Housing & Safeguarding Adults Alliance

Serious Case Reviews, Amy and James – lessons for support and supported housing providers

James, 33, who had learning disabilities, a mental health problem and hypothyroidism, died in November 2012. Amy, 52, who had learning disabilities, epilepsy and cerebral palsy, died in May 2013. Both had lived in supported living schemes in Suffolk and both died from complications arising from an untreated yet treatable medical condition – constipation. The two Serious Case Reviews concerning these preventable deaths were published in October 2015.

Once again, we have evidence of the 'poor relation' position that supported housing has in relation to health and social care. These two SCRs show how difficult it was for health and social care staff to communicate with each together, to be clear about each others' roles, responsibilities and boundaries, never mind understand the limitations of supported housing or work effectively with its staff.

The overarching themes of the two reports include:

- 'diagnostic overshadowing' (where symptoms of physical ill-health are seen to be a result of learning disability or mental ill health);
- poor clinical practice regarding bowel management;
- poor multi-disciplinary working and absent care co-ordination;
- poor understanding and practice regarding the Mental Capacity Act.

Of particular relevance to support providers and supported housing providers are the contributions of the following factors to the eventual deaths of Amy and James:

- The change of registration from care home to supported living (which was not fully understood by non-housing professionals, support staff or families)
- Poor understanding by support staff of the Mental Capacity Act
- Poor contract specification and contract monitoring
- Support staff with insufficient training on the needs of people with learning disabilities
- Support staff with insufficient advice or training on recognising and managing bowel problems including:
    - not understanding the connection between behaviour change and constipation or between medication and constipation;
    - staff misunderstanding the signs of severe constipation, misinterpreting overflow diarrhoea for normal bowel movements;
    - inconsistently recording bowel movements
- Lack of effective communication between medical and support staff regarding bowel management

- Lack of advice to support staff about their monitoring role - unrealistic to expect support staff to 'monitor' bowels and general health as 'not involved in clinical decision making and received no instruction concerning how, what or with what they were to monitor'.

I suggest that the low status of support workers working in supported housing was also a contributory factor in the deaths of Amy and James. It would also appear that responsibility for health care for tenants with complex needs was neither made explicit nor understood by the various professionals involved. Consequently some support staff were of the view that '*we don't do health*' and did not see themselves as advocates for their tenants. There are several instances, recorded in the two Serious Case Reviews (eg of very poor communications, factual errors between health professionals, differences of diagnosis/opinion between health professionals) which could and perhaps should have prompted support staff to be much more assertive. Leaving health care to health professionals is not enough, particularly for those with chronic and complex health needs; support staff have detailed knowledge about the people they care for and must be enabled to speak up when accompanying them to GP or out-patient appointments. Being seen as just '*chauffeurs*' is not good enough - they must be health advocates too.

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See also the accompanying document containing relevant extracts from the two Serious Case Reviews ('amy and james extracts nov 15 v2').

The purpose of these two documents is to help support and supported housing providers learn the lessons from these Serious Case Reviews. Lessons for housing providers from other housing related Serious Case Reviews were the subject of my dissertation for the Keele University MA in Safeguarding: Law, Policy and Practice and were published in the Journal of Social Welfare and Family Law in 2014. Note that the Care Act 2014 has made the commissioning and publication of Safeguarding Adults Reviews (formerly called Serious Case Reviews) statutory (Section 44).