Coventry Safeguarding Adults' Board Serious Case Review
Executive Summary of Case no: CSAB/SCR/2013/1

What is a Serious Case Review?

A Serious Case Review (SCR) is held when a vulnerable adult has died or been seriously injured or impaired, and abuse or neglect is known or suspected to have been a factor. The purpose of a serious case review is to carefully consider the circumstances surrounding the death or serious injury, in order to learn lessons to avoid a similar situation arising in the future. It is important to understand that this means that most deaths do not lead to a Serious Case Review, only those that meet these criteria.

Serious Case Reviews are undertaken as part of the overall National Government guidance "No Secrets", which provides a framework for Safeguarding Adults, and in accordance with the policies and procedures set out by Coventry Safeguarding Adults' Board (CSAB). Serious case reviews are not inquiries into how a vulnerable adult died or who is to blame.

This serious case review was conducted in line with the procedures and systems agreed across the city, by the CSAB. These procedures include the appointment of an independent author with significant experience, credentials and, most importantly independence from all of the organisations concerned to write the SCR. There is also the requirement of each organisation involved to undertake an Independent Management Review (IMR), and the submission and testing of those reviews to an SCR committee.

Once the IMRs are all received and analysed, a report is drafted by the Independent Author and considered by the CSAB SCR subcommittee. A final report is then presented to a specially convened CSAB meeting, and an action plan developed by the agencies and organisations concerned, in order to meet all the recommendations in the SCR's conclusions.

The Facts of the Case, Summary & Background

Mrs D died in the summer of 2011, in her late 80s. Mrs D had been admitted to University Hospital Coventry and Warwickshire (UHCW) two months earlier following a fall from her wheel chair. While Mrs D was in hospital it became clear that she had damaged a bone in her neck, although it was unclear whether the damage to the bone was recent and as a result of the fall for which she was admitted, or from a previous, unknown incident. The clinical team felt that conservative treatment rather than surgical intervention was in Mrs D's best interests, and on this basis, a neck collar was fitted and a period of rest recommended. In the hospital records of Mrs D's care, it is clear that several different sorts of collars were tried, some of which caused Mrs D discomfort, and also began to cause pressure ulcers. Despite this, Mrs D was discharged with a neck collar in place. The IMR showed that several aspects of care during this hospital stay were unsatisfactory.

The hospital did not arrange any care for Mrs D on discharge home. Concerned about an ulcer developing on Mrs D's neck, her granddaughter contacted Mrs D's GP about a week and half later, and as a result, some support was provided to Mrs D at home, starting that

day, mainly by the community District Nursing Service, part of Coventry & Warwickshire Partnership NHS Trust (CWPT). As part of Mrs D's treatment, the pressure ulcer on her neck and collarbone was assessed and treated. As part of the assessment, it was graded, in line with the local protocol on pressure ulcers, as a grade 3 pressure ulcer (grades are 1-4, with 4 being the worst). The local protocol requires a referral to the safeguarding team when a pressure ulcer of this severity is identified which could have been caused by poor practice or neglect, but this did not happen.

A week or so after having been seen by the district nursing team, Mrs D attended an Out Patient appointment at the hospital, UHCW, having been referred by the District Nursing team because of friction from her neck collar and the resulting pressure ulcer that had occurred. The district nurse did not make a written referral. The consultant, who (mistakenly) believed this to be a routine follow up rather than a specific referral for additional help, on seeing Mrs D did not recommend any change or alternative treatment, and discharged her from the Hospital's care.

A further fortnight later, Mrs D's condition deteriorated to such a degree that it caused the district nursing team to arrange for her to be readmitted to hospital, where she died 2 days later. The cause of Mrs D's death was recorded as Septicaemia, (or blood poisoning) as a result of a right clavicular (collar bone) pressure sore as a result of cervical spine (neck) fracture, and rheumatoid Arthritis. A referral was made to the Safeguarding arrangements in respect of the Grade 3 Pressure Ulcer on the day of Mrs D's final admission to UHCW, two days before she died. This referral was made by a member of the District Nursing Team. The safeguarding meetings were initiated as required, however they were significantly outside of the timescales required, almost a month beyond the specified 5 days. The Coventry Safeguarding Adults Board subsequently initiated a Serious Case Review.

As is made clear above, a Serious Case Review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of vulnerable adults in the future. In this case concerns have been raised about a number of issues including:

- That action taken in relation to the poorly fitting neck collar may have been inadequate or inappropriate, with a failure to properly identify or consider the potentially high risk that Mrs D would develop pressure sores.
- That there may have been poor communication between agencies at various points during the two months between Mrs D's admission to hospital and her death, and that there was no evidence of Social Care support in planning her discharge from hospital.
- That a safeguarding alert did not take place until 2 days before Mrs D died, several weeks after it became clear that a pressure ulcer was developing, and the safeguarding planning meeting which eventually took place, occurred four weeks after the alert was received (which was nearly four weeks after she died).

In the early part of 2011, before Mrs D's fall, she had had contact with the City Council's Social Care department. Mrs D was an elderly lady, in her late 80s, with an extended family of children, grandchildren and many other relatives, having had 16 children.

The City Council's Occupational Therapy, and then Social Services undertook assessments, in early 2011 which finally resulted in no services or provision to Mrs D as she either declined to accept services, or actively refused, not wishing to engage. The review found however that at least one aspect of potential support was not fully explored with Mrs D. Three months or so after her first contact with the City Council, her case was closed.

It is clear from the notes and interviews with staff and Mrs D's family, that she had the capacity to determine her own needs and care, and understood what was being offered, and refused it nevertheless. It seems likely that Mrs D was inclined to under-report symptoms, and refuse help offered. However the fact that Mrs D had capacity in this sense doesn't mean that she wasn't vulnerable. Indeed, as she subsequently developed a grade 3 pressure ulcer, which could have been related to poor practice or neglect Mrs D should have fallen within the City's safeguarding arrangements.

Analysis

Mrs D died following an accident and a brief period of treatment in hospital and the community. The injury which Mrs D sustained falling from her wheelchair in the summer of 2011, resulted in a period of hospitalisation and a decision to treat her neck injury using a supporting neck collar. The collar itself caused friction to her skin resulting in the formation of a pressure ulcer. This ulcer in turn eventually became infected and Mrs D died as a result of the septicaemia, or infection based blood poisoning which it caused.

In their comments to this SCR, Mrs D's family have expressed the belief that the pressure ulcer suffered by Mrs D may have become infected significantly before Mrs D was admitted to hospital for the second time. If this were the case, then treatment with antibiotics would have been the likely best thing. No evidence that this was the case has emerged from the IMRs, although Mrs D's wound was not tested for infection prior to her final readmission, 2 days before she died.

During Mrs D's first stay in hospital at UHCW it was evident that there was a difficulty in finding an appropriate neck collar for Mrs D but this was not properly resolved by gaining the advice of the Surgical Appliance Department. There was also evidence that a friction induced ulcer was developing but this was not properly addressed. Bearing this in mind, the decision to discharge her from hospital without planned follow up in the community increased the risk of complications in her condition. It is also important to note that Mrs D's GP was not advised directly of her discharge, with a patient held letter being the only communication.

At the point of her admission to UHCW, Mrs D was known to Social Care (having been referred, assessed and discharged 5 months previously), and there is also no evidence that Mrs D was visited by a social worker prior to discharge. During the initial contact the Social Worker did not follow up the suggestion of some kind of sitting service which there was reason to believe she might have accepted. Mrs D had refused a number of services which led to the closure of her file. However more should have been done to address the risks which had been identified. Mrs D's right to refuse support was rightly respected . However there were reasons to suspect that whilst having capacity Mrs D's ability to give informed consent may have been compromised by her fears about being taken away from her home. In these circumstances every effort should have been made to find a service option acceptable to Mrs D to help minimize risk, including the possibility of alerting other agencies.

Following her discharge from UHCW, The first and subsequent contacts made by Community Nursing staff also missed opportunities to refer her case to the Safeguarding arrangements and thus for urgent multiagency review of her case. The review found that the local protocol in use at the time was unclearly written.

At the outpatient appointment arranged by a member of the District Nursing Team, a fortnight before Mrs D died, it is clear that a potential opportunity for positive intervention in

Mrs D's case was missed. The District Nurse had made the referral hoping to have the neck collar reassessed and to get advice on its use bearing in mind that it had caused a significant pressure sore. The District Nurse's concerns, which were expressed by telephone (and not in writing), did not reach the Clinical staff reviewing Mrs D for reasons that are not clear, an important failure of communication and record keeping.

The UHCW clinical staff, as part of a consultant–led service, in turn detected no problem and discharged her following what they believed to be a routine follow up appointment. Even without a written referral it is unfortunate that a problem with the neck support sufficient to cause a Grade 3 pressure ulcer was not be picked up during the appointment. An opportunity for effective advice on the management of the effect of the neck collar had therefore been missed.

The use of the existing pressure ulcer protocol failed in the case of Mrs D. Her pressure ulcer was not (on at least two occasions) assessed and considered for referral to safeguarding in the prescribed and agreed manner. When a referral was finally made two days before she died, the safeguarding processes itself was not initiated until almost 4 weeks after Mrs D died, which was well beyond the time limits set and a further way in which services failed Mrs D and her family.

It is extremely difficult to say whether addressing any or all of the issues outlined above would have prevented her death. It seems possible, however, that the risk that her initial injury would ultimately result in her death could have been reduced, and the recommendations in this report will seek to address ways in which improvements could be made.

Conclusions

Mrs D was an elderly woman with a number of disabilities and health concerns prior to the incident which ultimately led to her death. She was extensively supported by her family and it is evident that it was difficult to persuade her to accept changes which may have improved her overall health. It is also clear that whilst staff did not seek to exclude them Mrs D's family felt they were not listened to as much as necessary, and had a valuable contribution to make within formal care environments alongside health and social care professionals. It is clearly important that staff ensure that carers have an opportunity to express concerns and have those concerns responded to .

There were some significant shortcomings in the assessment, care, treatment and services provided to her and some missed opportunities for closer working between agencies providing care to her. These failures were significant in relation to how Mrs D was cared for, and may ultimately have been significant in how, and when she died, although it is impossible to be certain of this.

Learning from this Serious Case Review emphasises that a positive and proactive approach to joint working is in the best interests of those receiving services, as well as basic standards of care being effectively and comprehensively delivered. The philosophy of Safeguarding Adults is based on this principle and arrangements will only be effective where the principle is properly owned by partner agencies and incorporated into their daily practice. The experiences emerging from this review of the circumstances of Mrs D's sad death must lead to improved progress in interagency working and to improvements in care.

What Happens Next?

Recommendations from the review form the basis of an action plan, which is regularly monitored to ensure that the recommendations are put into place. The action plan will be reviewed regularly until all of the agreed actions have been completed and implemented.

Summary of Recommendations

Recommendations have been developed that apply to all agencies, and also that apply specifically to individual agencies. The recommendations below summarise the actions that are needed to reduce the likelihood of the events leading up to Mrs D's death recurring in the future.

Multi Agency Recommendations:

- **Pressure Ulcers**
    - All agencies need to ensure that staff understand their responsibilities in relation to Safeguarding Adults and that the preventative opportunities of Safeguarding referrals are fully recognised and utilised as a positive way of achieving effective joint working in the best interests of vulnerable adults.
    - All agencies need to satisfy themselves that the new Pressure Ulcer Policy is fit for purpose and has resolved the ambiguities and lack of clarity which were evident in the previous Policy, and that there has been adequate multiagency training in the use of this Policy.

- **Commitment to the Philosophy, Policies and Procedures for the safeguarding of adults**
    - The Safeguarding Board and the Partner agencies should satisfy themselves that there is commitment from all Partners to the philosophy and principles of Safeguarding and that this is owned at all levels within the respective organisations and communicated effectively through joint and single agency training. Further, the board should ensure that processes and timescales set out in the joint procedures are audited and monitored effectively.

University Hospital of Coventry & Warwickshire (UHCW)

- **The grading of pressure ulcers**
    - UHCW should ensure that the training in Tissue Viability envisaged in their IMR has been completed. This must ensure that relevant staff are familiar with the process of pressure ulcer grading and the relationship of this to a referral into adult safeguarding procedures.

- **Clinical issues at discharge from hospital and outpatients clinics**
    - UHCW should ensure that any lessons for clinical practice arising from these circumstances, including, proper discharge planning and assessment at outpatient follow-up, have been addressed.

- **Record Keeping in hospital wards**

    - UHCW should ensure that actions proposed within the Independent Management Review to improve record keeping standards are implemented across the organisation.

- **Communication issues within UHCW NHS Trust**

    - UHCW should ensure that the case note recording systems used by medical, therapy and nursing staff link in such a way that risks cannot be missed by any of the groups of staff involved.
    - The Trust should ensure that the referral system for technical support from the Surgical Appliance Department is effective across UHCW.
    - The Trust should ensure that the discharge summary reporting system within UHCW to GPs is effective and that these summaries always sent to GPs.
    - The Trust should ensure that all written guidance identified in the IMR conducted by UHCW, which has been developed since the investigation, is being used and is fit for purpose.

Coventry and Warwickshire Partnership NHS Trust, Community Health Services:

- **The Use of Safeguarding Procedures**

    - CWPT should ensure that any lessons for clinical practice arising from review of these circumstances have been addressed.

- **The grading of pressure ulcers**

    - CWPT should be satisfied that that all agency nurses supplied to them are competent to grade pressure sores and understand the relationship of this to a referral into adult safeguarding procedures.

- **Communication issues**

    - CWPT should ensure that appropriate guidance is now in place for staff making a referral to outpatient clinics and that it is being followed.

Coventry City Council:

- **Ensuring that social work assessments are fit for purpose**

    Coventry City Council should ensure that practitioners are aware of the importance of taking account of all sources of information in making an assessment and explore all reasonable options which would minimise identified risk. The City Council should also ensure that practitioners always consider factors which might limit a person's ability to make informed choices.

If you would like to know more about Coventry Adult Safeguarding please go to:

www.coventry.gov.uk/safeguarding