Barnsley
Safeguarding Adults Board
Executive Summary

Report of the review
Into the death of XX
Case Review

In respect of XX

Died 6 July 2008

Report by:

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Independent Chair and author of the report
April 2010
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1. Introduction

1. The Barnsley Safeguarding Board resolved that a Serious Case Review should be undertaken in respect of the service user Mr. XX. An independent chair was appointed to chair a panel of senior representatives from the agencies involved in this case and to author this report.

2. XX was a regular participant of the Royal Mencap Society supported holiday scheme. The scheme is commissioned from Mencap by the commissioning team of the Partnership in Action Barnsley which is the Barnsley Integrated Learning Disability (BILD) services. XX had been on a number of holidays with this service in the company of his brother since 2004.

3. On 5th of May 2008 XX and his brother joined the holiday with a plan to travel to Llandudno for a five day break.

4. The party arrived in Llandudno in the evening of 5.5.08. XX had been incontinent of urine during the journey and continued to be incontinent when he arrived at the holiday destination. The staff supporting the holiday were concerned for him and on 6.5.08 sought advice both from their managers and the Community Learning Disability Team of Barnsley Integrated Learning Disability (BILD) Services. The result of this consultation was a decision that he should immediately return home. Advice was also given that medical attention should be sought in Llandudno. This did not happen.

5. A member of the Community Learning Disability Team (CLDT) a team that is part of the BILD services drove to Llandudno and returned to Barnsley with XX. When he arrived at his house it was clear that he was unwell and whilst bathing the staff member noted that he had seriously excoriated legs and buttocks that were causing XX some discomfort.

6. XX was taken to hospital and he was admitted as an in-patient. It rapidly became clear that his injuries were burns. XX had serious underlying health conditions and on 6th of July 2008 he died; the
coroner’s inquest on 27.11.08, in a narrative verdict, determined that death was by natural causes.

7. However the Safeguarding Board was concerned about the injuries that XX suffered and it was agreed that this Serious Case Review would be convened because the Board considered that the threshold had been met for a Serious Case Review. The South Yorkshire Adult Protection Procedures set out the criteria and thresholds for initiating a Serious Case Review. Paragraph 4.2 states that a Serious Case Review should be considered when:

A vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.

2. Commentary

1. It should be stated that it is not possible to conclude how XX suffered his injuries. Most significantly the agency responsible for investigation, the Police, decided not to progress the case and the file was not submitted to the Crown Prosecution Service because of lack of evidence. No prosecutions emerged and the coroner clearly recorded a verdict of death by natural causes. The report has been prepared within the remit of the Terms of Reference which specifically charged the Serious Case Review with the task of examining organisational and individual practice in agencies to determine whether lessons are to be learnt about the management and professional practice. XX’s relatives, hoped that this Serious Case Review would provide an account of how XX received his injuries. This cannot be provided; any projection of events on the evening of 5th of May 2008 can only be conjecture based on third party reports and circumstantial evidence. The review cannot conclusively ‘prove’ what happened because most notably XX’s health deteriorated and he subsequently died before the police could interview him.

2. The supported holiday service was commissioned by Barnsley Metropolitan Borough Council (BMBC) on behalf of the Partnership In Action Barnsley. Services for people with learning disability in Barnsley are provided by an integrated learning disability service which has a range of professionals working within it including nurses, social workers and support workers.
3. The supported holiday was a well established service that sought to provide a quality holiday experience for the participants using commercially available holidays.

4. Nonetheless there is a possibility that XX was injured during this holiday – we will never know exactly what happened and must be cautious at drawing conclusions that the facts do not support.

5. JH did experience a number of indignities in respect of the care provided regardless of how the injuries were caused. He travelled to Llandudno in wet clothes and during a city stop at Chester no attempt was made to change him either by retrieving some dry clothes from his suitcase which was locked in a ‘bus during the city visit or by purchasing some new clothes to ensure that we was comfortable for the journey. The following day he returned to Barnsley in wet clothes because he had run out of dry clothes and despite the fact that the staff had a cash float for emergencies no attempt was made to purchase some clothes to enable him to travel home in a dignified fashion. The staff were concerned about his condition and sought advice from managers and BMBC; an element of that advice was to seek medical help in Llandudno. This was not done and as a result he suffered the indignity of travelling home in some potentially extreme discomfort.

6. By the time that XX was admitted to the hospital the injuries had been sustained and he was treated accordingly and the hospital staff played their part in the safeguarding process.

7. The police undertook an investigation once alerted but did not attend the first strategy meeting. They knew about it and were told by the chair of the strategy meeting that he would make further contact if it was decided that the police were required.

8. Manthorpe and Martineau¹ comment on the importance of discussion about thresholds for safeguarding and if there had been an explicit discussion about thresholds then the police might have come to the first meeting. The police attended the strategy meeting of 11.6.08 and initiated an investigation but were unable to interview XX because of his health. XX died on 6.7.08 without being interviewed. In this situation the police investigation was hampered by the poor health of XX and his subsequent death.

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¹ Manthorpe J. And Martineau S, (2009), Serious Case Reviews in Adult Safeguarding. Social Care workforce Development Unit, Kings College London, (2009)
3. Conclusion

When a tragedy occurs such as the one described in this report it is understandable that the public may perceive that an individual or agency must be at fault. A serious case review was commissioned by the Barnsley Safeguarding Adults Board to determine if lessons could be learnt from this case about the individual work of agencies involved and about multiagency work as well. The review has therefore not sought to apportion blame but to examine the circumstances and make recommendations to improve the protection of vulnerable adults.

The serious case review panel in considering the events came to following conclusions.

1. There were shortcomings in a number of areas in respect of the care that XX received during the holiday.
2. It will never be clear exactly what happened on the holiday and how JH became injured. Therefore it is speculation, at best, to try to identify how the injuries occurred. This will be a blow to his relatives who aspire to know exactly what happened and how XX received the injuries, but it serves no one to fuel anxiety by suggesting one course or another when we do not know the exact detail.
3. There are major lessons to be learnt and assimilated.
4. There was insufficient and inadequate care planning for the holiday.
5. This was exacerbated by an unacceptably poor risk assessment arising in part from unsatisfactory practice and in part from poor Mencap risk assessment forms.
6. The staffing levels for this activity, which involved caring for people with complex needs, were not sufficiently high.
7. This staffing situation was not addressed in the regular monitoring meetings between the commissioners and the providers of this service. It behoved both to consider this – the providers should have raised it and commissioners should have examined the issue to ensure that the provision was safe.
8. There was some lack of clarity of commissioning; the in-house providers of learning disability service in Barnsley adult care also had a role in commissioning the service and this might not have led to the focus required to ensure clarity. The review was informed that this was being addressed in a restructure of commissioning arrangements.
9. The holiday service was not subject to external regulation. Reviewing the extent of XX’s care and support needs, it is the case that if the same care and support was delivered to XX in his home the standards of care and support would be subject to external regulation. These regulatory standards establish clear minimum standards in respect of both quality and staffing requirements. The application of these
standards to the holiday service would have provided a clear delivery focus for both Mencap as the service provider and Partnership in Action, Barnsley (BILD) as the service commissioner.

10. Regardless of how the injuries occurred there was some unsatisfactory practices in the support of XX. The carers went into Chester for the City visit en-route to Llandudno without money (they were supplied with a cash float but left it locked in the ‘bus)and thus they were not able to help XX out of wet clothes. The bathing checklist was not completed and somehow XX ended up in a bath (it cannot be confirmed that this bath sustained the injuries) without the knowledge of his carers. That he was a private man is not in dispute but the (minimal) risk assessment undertaken identified a strange environment as a risk. The hotel was strange and the bathing checklist was not completed. There is no avoiding the issue that the two carers are directly responsible for this poor practice, though it cannot be said that this poor practice led to the scalding. This practice stands apart from the injuries and even if there had been none would still be unacceptable. If the carers had not already resigned at the time of the holiday it would have required management action by Mencap, who made it clear to the review that they would have taken it.

11. Additionally the carers were given advice to seek medical help; they did not. This combined with the poor practice identified above amounts to neglectful practice. They did recognise that he needed help, sought managerial advice, covered him in towels and considered applying ‘cream’ but in the end did nothing further to seek professional medical help.

12. This was compounded by the failure of the person returning him to Barnsley to seek medical help before setting back for Barnsley once he had arrived in Llandudno. This indignity was further compounded by not arranging for dry clothes for XX, even though the staff did discuss the matter in Llandudno once the person from Barnsley arrived to return XX, but no action was taken to purchase some dry clothes. This too was unacceptable and XX must have endured a very uncomfortable ride home.

13. Once home it became clear that XX was seriously hurt and he was taken to hospital by car because he refused to go to hospital in an ambulance despite efforts to persuade him otherwise. He would have experienced a dignified entrance to hospital and could have received expert paramedic treatment before being moved. As it was the right decision was made and he was taken to hospital in a car in his pyjamas with his feet blistered and sore, with sores on his legs and scrotum and his skin coming off so excoriated were parts of his legs. Fortunately XX lived very near to the hospital and a car might well have been the quickest method of transport. Finally the SCR panel
acknowledged that the member of BMBC staff who took him to hospital had been working all day and driven hundreds of miles; there was genuine understanding of his commitment.

14. After the safeguarding process was initiated, following the initial activity, there was a loss of focus and unnecessary delay. The case should have been brought back to multi agency discussion sooner than it was. In the end this is about multi agency working. No one agency is responsible for safeguarding; all agencies hold that responsibility. The lead agency should have pursued the Safeguarding Procedures but the other agencies should have held the lead agency to account and progress chased matters. This is an issue that the safeguarding board ought to review to ensure that there are not delays in the future.

15. This serious case review was delayed by the inordinate amount of time it took the NHS to supply its IMR. This too was unacceptable both for other agencies involved and most importantly the relatives of XX who wanted to resolve the whole issue as soon as possible. The timely production of IMRs is essential to successful Serious Case Review practice. IMRs require commitment and resources to be devoted to the process by agencies and it would be valuable for the safeguarding board to review practice in the light of this review.

16. The serious case review panel timetable was also over ambitious and lessons can be learnt from this for the future. The author of this report and chair of the panel recognises his role in setting that over ambitious timetable, but it was based on the South Yorkshire Adult Safeguarding Policies and Procedures and the Board might like to revisit them.

17. XX received particularly nasty injuries and he sadly died of the underlying health issues he also suffered from. The core of the analysis of this review is that if the injuries occurred during the holiday they could, in all probability, have been avoided. There was a combination of poor individual practice by support workers, insufficient staffing levels for which both Mencap and BILD must hold some responsibility and the safeguarding process subsequently lost focus.

18. Added to that he experienced a series of indignities that if straightforward care tasks had been performed to a higher standard simply would not have occurred. That is the sadness of this case.