develop easy-read communications and engage with the LD community. All complaints and SIs that involve individuals with a LD are flagged to the safeguarding team to ensure that the ToR reflect the adjustments that EMAS staff should be making.

The trust continues to provide the staff with communications and training around documentation and face-to-face training on C-spine-identification has been rolled-out.

The safeguarding team continue to support the staff in developing skills around learning disabilities and mental capacity, and monitor the learning to ensure compliance through audit procedures. These items continue to remain on the agenda for the Safeguarding team of EMAS and are part of the work plan during 2013-2014 and going forward.