NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

Serious Case Review A

Report prepared for the

Nottinghamshire Safeguarding Adult Board

Concerning

Adult A

January 2009.

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1. Introduction

This Serious Case review was initiated following the death of Adult A in February 2007 when Adult A choked to death on a pickled onion provided by care staff at the residential care home where he resided.

The Nottinghamshire Coroner recorded a verdict of accidental death.

The author and members of the Nottinghamshire Safeguarding Adult Board, along with Derbyshire County Council, wish to express their condolences to Adult A's family and will offer to meet with them to share the findings of the review ahead of the publication of the executive summary.

It is of the utmost regret that a man's life was cut short as a result of these circumstances and that the family will continue to carry this tragedy throughout their lives.

2. Terms of reference.

The Nottinghamshire Safeguarding Adult Board, Serious Case Review protocol requires, *"a serious case review should ALWAYS be conducted into the involvement of agencies and professionals associated with the vulnerable adult when a vulnerable adult dies…AND abuse or neglect is known or suspected to be a factor in their death." A serious case review is not to apportion blame but to look at lessons that can be learned.*
In this instance the Board specifically wished to;

- Review the circumstances of the death of Adult A and make recommendations for future practice or policy changes
- Review the actions of agencies involved in Adult A's life prior to the incident and make recommendations for future practice and policy changes
- Share any lessons learnt with the agencies involved and where appropriate the wider partnerships

3. Contributors to review

Management report and chronology by Nottinghamshire County Council.
Management report and chronology by Derbyshire County Council.
Management report and chronology from the Home X
Management report and chronology by Nottinghamshire Police.
Management report and chronology By East Midlands Ambulance service.
Chronology from the Commission for Social Care Inspection.

4. Panel members and author of overview report.

Jon Wilson – Service Director, Nottinghamshire County Council (Chair)
Claire Bearder, Service Manager, Safeguarding Adults, Nottinghamshire County Council
Bob Ross, Detective Chief Inspector, Nottinghamshire Police
Amanda Sullivan, Director of Nursing and Integrated Governance, NHS Nottinghamshire County
Julie Cotton, Chief Operating Officer, Bassetlaw Primary Care Trust
Andrew Hambleton, Project and Planning Manager Safeguarding Adults, Derbyshire County Council

5. The facts

5.1 Adult A went to live at home X in October 2006 placed by Derbyshire County Council. The home was located in Nottinghamshire. The home provided 24 hour residential care to people with physical disabilities including Adult A. Adult A also received further one – one support hours provided as additional provision commissioned by Derbyshire County Council. These staff were provided by home X .

5.2 Adult A was a young man of twenty seven with profound physical disabilities caused by cerebral palsy, including a retracted jaw. Home X reported that he also had communication and behavioural difficulties although the specific nature of these is not identified.

5.3 Due to staffing shortages within the home two Turkish volunteers were recruited (English was not their first language). It was one of the volunteers, SH who on 5/2/07 gave Adult A his lunch including the pickled onion straight from the plate provided by the cook.

5.4 It is clear that Adult A's care plan identified that his food should be cut up for him as he was prone to choking.

5.5 Adult A choked on the pickled onion, the cook in the home and another staff member tried to perform the Heimlich manoeuvre to free his airway and called the emergency services.

5.6 Paramedics and ambulance services attended the home within agreed time scales for emergency services, they provided emergency treatment and dislodged a small piece of food by back slaps, but they were unable to undertake a sweeping of the mouth.

5.7 Adult A was taken via ambulance to Bassetlaw hospital.

6 Conclusions

6.1 This review dates back to February 2007. Changes have been made to legislation, in particular the Mental Capacity Act 2005 and local policy and procedure in relation to many of the concerns highlighted.

6.2 The requirement for a Safeguarding referral is a necessity when neglect or abuse is the suspected cause of a vulnerable adult's death and the implications to other services users must be considered in the wider context.

6.3 Inter agency communication was an issue and clearer processes are required within agencies to prevent future communication issues with clear definition of roles and responsibilities for notification both externally and within individual departments.

6.4 The panel acknowledged the parents praise of the advocacy services offered to Adult A during his transition to Home X.

7. Recommendations

7.1 The report acknowledges that a number of actions and improvements have already been made but makes further recommendations.

7.2 There were eight recommendations supported by the panel from the individual management reports. A further eleven are recommended to the Nottinghamshire Safeguarding Adults Board from the serious case review.

7.3 Some of the recommendations may have a national impact and wider learning for other agencies and these are marked with an asterix.

7.4 To Nottinghamshire Safeguarding Adult Board

7.5 At the next review of the multi agency policy and procedures consideration be given to include specific reference to a service user's death where there is suspicion of abuse or neglect.

7.6 All agencies should be reminded that the death of a vulnerable adult from suspected abuse or neglect requires a Safeguarding referral. *

7.7 Nottinghamshire County Council

7.8 Safeguarding investigations are fully concluded and recommendations followed up. Liaison between other agencies i.e. the police to conclude the investigation and determine roles and responsibilities for outstanding tasks, and ensure discrepancies identified are followed up by the appropriate agency.

7.9 Purchasing and Market Management teams to include reference to the appropriate use of volunteers in all contracts and alert all homes to the role boundaries of volunteers in writing. *

7.10 Purchasing and Market Management teams to develop processes for when Commission for Social Care Inspection reports show that statutory requirements remain unmet as this would mean homes are not fulfilling contract requirements. *

7.11 Home X

7.12 Volunteers should only be used above the required minimum staff ratios and should not provide any personal care tasks. *

7.13 The Mental Capacity Act should be used in the care planning process to enable services users to make their own decision or to provide a framework for making decisions when the service user lacks capacity. This ensures choice and risk are weighed and actions are taken in best interests *

7.14 Commission for Social care Inspection

Note: - the Commission for Social Care Inspection was replaced by the Care Quality Commission from April the 1st 2009. The Care Quality Commission are reviewing all their policies and procedures in this area.

7.15 The Care Quality Commission should provide management overview reports as part of the serious case review process.

7.16 The Care Quality Commission should ensure they follow their agency policy and have robust and transparent processes in place when statutory requirements remain unmet.

7.17 Recommendations agreed from individual management reports

7.18 Derbyshire County Council

7.19 Contracts should be completed prior to, or within an agreed timescale after any placement commences. *

7.20 A protocol should be agreed that gives clear decision making roles and notification responsibilities following a suspicious death to support care management training for those involved in the care management process. *

7.21 East Midland Ambulance service

7.22 To continue to review their awareness training for safeguarding vulnerable adults with the clinical education specialists. *

7.23 Home X

7.24 First aid training needs to incorporate how to carry out procedures with a wheelchair user.

7.25 Staff and service users involved in the incident are offered the opportunity to receive counselling for this matter.

7.26 That the requirements and recommendations made by Commission for Social Care Inspection and the service audit are fully actioned.

7.27 Individual support plans are monitored to ensure completion, accuracy and that they are signed and dated.

7.28 Nottinghamshire Police

7.29 A reminder is given to all Officers via weekly orders that where a vulnerable adult dies and abuse or neglect is suspected then a referral must be made to Adult Social Care as per Policy.

7.30 Comments

7.31 Agencies will develop Action Plans to address the recommendations, the implementation of which will be monitored by the relevant Local Safeguarding Adult Boards.

7.32 It should be noted that the home X is no longer operating as a residential care home.