Bournemouth and Poole Safeguarding Adults Board

Easy Read
Serious Case Review
about Miss A

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This is a Serious Case Review about a lady who we will call Miss A.

Miss A died in a fall from a height on 7th January 2008 – she was 36 years old.

In June 2009, it was agreed that a review was needed.

The reason for the review is to look at things like whether people could have told each other more information, and whether Miss A's death could have been stopped from happening.

1. Some background information:

1.1 Miss A had a severe learning disability and problems telling people what she wanted. This means that she needed support to do most things. She also had epilepsy which she took medicine for.

She lived with her mother who we will call Mrs A.

It was known that Miss A sometimes got up at night.

Before 2005, Miss A had occasional or respite care each month in 3 different health settings where there were staff awake at night.

After 2005, she stayed in 3 Social Care places. The first place had an alarm if residents got up at night. It was while she was at the third place that she died.

1.2 In September 2007, Mrs A had to have an operation, so Miss A needed to go into Social Care respite. The first 2 places where she had stayed had no space, so she went to the third place which we will call Residential Setting 3 (RS3).

RS3 had 8 residents who all had learning disabilities.

1.3 After Mrs A's operation, Miss A could not go home. Poole Adult Social Care agreed that she could stay at RS3 until another place was found.

Mrs A wanted Miss A to stay at RS3.

1.4 On 7th January at 7.15am, Miss A was reported missing. At 8.40am, she was found in the neighbour's alley.

It was found that she died because of a fall from a height. She had probably fallen from a first floor window but there was no proof of where or why this happened.

1.5 These people had been involved in Miss A's care:

Borough of Poole Children's Social Care	1982-1990
Borough of Poole Adult Social Care	1990-2008
Doctor	1972-2008
Dorset Healthcare Trust	1982-2006
RS3	September 2007–January 2008
Care Quality Commission (with RS3)	January 2007-January 2008

1.6 It was decided to start a Serious Case Review in June 2009.

1.7 In December 2009, there was another review to look at why the Serious Case Review was not done earlier.

1.8 The Serious Case Review Panel (a group of people from different organisations) met 8 times between December 2009 and July 2010.

2. The main things they looked at were:

- If enough information was shared between the different places Miss A stayed.
- If there was enough thought about the information and planning to make sure Miss A went to a place that was right for her needs.

- Looking at places to make sure they met the important needs.
- Thinking about the risks and needs of residents. Also how residents affect each other and the place they live.

3. Things decided:

3.1 Miss A would not have died if she had not fallen from an upstairs window.

This could have been stopped if the windows had restrictors (to stop them from opening too far).

The windows upstairs were small, so the risk of someone falling out was hard to think about.

In residential care for adults, there needs to be a balance between making the place feel like home and stopping all risks.

3.2 Risk assessment (checking risks)

3.2.1 Miss A's death might not have happened if there was a way of staff knowing if residents got out of bed and if staff were able to get to her in time.

It might not have happened if the check of Miss A's needs had said that she needed a residential place with staff who could get to her quickly if she got out of bed.

Even if both of these things were in place, the fall might still have happened.

3.2.2 When the Care Quality Commission inspected RS3 in September 2007, they did not say that there should be window restrictors to stop them opening too far.

The general guidelines for adult residential homes do not say that there should be restrictors on windows.

3.2.3 The National Minimum Standards (which are not law) say that the Manager of a home is responsible for the health and safety of residents (or must make sure the health and safety of the residents is all right). This includes fitting window restrictors if there is a risk to the residents. Nothing had happened in the past to say that any resident could get out of a small window.

3.2.4 The staff sleep in a downstairs room at the back of the house. It would be hard for them to know if a resident got out of bed.

3.2.5 In the daily log (diary) of RS3, there was lots written about Miss A getting up at night and sometimes going into other rooms.

3.2.6 There is some information about Miss A getting up at night before she was at RS3 and lots while she was at RS3. There was no written proof that there was good communication between RS3 and the Social Care Manager about this.

3.2.7 Each resident had a risk check at RS3. There should have been other checks done about the changing needs of residents.

3.3 Sharing Information

3.3.1 In the written assessment of Miss A's needs in 2005, it said that she got up at night. The healthcare place where she was staying had staff that are awake at night. When Miss A moved into the Social Care place, the Social Care Manager knew about this.

They thought about the need for a pressure mat to let staff know when she got up, but it was not needed because they had an alarm system.

3.3.2 The next written assessment of Miss A's needs in 2006 said that she needed 24 hour care. It did not mention that Miss A gets up at night.

3.3.3 The second Social Care place where Miss A stayed told the Practice Supervisor in 2007 that they were worried about night care. They agreed to let the Care Manager know if staff who are awake at night were needed.

3.3.4 In the daily log at RS3, it is written that Miss A got up at night lots of times. Sometimes she went into other people's rooms. There is no written information to show that the Care Manager was told.

3.4 Looking at Long Term Planning

3.4.1 There was no proof or evidence that a really good long term plan had been made. This would have thought about all of Miss A's needs and how to meet them.

This would have been really useful when Miss A changed from occasional respite care to permanent care. It would have told people about her getting up at night.

3.4.2 There was no check of carer's needs. This would have looked at Mrs A as a carer. It would have shown that Mrs A was getting older and finding it harder to care for Miss A. It would have shown the need for long term plans.

3.4.3 Care plans were written on September 2005, October 2005 and December 2006.

The first two plans showed that Miss A did not understand danger and she would not understand how her behaviour would affect other people. They also said that she gets up several times at night, and staff would need to know about this.

The third plan in 2006 was the one given to RS3 when Miss A stayed there. It did not say that she got up at night, but it did say that she needed 24 hour care. The information from the first two plans was not put in the third plan.

3.4.4 An Individual Service Design (Special Plan) started in December 2007 but it was not finished. It said that

Miss A sleeps through the night. The manager at RS3 says that she did not agree with this and told the people who wrote the report but there is nothing in writing to say that this happened.

3.5 Planning and Looking at Placements

3.5.1 When thinking about where a person should stay, their special needs must match the place. This includes looking at the safety of the building, who lives there already and whether there are enough staff at day and night.

3.5.2 Sharing information about people's needs must happen all the time because needs change. The commissioner (person who makes decisions) and the provider (organisation who provide care) need to make sure that this is written down.

The commissioner needs to check the service user's needs often. The provider needs to tell the commissioner if any needs change.

3.5.3 It needs to be clear who will make sure the service user gets the equipment they need. RS3 did not usually take residents who got up at night. The commissioner should have checked the needs at night and made sure Miss A had what she needed.

3.6 Serious Case Review Protocol (the way reviews are carried out)

3.6.1 After Miss A died, the Serious Case Review Protocol changed. In future things will be done differently.

3.6.2 All managers need to ask for a Serious Case Review if someone dies when it might have been prevented and to know the way to do serious case reviews.

3.7 Summary of main problems

- Sleeping staff at RS3 slept downstairs and had no alarm system. This meant that they could not easily know when Miss A got up at night.

- There was no proof of up to date check of risks at the home or the changing needs of the place and the residents at RS3.

  Social Care knew about Miss A getting up at night from her Care Plan in 2005. This was not put in the Care Plan in 2006. This meant that RS3 did not know before Miss A stayed there that she got up at night.

- It was written down in RS3's daily diary about Miss A getting up at night and going into other

resident's rooms but there is no proof that RS3 told Social Care about this.

- There was no up to date check of Miss A's needs when she changed from respite care to long term care in October 2007. Although Social Care thought they knew about the kind of place Miss A needed to stay, this was not based on an up to date assessment, which should have been done in October. It did not start until December 2007.

- Social Care did not check the needs of Mrs A as an older carer.

4. Suggestions of how to change things

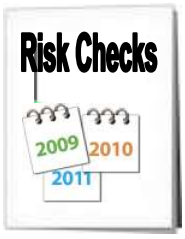
4.1 Risk Assessment (Check)

4.1.1 Inspections by the Care Quality Commission should make sure that up to date risk checks are done. These should be done for the home and for each resident at the home.

4.1.2 Residential Homes should do regular risk checks to make sure resident's changing needs are understood.

4.1.3 Sleeping in staff must be able to hear residents if they need help or get up at night. This can be done by sleeping in a room near to the residents or by having something like an alarm.

4.1.4 Regular checks need to happen to look at how residents affect each other. If anything changes at the home, this should be included in the check.



4.2 Long Term Planning and Sharing Information

4.2.1 A check of needs must look at things like:

- knowing about the service user's needs,
- things that have happened in the past,
- information from where the service user has stayed before,
- the needs of people caring for the service user,
- the short term and long term needs of the service user.

The checks must be done at least once a year. It needs to be looked at again if things change.

4.2.2 The Social Care Manager must make sure this happens.

4.2.3 Care Plans must look at night time needs of the service user.

4.2.4 A check of carer's needs must be done if the carer has needs of their own or if things change. There should be a plan to say what will happen in an emergency if the carer cannot look after the service user.

4.2.5 If the carer is older, this needs to be thought about when writing long term plans.

4.3 Commissioning (making decisions)

4.3.1 When a service user is moving, their needs must be met in the place they move to. This includes looking at the safety of the building, who lives there already and whether there are enough staff at day and night.

4.3.2 Sharing information about people's needs must happen all the time because needs change. The commissioner and the provider need to make sure that this is written down.

The commissioner (person who makes decisions) needs to check the service user's needs regularly. The provider (organisation who provides care) needs to tell the commissioner if any needs change.

4.3.3 It needs to be clear who will make sure the service user gets the equipment they need. The commissioner should do this if the needs are different from what the home usually provides.

This report was written by Jan Sayers in May 2010.

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It was made into Easy Read for Bournemouth and Poole Safeguarding Adults Board in November 2010.