South Lanarkshire Adult Protection Committee

SIGNIFICANT CASE REVIEW REPORT Adult 0057

HIGHLY CONFIDENTIAL

Executive Summary

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Executive Summary

Adult Support and Protection Significant Case Review

Background

Adult A0057 died in September 2021 at the age of 58yrs due to multi organ failure, sepsis and a history of liver cirrhosis secondary to alcohol. There had been significant involvement of several agencies over a few years prior to his death. Concerns had been raised about A0057's wellbeing by different agencies and members of the public including adult concern reports. A social work (SW) referral was received from Scottish Fire and Rescue Service (SFRS) in May 2021 which identified A0057 as an adult in need of support. In September 2021, Police Scotland submitted an adult at risk referral, however A0057 subsequently died in hospital.

Following A0057's death the South Lanarkshire Adult Protection Committee (SLAPC) received a request for consideration of a Significant Case Review (SCR), this was remitted to the SCRSG.

Terms of Reference for the Significant Case Review

The SCRSG agreed Terms of Reference (ToR) for the SCR. These were discussed and agreed with the SLAPC and formed the basis of the SCR and the approach taken.

Timeframe of the Significant Case Review

Although A0057 had a history of alcohol related illness spanning several years the main period, where circumstance appeared to deteriorate was identified as January 2019 – A0057's death in September 2021. It was deemed appropriate for the SCR to concentrate on this period.

A0057's story

The history of A0057 can only be determined from the interagency case files and his personal reflection through needs assessments.

A0057 appeared articulate and expressed his views clearly. Making sure that services and the people representing them understood what he would and would not accept in terms of support. And that such support would be on his terms.

A0057 described himself as a loner- "he had always been that way". He was an only child and no extended family. He was well educated and had run a successful business, owning his own home, and living independently. He suffered a significant injury and as a result, he could not work, and he lost his business and his home. In 2011 he moved to live with his father following his mother's death. A0057 had

Power of Attorney for his father's financial and health affairs. After his father died in a care home in July 2020. A0057 continued to live in the family home.

He had a history of alcohol dependency and had been referred to the Substance Misuse Service in 2015. His use of alcohol fluctuated from abstinence to drinking only small amounts.

A0057 self-reported as having Asperger Syndrome and he preferred less direct routes of communication such as email.

A0057's general health was also compromised. He had a history of haematemesis, melaena and hypotension and was significantly underweight (ranging from 37-42 kgs). It is noted that section 47 was completed during two of his admissions to hospital and on his final admission to hospital in September 2021 appeared malnourished and had a BMI of 14.2 (a BMI of below 18.5 is generally considered underweight). A0057 died in hospital on 21 September 2021 from multi-organ failure, sepsis and liver cirrhosis secondary to alcohol.

Over the period of the SCR from January 2019 to September 2021 A0057 had contact with the following agencies:

- South Lanarkshire Health and Social Care Partnership
- NHS Lanarkshire- Acute Service and Primary Care.
- Police Scotland
- Scottish Fire and Rescue
- Scottish Ambulance Service

Significant Case Review Process

The SCR was commissioned using the local and national framework for SCR's extant at the time. This framework was established to reflect the requirements of the Adult Support and Protection (Scotland) Act 2007.

- A mix of Social Care Institute for Excellence (SCIE) and Root Cause Analysis approaches were used. The Review Team conducted 13 conversations with staff taking a learning focus.
- A detailed chronology was compiled which drew from all information available
- Staff were briefed on the purpose of the SCR before taking part

Practice and organisational learning

The Review Team undertook a reflective exercise concentrating on key episodes in A0057's care. There were some aspects that were circumstance and context specific and others that appeared to bridge each episode.

To add focus to such an exercise the Review Team, completed a Fish Bone diagram as part of the root cause analysis approach which helped summarise the key drivers for the areas recommended for improvement.

Additionally, because there was no family to engage with the review team completed an exercise which summarised their key concerns and how working with this case, made them feel. Although this could not replace A0057's voice it is hoped that it adds some wider context to the learning from this SCR.

Effective practice

The Review Team as part of the SCR process identified the following areas of effective practice:

Police Scotland response to A0057 in September 2021 was considered and compassionate. The officers recognised the urgency of the situation but also the need to act in the longer term should A0057 return home.

Scottish Fire and Rescue Service made an initial referral for support in May 2021 following the house fire. On receipt of the Police Scotland AAR referral in September 2021 SFRS offered to undertake a joint home visit with social work to assist with risk assessment and actions. Unfortunately, A0057 died whilst in hospital and this visit did not take place.

Responding to the COVID 19 Pandemic the Review Team acknowledge the impact of the pandemic on service delivery, organisations, and colleagues. It was striking how colleagues could reflect their experiences and contributions whilst continuing to put the needs of the people and services first.

Improving practice and systems

The Review Team highlighted the following as areas for practice and organisational learning:

Person Centred Care

To refresh the values-based approach to care, example an Ethics of Care framework.

The principles of trauma informed care should be embedded across the agencies.

There should be a review of patient discharge arrangements to ensure they are person centred including individual's social circumstance and potential challenges**.**

A refresh of the Complex Case Escalation Policy ensuring it has clear pathways for services to follow. The awareness of this policy also requires audit.

Staff should be further supported to understand the concept of self-neglect and managing resistance and should be supported to access SLAPC training, support, and professional guidance in this area of practice.

Effective communication and record keeping

Review standards and systems for information sharing including informal discussion.

A programme of case file audits and a refresh of required standards should be re-implemented in Acute Services.

Acute Services should, as a matter of priority, undertake a refresh of its approach to Section 47's, to ensure the understanding of their application and recording is in line with the Mental Welfare Commission guidance including regular audit.

Acute Services should review discharge letters, to ensure the wider health and social care support needs of the patient are related to General Practices.

A multi-agency chronology recording pathway should be explored and implemented.

Understanding and coping with difficult to engage people

There should be a refresh, across health and social care, of the approach to stopping services to people ensuring appropriate, guidance, training, supervision, and audit is in place.

There should be a review of the approach to anticipatory care to ensure that it is an active tool identifying those at risk, establishing effective alerts and care packages.

Implement awareness, guidance and training for staff across the Partnership to provide support and care to difficult to engage individuals.

Awareness of Adult Support and Protection – its true purpose

SLAPC should review the reach and impact of its training, development, and awareness sessions on the wellbeing of the people receiving care.

NHS Lanarkshire should draw to the attention of the Scottish Government, Director of Primary Care, the lack of sufficient external monitoring and assurance of the training and awareness of ASP in General Practices and contractor services; and the need for ASP Committees to be provided with reliable information in respect of that.

SLAPC should refresh its ASP decision making pathways to ensure clear guidance is in place for robust assessment, risk appraisal and outcome decision context.

SLAPC should encourage the establishment of a network of ASP advisors across agencies to ensure that staff have access ready support wherever they work.

Acute Services should review its record structure, standard and training to ensure ASP becomes a more obvious consideration when assessing patient needs.