Lessons Learned

Warwickshire Safeguarding

Alan's Story…. Alan was born 3 months prematurely at home and due to a lack of oxygen he suffered from brain damage causing him to have physical and mental health issues; he had learning disabilities, was on the autistic spectrum and suffered from bipolar disorder. Alan lived at home from birth up until he was admitted to hospital as an inpatient, in October 2018, having been sectioned under the Mental Health Act.

Alan was discharged from the hospital in 2019, when he was housed in a Housing Association tenancy, achieved through the local authority, in his new home in Warwickshire where he was cared for by a local care provider. He was provided with 2 to 1 care 24 hours a day with 1 waking night and 1 sleeping night carer. Towards the end of Alan's life, the level of care at night was increased due to Alan's behaviour becoming more challenging.

In December 2019, he was admitted to Warwick Hospital via the Emergency Department, having been found unconscious whilst sleeping. Alan passed away a week later. Alan was 44 years old at the time of his death.

What we have learned….

The Mental Capacity Act (MCA) was not actively and systematically used as it should have been. **Learning for Practice:** *Alan's family had applied for a deputyship order, but this had not been finalised. Where Deputyship, Lasting Power of Attorney or Court orders are thought to be in place, agencies need to make sure they check these are valid and that they understand and follow their provisions. Agencies should have suitable processes for the receipt, understanding, dissemination, and recording of Court of Protection Applications and Orders.*

There was an occasion that Alan was administered PRN medication, the dosage of which, did not feature on the Medicines Administration Record. The inadequate record-keeping contributed to confusion at the time of his admission to hospital. **Learning for Practice:** *all care providers involved in the administration of medicines should adhere to NICE guidance in particular with regard to short course and PRN medication and ensure that training and appropriate checks and measures are in place.*

Lessons Learned (cont.)

Warwickshire Safeguarding

What we have learned (contd.)…..

Multi-disciplinary team (MDT) meetings were held but the family disputed some of the outcomes. The meetings did not always include all relevant agencies and were not recorded appropriately. **Learning for Practice:** *MDTs should include all relevant parties, have a good structure and be clearly recorded. Where there are disagreements on what is in the person's best interests this should be fully explored using the framework of the Mental Capacity Act. There should be a clear plan in place when resolution is not achieved, and this should include escalation to the Court of Protection to resolve any disputes if necessary.*

What do I need to do….

Advice for professionals

- Read the BMA Guidance on best interest decision making for those who lack capacity
- Familiarise yourself with NICE guidance in respect of the administration of medication
- Read the SCIE information in respect of MDTs; what they are and why are they important

Advice for communities

- There is useful information for families in respect of next of kin and power of attorney
- The Citizens Advice Bureau provides information and advice if you need to support an individual with managing their affairs
- This briefing provides information for families about the Mental Capacity Act