APPENDIX 1

Adult P19 SIGNIFICANT CASE REVIEW

- ANGUS ADULT PROTECTION COMMITTEE
- PRESENTATION TO ELECTED MEMBERS
- FIONA RENNIE & GRACE GILLING
- 25 NOVEMBER 2021

P19's Story

P19 took great pride in personal appearance and was always smartly dressed.

A kind, caring person with a 'wicked sense of humour'.

Had a long-standing interest in Northern Soul music.

P19 was close to their family and was proud of them.

Multiple Sclerosis (M.S.) had been diagnosed in December 2014.

P19 undertook a bowel screening kit in October 2017, testing positive.

Significant involvement with services in the months leading up to death.

Known to a variety of services prior to August 2018 and was identified as an 'adult at risk' in August 2018.

Died in December 2018 at the age of 50 as a result of Disseminated Malignancy (advanced cancer).

At the time of death, P19 was emaciated, weighing only 42 kgs and with a BMI of 14.2.

P19 died in a lot of pain, unable to mobilise and in very unsanitary conditions.

P19 received support at home in 2014 with the service ending in April 2018. 4 months later, in August 2018, P19 was found living in these conditions:

Methodology

Terms of Reference	Stakeholder Briefing	Case file review	Staff engagement
Network of Support meetings	Development of detailed chronology and specific chronological timelines	Development of Cause-and-Effect Diagrams	Views of family
Case Review Group provided oversight and challenge	External Independent support for lead reviewers	Robust and collaborative process	Focus on independent challenge and learning

Research Questions

- **Research Question 1:**
- In respect of P19, to what extent was the information held by Agencies shared appropriately within that Agency and with other partner Agencies?
- **Research Question 2:**
- Determine the extent to which decisions and actions were person centred.
- **Research Question 3:**
- To what extent did one Professional/Agency have a lead role and hold responsibility for P19 and their Protection Plan; to monitor what was being achieved, any gaps in assessment, planning and decision making and associated risks?
- **Research Question 4:**
- How effective are the current processes for requesting a Capacity Assessment within NHS Tayside and how these processes are applied in practice?
- **Research Question 5:**
- To what extent is Self-Neglect understood across the multi-agency Adult Protection partnerships and wider Adult Protection providers?
- **Research Question 6:**
- To what extent and detail should information be provided to COPFS when someone who was subject to Adult Support and Protection measures dies to ensure that COPFS are able to assess the circumstances surrounding a death in those circumstances and direct further investigation and enquiry?
- **Research Question 7:**
- Did all Agencies exercise their full legal Powers to ensure the safety and well-being of adult P19?

Good Practice

- Some good practice in relation to record keeping was identified.
- Regular communication and information sharing and good team working was identified in some areas.
- A range of investigations and referrals progressed during 7 Day Detox Inpatient stay
- Police progressed VPD following initial contact and urgency identified by ASP Reviewing Officer which resulted in referral to AIDARs team
- Escalation of concerns by Care Provider
- Consistent Police rep at ESG (and now NHS AP Advisor)
- Angus APC arranged for the National Adult Protection Co-ordinator (NAPC) to deliver a learning session to a wide range of practitioners on self-neglect in Nov 2019
- COPFs engaged with review to inform national learning

Q 1 Information Sharing

In respect of P19, to what extent was the information held by Agencies shared appropriately within that Agency and with other partner Agencies?

Findings

- The variety of recording systems across and within agencies is a barrier to effective information sharing and impacted on decision making and robust risk management.
- Information sharing was found to be disjointed, often insufficient and sometimes not accessible to other key professionals.
- Co-ordinated discharge planning did not happen.

Recommendations

- Implement methods that will enable interoperability and access of recording systems, with a focus on improving information sharing between acute, primary care and the Scottish Ambulance services and effective information sharing at points of transition of care between primary care services, adult care services, housing and care providers.
- Review hospital discharge procedures to ensure processes for sharing information on hospital discharge are robust and this happens timeously to inform community services. District Nurses should be included in these procedures.

Q 2 Person Centred Practice

Determine the extent to which decisions and actions were person centred.

Findings

- Earlier identification when a person would benefit from a palliative care approach
- Symptom management should be parallel to any ongoing investigations rather than waiting until a diagnosis has been made.
- Some services considered P19 to be 'non-engaging' with the result of failure to see the person and this led to missed opportunities to work with P19.

Recommendations

- Review the process for referring to District Nurses to adopt a person centred rather than a task focussed approach. Written criteria relating to the role of the District Nursing service and the referral process should be made widely available to aid understanding of the District Nursing role and how it can be accessed.
- Ensure services support integrated working and the involvement of the correct professionals/agencies at the correct time. There is a need for clear information and guidance to be made available for staff about what health services are available and how these can be accessed.
- Consider a pathway for admission to an acute medical hospital setting for people with chronic long-term issues where wider acute medical problems cannot be managed within primary care settings.

Q 3 Adult Support and Protection

To what extent did one Professional/Agency have a lead role and hold responsibility for P19 and their Protection Plan; to monitor what was being achieved, any gaps in assessment, planning and decision making and associated risks?

Findings

- **Absence of health representation at ASP core groups**
- **Adult Protection did not effect the necessary changes to mitigate identified risks**
- **Lack of clarity and shared understanding around roles, decision making and escalation**

Recommendations

- **Ensure Service Leaders have a robust system in place for monitoring ASP cases and raising these with Team Managers in supervision. Consider the extent to which there is a culture of support in managing complex adult support and protection cases, including time for cases to be explored, risks to be escalated and decisions to be given some further oversight and governance**
- **Ensure that membership of core group meetings include health professionals and the introduction of Adult Protection Advisor posts within NHS Tayside should be considered to support ASP meetings to ensure there is always adequate representation, good decision making and escalation.**
- **Review the learning and development and quality assurance opportunities in place to support staff, managers and Review Officers to develop consistent practice in producing adult protection plans that are linked to a clear assessment of need and risk, which are reviewed to ensure they are dynamic in nature, clear for the adult at risk and offer direction to agencies involved**

Q 4 Capacity Assessment

How effective are the current processes for requesting a Capacity Assessment within NHS Tayside and how these processes are applied in practice?

Findings

- There were numerous attempts to identify someone to undertake a capacity assessment for P19 and varying understandings of who should/could do this. This resulted in no assessment of capacity being undertaken.
- There is no clear pathway for people to access an assessment of capacity, including people with alcohol issues. This currently appears to be dealt with on a case by case basis.
- Professionals who assessed P19 did not appear to have an understanding of the link between prolonged alcohol use and impaired mental capacity. Alcohol Related Brain Damage (ARBD) was not assessed.

Recommendations

- Develop a clear pathway for accessing an assessment of capacity.
- Develop a protocol for sharing the outcome of a capacity assessment with the care team.
- Ensure appropriate AWIA education and training is provided to relevant acute and primary care services on the difference between an assessment of capacity and S47 consent to treatment.
- Provide guidance and training for staff around the relationship between alcohol, care, capacity and ARBD.

Q 5 Self Neglect

To what extent is Self-Neglect understood across the multi-agency Adult Protection partnerships and wider Adult Protection providers?

Findings

- Staff did not fully understand P19s circumstances and what led to the extent of the self-neglect and there was a failure to fully recognise and understand the relationship between alcohol misuse and self-neglect.
- The reviewers recognise the efforts that Hillcrest staff went to in their efforts to support P19 and that included their persistence to escalate concerns to health professionals and managers.
- Assumptions were made by services about alcohol misuse being the cause of P19's physical ill health and non-engagement.
- P19 was offered services, but many services failed to pursue non-engagement.
- No regular inspecting programme is in place in relation to the inspection of properties.
- The majority of respite provision in Angus is registered with the Care Inspectorate to provide care to people over 65 only.

Q 5 Self Neglect

Recommendations

- Consider additional learning opportunities on understanding and dealing with self-neglect on a multiagency basis and include information on the legal framework surrounding this issue.
- Ensure that learning and recommendations from this SCR are shared within Angus and across Tayside and provide assurance to staff that a range of improvements will be implemented to decrease the chances of such a situation happening again.
- Ensure all relevant staff receive training and awareness in relation to alcohol use, substance misuse and co-morbidities to address the attitudes and stigma surrounding these.
- Develop guidance to assist practitioners in providing safe and appropriate care for individuals who are difficult to engage or who do not attend an appointment.
- Consider how to meet the needs of people under the age of 65 who have a need for respite care and progress plans to develop adequate provision.

Q 6 Notification to COPFS

To what extent and detail should information be provided to COPFS when someone who was subject to Adult Support and Protection measures dies to ensure that COPFS are able to assess the circumstances surrounding a death in those circumstances and direct further investigation and enquiry?

Findings

- **The sudden death report failed to identify P19 was an adult at risk and ongoing issues in relation to mental capacity which may have been relevant**
- **National documentation fails to specifically request whether deceased was or should have been an adult at risk at time of death**

Recommendation

- **Develop clear guidance for GP's and police detailing the information that sudden death reports should contain including good practice principles on how these reports should be written**

Q 7 Use of Legislative Powers

Did all Agencies exercise their full legal Powers to ensure the safety and well-being of adult P19?

Findings

- Not all legal powers available were considered and not all legal options had been fully explored within the ASP case conference and core group meetings.
- There was no evidence that the powers contained within the Adult Support and Protection (Scotland) Act 2007 had been considered and fully explored.

Recommendations

- Amend local operating processes to ensure that a prompt is built into the core group meetings where the core group should consider the need for any of the legal powers available.
- Review adult protection training to ensure, within the training, that there is a clear focus on the use of emergency powers covered in the training, as well as clarity of communication; ability to challenge another professional's decisions and that the views of others are considered.
- Consider the introduction of training for relevant staff that provides an overview of the 3 Acts available to keep people safe: the Adults with Incapacity (Scotland) Act 2000 (AWIA), the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and the Adult Support and Protection (Scotland) Act 2007 (ASPA). From a learning perspective consideration should be given to requesting input and guidance from the Sherriff's Office in terms of criteria around the use of relevant orders including how these are used effectively in other areas of the country.

Conclusions

- **Staff engagement throughout SCR must be recognised**
- **P19 had advanced bowel cancer and the end outcome would not have changed**
- **P19s experience throughout the weeks and months leading up to death should have been better**
- **Build on the recommendations to effect sustainable change in policy and practice**

Next Steps

- Sharing learning to effect change
- See the SCR within a 'bigger picture' of evidence informing continuous improvement.
- Improvement Plan
- Publication and Dissemination
- Communication and Engagement strategy
- Support for Staff
- Family support
- Role of Self Evaluation and Continuous Improvement Sub Group

Questions/Reflections?