# SERIOUS CASE REVIEW

# MR W

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## 1. Background

Mr W was an 86 year old man who died on the 17 August 2013 after having been admitted to St Mary's Hospital from a Nursing Home. The death certificate stated that Mr W died of Septicaemia.

It is striking that whilst Mr W was known to a number of agencies that very little seems to be known about his family background and life and that whilst individual professionals held some information this was not consistently shared between agencies and what was known was often conflicting information. Some professionals described Mr W as hard to engage with, loud, rude to people and very distrusting of others. Others were able to engage with him and were therefore able to find out more about his life, but the information was patchy and inconsistent.

The records indicate that he had a brother-in-law and a niece living on the mainland, with whom there was some contact. It is known that he moved to the Isle of Wight to live near to his sister, in 2012. His GP described him as having a close relationship with his sister and that she was very supportive.

He was described by his GP as a very private and proud man, who talked about having served in the Korean War, having a collection of models, which may have been aircraft and magazines of a similar nature.

In March 2007, Mr W reported an alleged theft of money and bank cards, whilst out shopping with his sister. The money was subsequently found in the pocket of a coat, the Police '*concluded that this was a genuine mistake by an elderly victim who was clearly confused regarding the circumstances*'. At this time Mr W was not living on the Island but was in the process of buying a flat on the Island to be near to his sister. Whether the flat was his or not seemed unclear, with records stating that he owned his flat, that it was owned by his niece and he rented it from her, that he had money but was careful with it or that he had no money.

In October 2012 Mr W reported theft of money from his flat. Police attended and following contact with Mr W's brother in law on the mainland, the money was found. During this contact with the Police Mr W reported that his sister had died recently and he wanted his life to end.

The loss of his sister appears very significant both in terms of the emotional support she provided for him but also she supported him with his care needs. His GP recalls how his sister had always brought him to the Surgery for appointments and had done a lot for her brother, but following her death the GP visited him at home and was concerned about how he would cope at home without the help of his sister. The GP was also concerned about his mental health following his sister's death and had referred Mr W to a Community Psychiatric Nurse. Due to the nature of his physical health the GP also arranged for District Nursing Services to visit.

In April 2013 he was admitted to Hospital after a small house fire, caused by cooking. The Emergency Services had problems persuading him to leave his flat to go into hospital.

Whilst in hospital he had a few falls, there were concerns about his cognition and his ability to cope at home. He was referred to the Hospital Social Work Team for an assessment. Throughout his assessment he was adamant that he would not pay for services. A Reablement Service of 1 visit per day, was set up and he was discharged home with a package of care.

During the period of his Reablement Care, between April and July 2013, the District Nursing Service were also going in. During this period there were different perceptions about Mr W's physical and mental health and his living conditions. He was described by most who visited him as resistant to the help being offered and at times Mr W would not let the Carers in.

During the summer of 2013 his physical health and living conditions had deteriorated, resulting in an urgent request from the District Nursing Service to Adult Services to visit and reassess. This visit led to an emergency placement being made in a Local Authority Care Home, Mr W was consenting and seemed relieved to be receiving help.

Mr W's physical health declined further in the Care Home and a Nursing Home bed was sought, he was admitted into a private Nursing Home in August 2013.

Following an assessment after admission, the Nursing Home Deputy Manager raised a concern of neglect, Mr W was admitted to Hospital and a safeguarding alert was reported to the Safeguarding Team by the Deputy Manager

The nature of the safeguarding concerns were as follows:

- Grade 3-4 pressure sore on right heel (wound being infected)
- Grade 3 pressure sore on sacrum (wound being infected)
- Grade 3 pressure sore on left calf (wound being infected)
- Grade 1 and 2 pressure sores on sacrum (wound being infected)
- Grade 1 and 2 pressure sores on toes, left and right foot
- Scratches noted on both arms and legs, most of them being infected
- Red areas of skin noted on the whole of back area, groin area
- Ulcerated lower legs (ulcers of various sizes).

The Deputy Manager contacted both the Residential Home and the District Nursing Service and both stated that they were not aware of the pressure wounds.

This subsequently gave rise to questions about the way in which local professionals and services had worked together with Mr W and whether agencies could have intervened earlier.

## 2. Methodology

A formal decision to conduct a Serious Case Review was made by the Serious Case Review Sub Group of the Isle of Wight Safeguarding Adults Board in accordance with the Multi-Agency Safeguarding Adults Procedures on the following grounds (as set out in the procedures):

The responsibility to undertake a Serious Case Review comes from the document 'Safeguarding Adults' published by the Association of Directors of Social Services (ADSS) published in October 2005. This document provides a National Framework of Standards for good practice and outcomes in adult safeguarding work. One of the standards in this document states that as good practice Safeguarding Adults Boards should have in place a Serious Case Review Protocol.

The purpose of having a Safeguarding Adult Review is not to reinvestigate or to apportion blame, it is:

- To establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard vulnerable adults
- To review the effectiveness of procedures
- To inform and improve local inter-agency practice
- To improve practice by acting on learning
- To highlight good practice

The Serious Case Review brings together and analyses the findings from individual agencies involved in order to make recommendations for future practice where this is necessary.

Serious Case Reviews are not disciplinary proceedings and should be conducted in a manner which facilitates learning and appropriate arrangements must be made to support staff.

Serious Case Reviews are also not enquiries into why an adult dies or who is culpable. These are matters for Criminal Courts and Coroners Court.

The Review Panel agreed the following process:

- Produce a single Multi-Agency Chronology
- Identify Professionals for face to face interviews and Panel members to undertake these interviews
- Panel Meetings to discuss the findings from the above and to produce a Report.

The Review Panel agreed look at records between March 2007 and up to his death in August 2013.

The Serious Case Review Sub Group agreed the following process:

- Set up a Review Panel
- Appoint an Independent Chair
- Appoint an Independent Overview Writer.

The integrated chronology, shows contacts from a range of agencies with Mr W between the periods of May 2012 to his death on the 17 August 2013 is too lengthy to reproduce here.

**Who we spoke to:**

2 GP's

District Nurse Team Leader

First Response Social Care Officer

First Response Senior Social Work Practitioner

Hospital Social Worker

Reablement Staff, Senior and Managers

Manager and Senior from the Care Home

Deputy Manager from the Nursing Home.

The Review Panel have benefited from the willingness of individuals interviewed to contribute towards this process. Their openness and commitment to wanting to do the best in difficult circumstances was appreciated.

This Serious Case Review was commissioned prior to the implementation of the Care Act 2014, which as from the 1st April 2015, places a responsibility for Safeguarding Adults Reviews, (Section 44 Care Act 2014).

This Serious Case Review provides a synopsis of the most significant involvements and practice episodes, the factors that influenced the work of professionals at that time and what these practice episodes show us about health and social care systems and processes at that time.

## 3. Limitations

The review of the records threw up the possibility of exploring other areas of practice and often raised more questions about Mr W's circumstances than there were answers, however it was not always easy to access all the records in a timely fashion nor was it seen as the best use of resources to pursue all these avenues, so the Review Panel agreed which issues to prioritise.

Some of the face to face interviews identified that there were other records which gave more detail than was shown in the combined chronologies, this caused further delays from having to request additional records, but did help to provide a

fuller picture of input and outcomes. This has highlighted the need to be clear with agencies at the outset about the amount of detailed records required to support the Serious Case Review.

There were problems with arranging the face to face interviews with dates having to be rearranged to accommodate availability and some interviewees not turning up for interviews, which then needed to be rearranged. There seemed to be a lack of understanding as to the nature of a SCR and an understanding of the need for the face to face interviews. Whilst letters did go out to all agencies and interviewees perhaps more thought needs to be given as to the expectations upon agencies to engage with the Serious Case Review process.

Some Interviewees did not return their notes from their interviews, despite requests.

The review panel were hampered by considerable delays in accessing Healthcare Records from the Trust and despite repeated requests from the start of the Review, this information was not forthcoming, the week before the Serious Case Review Report was due, the In-patient notes were made available, which meant that there was limited opportunity for Reviewers and the Report writer to analyse this information. Given the amount of information the deadline was extended to allow any learning to be incorporated into the Serious Case Review.

Whilst Hospital records were finally made available, other records were still not made available e.g. Mental Health Records and District Nursing Records. The absence of these records did hamper the Review process, leaving significant gaps in knowledge about the mental health and district nursing services received by Mr W. The Review Panel could only summarise on the interventions provided by these services and can just pose questions of these agencies for them to reflect on and learn.

The NHS Trust representative on the Panel was unable to attend any of the Panel Meetings and had left their post before the end of the Review. The Review Group therefore lacked the specialist in-patient knowledge to be able to contribute to the Serious Case Review and assist with the analysis of the in patient records.

The Report Writer was commissioned to undertake this work during a 3 month period mid to end of 2014. The limitations referred to resulted in delays which pushed the work into spring 2015, with the Report Writer having other commitments which impacted upon further delays.

The Chair of the Review Panel left the Council to take a new post before the Review Report was completed. The Chair was very considerate and agreed to continue for a period, but it was not clear whether the Board or the Serious Case Review Sub Group were aware of this and aware of when the Chair ceased this function. The Review Panel were at a Review Meeting waiting for the Chair unaware that by this point the Chair was no longer fulfilling this role.

Not all Review Panel members were able to attend the Review meetings. In particular the NHS Trust Representative was unable to attend any of the Review Meetings, which is unfortunate as their contribution would have been very valuable.

In summary there was a lack of commitment and accountability from some agencies to this process, a lack of understanding about the process and the information sharing requirements which hindered the timeliness of this process.

**4. Role of the Board**

**Whilst the Serious Case Review was commissioned prior to the Care Act Statutory Duties the Board now needs to reflect on the learning from this Serious Case Review, in respect of its current duties under Section 44 of the Care Act 2014**: An Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) Identifying the lessons to be learnt from the adult's case, and

(b) Applying those lessons to future cases.

**Section 45 of the Care Act 2014: Supply of information**

(1) If a Safeguarding Adults Board requests a person to supply information to it, or to some other person specified in the request, the person to whom the request is made must comply with the request if—

(a)conditions 1 and 2 are met, and

(b) Condition 3 or 4 is met.

(2) Condition 1 is that the request is made for the purpose of enabling or assisting the SAB to exercise its functions.

(3) Condition 2 is that the request is made to a person whose functions or activities the Safeguarding Adults Board considers to be such that the person is likely to have information relevant to the exercise of a function by the Safeguarding Adults Board.

(4) Condition 3 is that the information relates to—

(a)the person to whom the request is made,

(b) A function or activity of that person, or

(c) A person in respect of whom that person exercises a function or engages in an activity.

(5) Condition 4 is that the information—

(a) Is information requested by the Safeguarding Adults Board from a person to whom information was supplied in compliance with another request under this section, and

(b) is the same as, or is derived from, information so supplied.

(6) Information may be used by the Safeguarding Adults Board, or other person to whom it is supplied under subsection (1), only for the purpose of enabling or assisting the Safeguarding Adults Board to exercise its functions.

## 5. Key Practice Episodes

The Review Panel have identified from the interviews and the combined chronologies key practice episodes during Mr W's journey through services.

The records have been read and evaluated with reference to contributory factors and related questions.

### A. Police

**26 March 2007, 7 October 2007, 17 April 2013 and 29 April 2013**

The Police contact with Mr W in 2007 was during the period in which his sister was alive. The latter contact was after his sister had died. On all 4 occasions the Police are concerned about his confusion.

| **Judgement of Practice** | **Contributory factors and related questions** |
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| **26 March 2007**, Mr W (who was not at that time ordinarily resident on the Island), but was in the process of buying a flat on the Island.<br><br>Mr W reported an alleged theft of money and bank cards, whilst out shopping with his sister, Police reports stated that he was with his sister at the time. The money was subsequently found in the pocket of a coat, the Police '*concluded that this was a genuine mistake by an elderly victim who was clearly confused regarding the circumstances*'. | Whilst the Police commented that Mr W was '*clearly confused*' he may not have been seen as a vulnerable adult and therefore would not have triggered a CA12. |
| **7 October 20012** – Mr W comes to the attention of the Police again, alleging theft of £200 by his brother in law.<br><br>He reported that his sister had recently died and since her death his brother in law was staying with him and he had recently left to return to his own home. | The Police complete a CA12 and sent it to Adult Services.<br><br>Adult Services phoned the Community Psychiatric Nurse to ask if Mr W needed a social care assessment. The Community Psychiatric Nurse advised that Mr W was known to mental health services due to low mood and they |

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| The Police follow up on the alleged theft and following contact with the brother in law, the money was found in Mr W property.<br><br>Police note that Mr W seems confused, disoriented and appeared drunk, although he said that he did not drink.<br><br>Mr W informed the Police that he did not want to be here anymore, he then turned the gas on without lighting it. Mr W stated that he had not eaten for several days, contact with his brother in law who had recently visited, stated that he had thrown a lot of out of date food away and had given the flat a good clean.<br><br>The Police contacted Mental Health Services to request a visit, they found out that Mr W had recently disengaged from Mental Health Home Treatment Services. Mental Health Services had no staff available for a home visit but a referral was made to the Community Psychiatric Nurse to request a home visit the next day.<br><br>The Police Officer in attendance was supportive to Mr W and made sure he could light his fire and helped him microwave some food and ensured that the flat was secure. | were continuing to work with him. Case was then closed to First Response Adult Services.<br>It would seem reasonable that First Response, having contacted the Community Psychiatric Nurse, would accept the professional view that Mr W did not need a Social Care Assessment.<br><br>Due to the absence of Mental Health Records it is not known whether the Community Psychiatric Nurse did a follow up visit as requested after the incident on the 7 October 2012.<br><br>There is no record in the Adult Services records that the Community Psychiatric Nurse ever liaised with Adult Services and or referred Mr W for a Social Care Assessment.<br><br>The lack of integrated notes would have hindered any practitioner's ability to work holistically with an adult at risk.<br><br>Discussions with Adult Services Practitioners would suggest that there is a flag on the electronic system that would indicate mental Health involvement. |
| **17 April 2013** the Police attended following a cooking fire at Mr W's flat, he was described as aggressive to the ambulance staff, but Police were able to persuade Mr W to leave his flat. | There is no record that on this occasion that this incident triggered a CA12.<br><br>Given Police previous involvement with Mr W and their concerns about his vulnerability should a CA12 have been completed and sent to Adult Services? |
| **29 April 2013** the Police Community Support Officer who visited Mr W following his phone call, was concerned for Mr W welfare and | A CA12 was sent to the Central Referral Unit and to Adult Services who received it on 30th April 2013. |

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| described him as agitated and confused. He was talking about his sister's death, '*appeared agitated and confused and believes the Korean war was still ongoing*'.<br><br>The Police Community Support Officer identified that he had Reablement Service Carers going in, they also contacted the GP who agreed to carry out a home visit. | The records do not show any action taken from Adult Services following receipt of the CA12.<br><br>Why did this intelligence against the back drop of the previous CA12's trigger social care contact with Mr W?<br><br>What systems were in place to assess all CA12's when they are received by the CRU and Adult Services?<br><br>CA12's provide useful intelligence about the lives of vulnerable adults in our communities. They can be viewed by Adult Services as an additional workload pressure and as such can impact upon the way in which they managed. Information from emergency services, e.g. Police, Fire and Ambulance would benefit for a system that not only records these accurately but analyses this community intelligence in a meaningful way. |

**Review of Practice**

The Police took all appropriate action including checking that Mr W's immediate welfare needs were being met and sent a CA12 to Adult Services.

CA12's are a valuable tool, used by the Police to alert Adult Services and Community Mental Health Teams about adults who may be deemed to be at risk in the community and enables the agencies to carry out cross checks to see if the adult is known and or is in need of a community care response. They can be hampered by limited information available on the CA12 and will sometimes require a follow up call to the Police to see if they have more information. In this case the records would indicate that good information was provided on this CA12 with a call also to Mental Health Services.

CA12's are also used by the Police to raise an adult safeguarding alert, although it is not always clear in the records if the Officer is identifying the adult as being an adult at risk of abuse or an adult causing harm. It is also not clear whether the Police have tried to seek the adults consent to share this information with Adult Services.

A series of CA12's about the same person should trigger an escalation of concerns and any patterns should be risk assessed by Adult Services and cross checks

undertaken with other Emergency Services to determine if any of the following are needed for example, referral to other agency, advice and information, wellbeing assessment, safeguarding concern, Section 42 Enquiry or no further action.

## B. Mental Health Services

During 2012 records would indicate that Mr W was receiving a service from NHS Adult Mental Health Services and was reported to have 'disengaged from Home Treatment Time' and was open to a Care Co-ordinator from Mental Health Services.

**The absence of these records, despite requests has made it impossible for the Review Panel to identify any examples of good practice, missed opportunities or lessons learnt.**

**The records below has been gained from GP records and the GP interview.**

| **Judgement of Practice** | **Contributory factors and related questions** |
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| **31 August 2012** Mr W's GP referred him to the MHATS Team because he was threatening to kill himself, saying he had nothing to live for, saying he is a trained killer, as he is ex-military and he could jump off a cliff. He was also reported not to have eaten for 3 days. | What physical and mental health assessments were considered/undertaken?<br><br>What risk assessment were undertaken in respect of risk of suicide? |
| **8 October 2012** an email was sent to the mental health worker by the safeguarding team to advice as to the content of the CA12 and to request a visit to assess Mr W's needs and risks and in particular an assessment of his safety needs. | Was this undertaken and if so why was this assessment not shared back to safeguarding team? |

### Review of Practice

The GP had contact with Mr W when his sister was alive and when he came to the surgery he would always come with his sister and she did seem to play an important part in his life and she would oversee aspects of his healthcare. Mr W was a patient in a small practice at that time where all patients were known by staff, it was very much a community practice. His GP knew Mr W well and described him as a nice man, who could be quite secretive and was very proud. He also had private healthcare and they would regularly follow him up.

The GP was concerned about his mental health following the death of his sister and referred him to mental health services. He said he was lonely, he was offered

services, but frequently told his GP that he did not want any help and was very reluctant to pay for any services. The GP stated that Mr W was visited at home by a mental health professional and there were no specific acute mental health concerns. He was prescribed anti-depressants.

Whilst the GP referred to mental health services and was not aware of any acute concerns, the absence of mental health records leaves gaps, given that the GP was aware that he had been seen by a Consultant Psychiatrist and was receiving home visits from a Community Psychiatric Nurse and had made suicide threats.

The mental health notes, despite frequent requests, were never made available to the review panel. The records would suggest that at the time of the safeguarding concerns being raised by the Police, via a CA12, that Mr W was open to mental health services, therefore this team should have taken responsibility for the safeguarding investigations (in line with safeguarding procedures at that time).

The level of awareness and understanding of adult safeguarding was poor within this service, this is reflected in the number of alerts being raised by mental health services (both in-patient and community) and was below the national average for this sector. Whilst there has been some increased awareness in this sector, this is still an area of concern.

### C. Ambulance

**January 2013 – August 2013**

During this period Mr W had 2 call-outs from the Ambulance Services one of which resulted in a referral to Island Doctor On Call Service and the latter an admission to hospital.

After the first admission Mr W was in contact regularly with the GP Practice. The main areas of concern his mental health and his skin condition, which was recorded as Eczema which Mr W described as very itchy as was on his arms, thighs and scalp to which medication was prescribed.

The last contact the Ambulance Service had with Mr W was the call out to the Nursing Home, query Sepsis and he was admitted to hospital.

| **Judgement of Practice** | **Contributory factors and related questions** |
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| The first Ambulance call out did check with Mr W if he needed help at home, where he stated that he manages at home and had previously declined care at home.<br><br>The Ambulance Service did refer to Island Doctor On Call Service on the 5 | It is not clear from the records who he declined care at home from. |

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| January 2013 | |
| Following the Ambulance call out Mr W had 6 contacts from the GP Practice between **7 January 2013 and 30 January 2013** all in relation to his skin condition and treatment. | Records would suggest that at this time Mr W was able to make contact with his GP Practice and ask for visits/medication. |
| Records show that GP did ask Mr W about help at home, Mr W stated that he had help at home. | Did the GP have concerns about Mr W ability to cope at home and if so should information have been shared between Ambulance and GP Practice?<br><br>Was there any evidence that he was receiving help at home?<br><br>Would these concerns have triggered the need to share information with Adult Services? |
| **9 April 2013** – the GP did speak to Mr W about having help at home and suggested a referral to Social Services. Mr W stated he would call if he needed help. | Where there are concerns about an adult living alone and their ability to care for themselves, should there be a mechanism for sharing of information between agencies?<br>Where there are concerns about adults at risk in the community should this be shared with Safety Net?<br><br>Is Safety Net fully utilised and fully accessible? |
| **17 April 2013** – A cooking fire occurred in Mr W flat, Fire Service attended followed by Ambulance and then Police. The Police were able to talk Mr W out of his flat, he was aggressive towards the Ambulance crew and was refusing to leave his flat. | Following the fire would Mr W have benefited from a free Fire Home Safety Check as he may well have met their criteria for this?<br><br>Where there are concerns for the welfare of older people, particularly living alone, with health problems and fire risks, should this information be shared between agencies?<br><br>What risk assessments are undertaken by agencies?<br><br>Should/do agencies do their own risk |

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| Ambulance service note ulcerated left leg with cellulitis. | assessments and should they/do they inform decisions to share information and/or intervene?<br><br>Would agencies benefit from a single risk assessment framework where there are concerns about adults abilities to self-care in the community?<br><br>Would agencies benefit from a generic self-neglect risk assessment tool?<br><br>Was Mr W being seen regularly by the District Nursing service at this time? Were they aware of his cellulitis and leg ulcer? |
| Mr W did inform the Ambulance crew that he was not coping at home and wanted help. The Ambulance crew informed Accident and Emergency of this. | Should this information have been an automatic trigger for the Ambulance Service to share this information to Adult Services? |
| The Accident and Emergency Admission notes record that Mr W informed ambulance crew that he was not coping at home. | What mechanisms are in place or need to be to ensure that information shared with one agency is transferred to other agencies that need to know? |
| Mr W consented for treatment and was admitted to Accident and Emergency on the **17 April 2013.** | |
| **15 August 2013** Mr W was admitted from the Nursing Home into hospital with query Sepsis. | Given the circumstances of the concerns about Mr W's pressure wounds, should this have been enough for the Ambulance Service to have raised a safeguarding concern (alert) to Adult Services? |

**Review of Practice**

There were a number of areas where practice was good, for example the fire, police and ambulance services did share their concerns, however to maximise joint working between agencies it may be beneficial to review the joint information sharing protocol and the training strategies of these particular agencies to ensure that they have enough of an awareness of safeguarding concerns, the mental capacity act and in particular recognition and reporting of concerns of self-neglect and how to raise alerts and who to report to.

## D. Hospital

| **17 April 2013 - 17 August 2013**<br>Mr W was admitted to hospital following the cooking fire in his flat. He had smoke inhalation, legs and arms swollen, red and itchy. Cellulitis, lymphedema, hypoproteinemia, scabies.<br><br>Mr W was subsequently admitted into Hospital from the Nursing Home with pressure wounds. | |
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| **Judgement of Practice** | **Contributory factors and related questions** |
| When interviewed the Hospital Social Worker was not fully aware of the circumstances of Mr W's admission and his involvement with Mental Health Services. | What systems and processes are in place to ensure that information related to a patient is shared/accessible to all professionals involved in the patients care? |
| Hospital records note that Mr W was involved with Mental Health Services regarding concerns about his cognitive ability and a referral was made to the Dementia Liaison Nurse. | Would it have been helpful for the Ward and the Social Worker to have requested access to Mr W's Mental Health records?<br>No records to show that Mr W was seen by the Dementia Liaison Nurse.<br><br>This was this a missed opportunity to have assessed his cognition and capacity to make decisions and assess his social and health care needs. |
| Nursing notes during his admission on the **17 April 2013,** state that Mr W was: mobile and able to meet his personal care needs.<br>• History of falls<br>• eating and drinking without | |

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| assistance<br>• there were occasions when he was found wandering and appeared disoriented<br>• Described as wanting to be independent<br>• Cellulitis but no broken skin area. | |
| The Hospital Social Worker referred Mr W for an Occupational Therapy assessment as he had reported having falls at home and was using towels on the floor in the bathroom at the hospital to prevent himself from falling.<br><br>Mr W was seen by an Occupational Therapist before discharge but was reluctant to have any support at home and unwilling to pay for services. He was known to live in a first floor flat with two flights of stairs.<br><br>Mr W talked of feeling lonely and unable to cope at home and sometimes forgets to take his medication. He talked about strangers in his flat. | Where patients show some confusion, with some history of concerns about their mental ill health, bereavement, forgetfulness, falls, allegations of assaults and thefts, (not proven) fire risks, reluctance to engage and with comments about an inability to cope at home, feeling lonely and with physical health problems, this should trigger a more holistic health and social care assessment, including mental health and mental capacity assessments. |
| **24 April 2013** Mr W alleges that he was assaulted prior to hospital admission. | Whilst this was recorded in the clinical notes but there is no record that this was reported to Adult Services as a safeguarding concern.<br><br>It is difficult to understand how such a straightforward report of an alleged assault could be ignored and not reported to Adult Safeguarding? |
| **15 August 2013** Mr W is admitted into Hospital via Ambulance from the Nursing Home, query Sepsis, breathing problems and pressure sores on buttocks, Grade 3 on Sacrum noted.<br><br>MRSA Test undertaken. | Despite his involvement with agencies the hospital had limited knowledge of his care/treatment at home, or his time in the residential care home.<br><br>Some of the medical records are undated.<br><br>The records are all handwritten and |

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| | some are extremely difficult to read<br>No record in Hospital records of outcome. |

**Review of Practice**

Mr W tried to maintain his independence whilst in hospital and would often refuse assistance with personal care. He was having difficulties at times, with his mobility and problems managing his bowels. Assessments with the Occupational Therapist and the Social Worker, indicate that Mr W would not accept most of the services offer and he was unwilling to pay for services. He reluctantly agreed to accept a Reablement Services, which he did not have to pay for.

The pressure on staff to discharge patients could have impacted upon a lack of good quality assessment of his health and social care needs and on following up of the referral to the Dementia Liaison Nurse, which never took place.

Despite frequent requests the review panel were not provided with the in-patient records. This needed to be escalated to the Chair of Safeguarding Adults Board before the records were made available, only arriving 2 weeks before the conclusion of the report, allowing limited time to fully analysis the information. The records provided were in some instances lacking dates and signatures and in some instances very difficult to read. The main themes arising from these records were that Mr W received good quality of care, but that there were missed opportunities to have: raised safeguarding concerns, requested assessments re possible dementia or other causes of memory loss.

**E. Adult Services (Hospital Social Work and First Response)**

**7 October 2012 – 17 August 2013**

Mr W first becomes known to Adults Services when the Police raised a concern via a CA12, regarding his welfare on the 7 October 2012, on the 9 November 2012 contact is made to the Community Psychiatric Nurse to ask if Mr W needs a Social are Assessment.

Mr W's case was then closed to Adult Services, First Response when the Community Psychiatric Nurse advised that this was not needed.

Case records show regular recordings from Adult Social Care from **April 2013** until his death on the **17 August 2013.** During which time he is assessed by Hospital Social Worker, Reablement Services and First Response.

| **Judgement of Practice** | **Contributory factors and related questions** |
|---|---|
| Hospital records note that Mr W was involved with Mental Health Services regarding concerns about his cognitive ability.<br><br>The records do not show that any checks were made by the Hospital Social Worker with Mental Health Services. The electronic records do show that mental health services had been involved but the Social Worker did not pick this up as part of their initial assessment.<br><br>Discussions and records would suggest that some of the known information and risks in relation to Mr W were not fully shared with the Hospital Social Worker, nor is there any evidence of attempts to access records.<br><br>The Social Worker did not take into account his past history as this was not known by the Social Worker and the records that the Social Worker did have access to did not contain this information. | During that time there was a fast turnover of patients and the Social Worker at that time had undertaken over 300 assessments over the year.<br><br>The Social Worker was newly qualified and in their assessed year in practice and talked about the pressure of the workload at that time and still today.<br><br>Social Workers in their assessed year in practice should have protected caseloads and regular supervision and support. The Social Worker had discussed and recorded in their supervision concerns about their caseload, pressures to discharge patients and the long hours worked to cover all of the assessments. |
| The Social Worker was able to engage with Mr W whilst on the ward and described Mr W as a very private man who was reluctant to have services if he had to pay for them. | The Social Worker acknowledged that it was difficult to properly assess patients in the Medical Assessment Unit and difficult to access past information to inform the assessment due to the fast turnover of patients on this ward. |
| Case recordings were not robust. | The Social Worker was concerned about the quality of case recording due to pressure of work and time constraints, this concern was raised by the Social Worker in their Supervision with their Line Manager. |
| In **April 2013** the Hospital Social Work | Forms are now in place to flag patients |

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| Team did not have a formal system for flagging patients although Mr W was referred to the Social Work Team by the Ward. | that may need support and a form which states when they are fit for discharge. |
| The Hospital Social Worker did refer Mr W for an Occupational Therapy assessment as he had reported having falls at home, he was using towels on the floor in the bathroom at the hospital to prevent himself from falling.<br><br>Records indicate that Mr W was seen by an Occupational Therapist, before being discharged, but he was reluctant to have any support at home. | He was known to live in a first floor flat with two flights of stairs. |
| The Social Worker said that they had no reason to be concerned about Mr W capacity to make decisions about his care and support needs at home.<br><br>The Hospital Social Worker recalls that Mr W talked about his sister, who had died. | With the benefit of hindsight, If the Social Worker had been aware of Mr W's previous history, this should have triggered a more detailed assessment of his need and risks, plus a focus on more specific decision making questions in respect of ability to care for himself at home, insight into the fire hazards, his physical health care needs and his reluctance to accept services, plus liaison with mental health services to ascertain any underlying mental ill health? |
| There are records that state that Mr W was reluctant to pay for services. Having a Lifeline fitted was discussed with him but he refused as he did not want to pay. | The impression gained from the Social Worker from the Hospital was that it was not possible to undertake good assessments due to lack of time, not enough Social Workers and difficulties in accessing patient record.<br><br>If all the risks were known at the time of the assessment, consideration could have been given to escalating concerns to line management for consideration to waive the fee for any assessed eligible services due to the presenting risks.<br><br>The hospital Social Work assessment did not reach the Carers from the |

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| | Reablement Service which meant that the Carers knew very little about Mr W and his needs when they started his service.<br><br>During the interviews with the Carers, they stated this this was common practice at that time. |
| The Hospital Social Worker contacted Action on Hearing Loss as Mr W was hard of hearing, as there were concerns that he may not hear his own door bell. | There is no record that this visit took place and no record that this was followed up during the first review of his care.<br><br>It would seem that information sharing between agencies was poor and when actions were agreed there was no clear process of follow up and sharing of further concerns.<br><br>The Social Worker was hampered by a lack of information about the circumstances of Mr W's admission and his health care needs prior to admission. Alongside work pressures and time constraints which impacted upon the Social Workers ability to carry out a thorough assessment.<br><br>The Social Worker was concerned that there are still unacceptable pressures, with staff working after 5pm and sometimes until 9pm and things can be missed.<br><br>Information from the GP was not routinely gathered prior to any assessment of a patient who has needs for care and support. |
| Whilst in Hospital Mr W recounted to the Social Worker that he had been mugged and £500 had be stolen. | There is no record of a safeguarding concern being raised. This was a further missed opportunity to have looked more carefully at the safeguarding needs of Mr W. |

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| Mr W recalled his sister's death in 2012 but could not recall the reasons for his hospital admission. | Was this a further trigger to have assessed Mr W capacity and explored further any other contributory factors?<br><br>How well trained are Hospital staff to the possible indicators that could affect a person's capacity to make decisions and to recognise indicators or early dementia? |
| The Social Worker described patients with dementia being moved at night.<br><br>The Social Worker has raised concerns about this practice with Managers. | Were these moves made with reference to patients' rights in accordance with the Mental Capacity Act 2005?<br><br>Should Safeguarding Alerts have been raised by the Social Worker/s who were aware of this practice? |
| The Social Worker referred Mr W to the Reablement Service, to help him regain his independence at home. The Social Worker referred to Sound Advice. | No evidence that this referral was followed up. |
| **24 April 2013** Mr W Niece phones to raise concerns about her Uncle, as he was refusing care and the neighbours were going away. | The contact with the Niece could have been an opportunity to have gathered more background information about Mr W, family members can often provide additional insights. |
| Reablement was to start on the **26 April 2013,** 1 call per day, 30 mins for 4 days and 45mins for 3 days.<br><br>Once discharged from hospital Mr W was transferred to Adult Services First Response who undertake a 6 week review. | |
| **26 April 2013** the Reablement Carer calls First Response to report difficulties | At the point in which Mr W was discharged there were already |

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| in gaining access to Mr W flat, Mr W refusing personal care and only wanting housework and shopping. Between the end of **April 2013** and June **2013** there are regular reports of ongoing concerns regarding Mr W Welfare.<br><br>As concerns increase attempts are made to escalate concerns to Reablement Manager, Senior Practitioner First Response and latterly to Service Manager for Reablement. | indicators that Mr W was resistant to services being provided, he was requesting different services, there were concerns about decline in physical health care, concerns about alcohol consumption, confusion, grieving over the loss of his sister, smelly and dirty leg dressings, not eating properly, with the concerns regarding his leg dressings being raised with the District Nurses and GP.<br><br>None of the above concerns triggered a reassessment of his needs.<br><br>The records also raise safeguarding concerns, reports that the neighbours only want his money.<br><br>Mr W reported paying them £50 per week to do his dinner and washing. No Safeguarding Alert was raised with the Safeguarding Team. |
| **1 and 2 May 2013** the Reablement Senior sent emails to the Social Worker at First Response, raising concerns about Mr W and referring the Social Worker to the Profile notes made by their service.<br><br>Both District Nurses and Reablement Carers described the difficulties in getting through to First Response on the phone. | The records show that a request was made to First Response for a reassessment of Mr W needs.<br><br>At the time the case load of Social Workers in First Response was between 50 – 60 clients. The Social Worker said that there was not enough time to give to each client, the Worker described this as very difficult to deal with.<br><br>The worker described how difficult it was to find the time to read all records and even if they were read there was no time to reflect and make sense of the records and decide if any action was needed.<br><br>Current practice has now improved, due to an increase in staff at First Response and a different system in place for referrals coming in. |

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| | Caseloads are less, an average of 30 cases per worker. |
| **4 June 2013** the First Response Social Care Officer contacts Mr W Niece to advise that Mr W is refusing care and that the Reablement Service would be ceasing.<br><br>There were discussions about how he would manage, his Niece agreed to talk to Mr W brother in law as he appears to be the only person Mr W will listen to. | There is no record that the Niece got back to the Social Care Officer and no record that the Social Care Officer followed this up.<br><br>This may have been another point for a reassessment of needs and risks and an assessment of Mr W's decision making, Whilst capacity must be assumed, if an adult is refusing such essential care and support along with the presenting risks being highlighted by the Reablement staff, evidence of Principle 2 of the Mental Capacity Act should be applied to ensure that Mr W had access to advise and information to enable him to make informed decisions about his health and social care needs, this may have also moved onto an assessment of his decision making, exploring insight and ability to execute decisions. |
| **4 June to 11 July 2013** there are Profile Notes recorded by Reablement, highlighting ongoing concerns. | No record of any response to these concerns from First Response.<br><br>In the face to face interview, the Social Care Officer acknowledged that whilst Profile Notes are read there is not always time to respond to them.<br><br>It was assumed that if the Reablement staff were referring health related concerns to the District Nurses, then they would be responding. Without the District Nurse records it is impossible to make any comment.<br><br>The Social Care Officer was aware that external professionals at that time did report that it was difficult to get through on the phone to First Response so emails and case recording we relied upon to flag issues. |

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| **11 July 2013** profile notes records emails being sent to Social Worker at First Response by the Reablement Service, referring to concerns and profile notes. | No record of any response from First Response to these emails. |
| **16 July 2013 t**elephone call from District Nurse Manager raising concerns about Mr W; his heating had been on full for 3 weeks, (during hot weather) it was very hot in his flat and Nurses visiting Mr W were very concerned and distressed as to his general wellbeing. | No records were made available, to have examined the input and reflected upon the concerns that the District Nurse staff were raising with their Manager.<br><br>The First Response Social Care Officer reacted quickly to this call and visited Mr W later that day with the District Nurse Manager. |
| **16 July 2013 –** Home visit by First Responses Social Care Officer.<br><br>The Social Care Officer made good engagement with Mr W, despite at times his annoyance that the Social Worker was there.<br><br>The assessment visited highlighted the following areas of need:<br>Excessive heat in the flat<br>Complaining of being hungry<br>Little food in the flat<br>Floor covered in dead skin<br>*'Reminesencing about his family, his childhood and his time in the Marines and how easy it was to kill someone'*.<br>The Social Care Officer looked in his Care Diary record and apart from a mention of the heat in the flat there was no record of any other concerns. | This would probably have been a difficult visit for the Social Care Officer, given Mr W presentation and his demonstrations of how to kill someone whilst waving a knife in the air.<br><br>Discussions with Mr W were had about the cost of care and Mr W continued to indicate that he was not prepared to pay.<br><br>What assessment was made of his wish to die, his talk about the past and the risk to himself in terms of self-harm and/self-neglect? |
| **17 July 2013 –** A GP visited agreed to secure a GP bed in a Respite Service | |

**Review of Practice**

The Hospital Social Worker described the considerable pressures upon the Social Work Team to discharge patients, assessments are done with little or no ability to assess the home circumstances, problems accessing all relevant records to help inform the assessment, with staff working long hours to keep up with the work. The Social Worker raised concerns within supervision about the work pressures and the impact this was having on the quality of assessments.

Mr W left no doubt in the mind of the Hospital Social Worker that he did not want any help at home and that he was reluctant to pay for any services.

It is important to respect the wishes of an adult and their right to make their own decisions. **(Principle 1 of the Mental Capacity Act 2005) but** where there are concerns about an adults wellbeing then reasonable steps should be taken to share with the adult any reasons for concern about their ability to meet their own care and support needs. **(Principle 2 of the Mental Capacity Act 2005.)**

There is no evidence in the records that any questions were asked about Mr W capacity to make decisions are about health care and personal care needs. Due to the absence of mental health records it is not clear why Mr W was referred to mental health services but there are some records that refer to depression following bereavement.

Records do indicate that Mr W did not always remember to take his medication, he was having falls at home and not eating regularly. Hospital records indicate that he was wandering on the ward. When the Social Worker talked to him about the reasons for his admission he had no recollection of the circumstances surrounding his admission. The Social Care Assessment was limited with no evidence of a risk assessment.

Judgments seem to have been made that it was not necessary to assess Mr W's capacity regarding the risks at home. The presenting risks should have been considered and shared with Mr W to help him to understand the risks and explore his decision making. The risks to Mr W in going home were not assessed or recorded. This assessment would have been used to have informed the engagement of the Reablement Services and any actions/reviews by First Response.

The systems in place for recording and ensuring that all relevant professionals can access these records seemed inadequate.

All professionals involved with Mr W believed him to be highly resistant to professionals coming to his home or trying to support him at home. He left no-one in any doubt that he did not want their help. The prevailing beliefs amongst professionals was that Mr W did not want their help; that they could not force it on

him, this does appear to be one of the factors that influenced the decision for Reablement Services to end their involvement. Although one of the Reablement Workers felt that Mr W did want help, but it was with shopping and cleaning, this worker recorded this on several occasions and fed this back to their line manager. Despite Mr W repeatedly asking for help with shopping and cleaning no assessment was forthcoming. His reluctance to pay for service was not explored with him and no evidence that any risk assessment was undertaken to inform any decisions as to the need to consider a referral to voluntary sector services or waive of charges for services.

Staff involved with Mr W seemed to perceive that having raised their concerns about Mr W they had nowhere else to go in terms of their involvement. There seems to be a lack of any service to work with vulnerable people like Mr W who require a long term softly, skilfully negotiated approach and whilst this would sit with the role of social workers, they do not have nor are they given the time to undertake this kind of engagement work.

Within the multi-agency context, health and social care were unable to take ownership and responsibility to produce workable solutions for Mr W, with a common reaction being to refer Mr W to someone-else, in hope that they would be able to take on responsibility and follow up on concerns. Within Adult Social Care there seemed to be a reliance on emails and the assumption that case records will trigger a response, there seemed to be no other methods used to escalate the concerns.

## F. Adult Social Care Reablement Services

**25th April 2013 – 21st May 2013**

Mr W is discharged from hospital. His niece was made aware of the support being provided via Reablement Service, 7 morning per week to support with personal care.

During this period there are daily records which refer to concerns about Mr W:

- Refusing personal care
- Repeatedly asking for help with shopping and cleaning
- Low mood
- Sleeping in chair
- Aggressive
- Alleging that volunteers were taking his possessions
- Appeared confused
- Drinking lots of alcohol
- Grieving over his sister
- Low in mood
- Alleged that neighbours only want his money

Carers were not always aware whether District Nurses were visiting and when.

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| Carers referred their concerns to their Senior Reablement Worker.<br><br>Because Mr W was continuing to refuse Reablement, carers began to feel that he no longer needed Reablement services and would be best referred for a Homecare service. | |
| **Judgements of Practice** | **Contributory Factors and related Questions** |
| **26th April 2013** Mr W receives his first visit from Reablement. The worker had problems accessing the property as Mr W could not hear the doorbell.<br><br>Discharge Plan indicated that he had been referred to Action on Hearing Loss.<br><br>The carer records that Mr W was refusing personal care and not dressing. | No record that he received any contact from Action on Hearing Loss. If this was in his support plan who was responsible for following this up?<br>Was Mr W made aware of the nature of the Reablement support, records would suggest that it was discussed with him, but he had a different expectation as to the service he should have received, he thought that he was supposed to be getting help with shopping and housework.<br><br>Should the Reablement Service have referred Mr W to First Response for a reassessment of need given that he was expressing different needs and was refusing the personal care and the carers were already expressing concerns about Mr W ability to care for himself? |
| The GP visits to see Mr W at home, indicate that there were no particular cause for concern.<br><br>The GP during visits and phone contact with Mr W found him to be alert and his conditions seemed to be being managed, and expressed no concerns for his welfare. | The GP was unaware of the concerns being raised by the Reablement Carers and unaware that the carers were contacting the District Nursing service to express their concerns about the condition of his legs, so the GP visits were occurring in isolation of the bigger picture.<br><br>Communication between the DN service, the Reablement Service and the GP was poor and even when there was communication the concerns did not to escalate into any action.<br><br>A joint review discussions or meeting between services would have helped to |

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| | have shared concerns and perceptions about risks.<br><br>People are most likely to improve if they are willing and enthusiastic about Reablement, Mr W did not seem to want the service offered, and he repeatedly asked for help with shopping and cleaning and although this was recorded by the carers there is no evidence that this triggered any action/decision, i.e. there was no reassessment of needs and risks and no assessment of his capacity to make the decision about refusing care. |
| **April, May and June 2013** the Reablement carers continue to record on Profile Notes concerns about Mr W and these are raised with Reablement Management, they also report Mr W continues to request help with shopping, cleaning and housework.<br><br>The concerns were escalated by the carers to their line management verbally and in an email and on one occasion a senior Reablement worker visited Mr W but did not recommend or undertake any action other than Mr W case should be closed to Reablement. | There is evidence of this from the Social Care Records, but although carers were recording their concerns there is little evidence that these were being read by anyone and/or acted upon.<br><br>Despite this visit the concerns were not escalated and action requested.<br><br>Where there are multiple agencies visiting this could have given workers cause to believe that everything is being done to support the person and that the risks are being managed.<br><br>There is no evidence in the records seen and the interviews undertaken that any risk assessment was undertaken and no approach in place to undertake a multi-agency risk assessment.<br><br>The co-ordinating agency were Adult Services but no contact was made with Mr W by Adult Services, First Response Social Worker until June 2013. |
| **1st May 2013** continued concerns being recorded by Reablement carers, concerns about his welfare and he was described Mr W as aggressive at times. | The pattern of case recording suggest that it was usual practice to record visits and any concerns in SWIFT, however there was little evidence in the records that concerns were responded to by those |

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| | who may be reading them and little evidence that any other system was used to escalate concerns.<br><br>Did workers assume that by recording their concerns that someone else would read and respond? |
| **1st and 2nd May 2013** Reablement Senior sent emails to the Social Worker at First Response raising concerns about Mr W and referring the Social Worker to the Profile notes.<br><br>Both District Nurses and Reablement Carers described the difficulties in getting through to First Response on the phone. | The adult social care electronic records show no evidence that the records were read/acted upon. |
| | Senior management should be aware of the risks if staffing numbers decrease and the impact upon practice. |
| **2nd May - 7th May 2013** Reablement carers raise further concerns and record in the records, report to senior carer and contact the District Nurses. | All these factors and the previous concerns of a similar nature should have raised a concern and triggered an assessment visit from a social worker from First Response.<br><br>Given that Mr W had been known to mental health services and current concerns about his confused and at times aggressive behaviour should this have been shared with the GP?<br><br>No evidence of a safeguarding concern being raised.<br><br>The Social Worker in First Response read the notes and their interpretation was that the District Nursing Service was responding and addressing the concerns about Mr W's healthcare needs. |

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| | The Social Worker was aware that the Reablement Service was having regular meetings with a Senior Social Work practitioner, so their view was that any concerns about Mr W would have been shared at these regular meetings.<br><br>The Social Worker could only recall discussing Mr W once within her supervision with the Senior Practitioner but could not recall the nature of the discussions. |
| Mr W received care from a number of different carers, one carer in particular seems to have developed a closer relationship with Mr W and had developed a good rapport with him.<br><br>This carer described his grief for his sister, his problems doing his shopping, his concerns about not getting help with shopping and cleaning.<br><br>This carer did do some shopping for food for Mr W as he had no food in the house. The carer did get agreement from their manager to do this.<br><br>All of the carers recorded concerns about his skin condition and that his leg dressing were leaking with liquid.<br><br>The carers stated that they made phone calls to the District Nurses to share their concerns. One of the carers recalls phoning 111 to request a visit from a District Nurse.<br><br>One of the carers said in their interview that Mr W was very concerned about the state of his flat and the dead skin on his carpet floor coming from his skin condition. | One of the Reablement carers described how frustrating it was trying to raise concerns but seeing no action, '*it was like banging your head against a brick wall'*<br><br>The sense of frustration with raising concerns but seeing no change was a feature in the interviews with the staff from the Reablement Service. |

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| This carer was able to apply cream to Mr W body and he was co-operative and socially interactive with the carer.<br><br>The Reablement staff felt that Mr W did not need Reablement and would benefit more from a Homecare service.<br><br>A decision was made by the Assistant Manager that the Reablement Service would cease. | Despite the indicated need for a Home Care Service there was no evidence that any assessment was undertaken. |
| The Senior Reablement Carer records indicate that their concerns about Mr W were being recorded and emails also being sent to First Response.<br><br>The Senior Carer stated that often referrals for Reablement had very little assessment information about the client.<br><br>The Senior Carer also escalated their concerns to the Service Manager.<br><br>All concerns were recorded on Swift records and emails sent.<br><br>The Senior Reablement Carer view was that Mr W did not need a Reablement Service but a Homecare Service. A request was made for a reassessment of need. | During the time in which Mr W was receiving a service from Reablement, the service was having difficulties, due to lack of staffing, the service was going through registering with CQC. The Service Manager was informed regularly of the staffing problems.<br><br>Direct contact by phone may have helped to speak directly to the Social Worker to have shared the concerns but to have also agreed any action.<br><br>Reablement carers reported continuous problems with getting through to Fist Response on the phone.<br><br>Where there are health and safety risks, for example fire risks, environmental risks etc. how would these be recognised, recorded, shared with the client and agencies that would need to know?<br><br>What training is available to Reablement Staff on Risk Assessment, Mental Capacity, Health and Safety and adult safeguarding? |

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| Health and Safety risk assessments were not undertaken by the Reablement Service. | When services are going into a person's home an assessment of health and safety hazards would highlight hazards and risks to the services user and to staff visiting the property. Such assessments should be assessed in the context of service user and staff safety. Risks should be shared with the service user and discussions about the need to refer if necessary to other agencies, i.e. Fire and Rescue Service. |
| **13th May 2013** a decision was made to reduce Mr W Reablement visits to 30min a day. Reablement carers were doing less for Mr W as he would often refuse help with washing and creaming his body. The main concerns were related to his health care and need for regular homecare to help with food preparation and shopping. | It was not clear as to the role of the Reablement Team Leaders as to their ability/capacity to do home visits, carry out assessments, and trigger referrals to other services and request reassessment from First Response.<br><br>It seems that this service was overstretched, under resourced and that staff were regularly providing a service to clients I the community with little or no assessments available to inform their work. |
| **During June 2013** Reablement staff increased their electronic recording with daily concerns about Mr W, who was not allowing carers in, would not answer his phone.<br><br>Discussions with his niece, raised concerns about how he would cope when the Reablement Service ceased, how he would get his shopping as his neighbour was now unwilling to do this as Mr W had accused his neighbour of wanting his money. | Whilst staff were recording there concerns there is no evidence that these records were triggering any response.<br><br>The concerns were escalated to the Assistant Reablement Manager who agreed to undertake a home visit, this visit triggered an email to be sent by the Assistant Manager to First Response and to a Senior Practitioner in First Response. |
| **11 June 2013** Mr W was visited by the Assistant Reablement Manager.<br><br>The records refer to Mr W only having is back creamed and as he has had 76 days of Reablement he | Given the history of concerns being raised by Reablement staff, the records are brief and only really reflect the need to close the case. |

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| needed to be closed or transferred. | 5 days later the District Nurse Team Leader reports serous concerns, Mr W stating '*he was hungry and wanted to die'*, leaking legs, little evidence of any food and Mr W reporting that '*he was hungry, risk of dehydration, carpet and flooring covered in dead skin, 'flat very hot and oppressive'* |

**Review of Practice**

The interviews with those working for the Reablement Service at that time, reflect a service that was not fully resourced to start operating safely, this was recognised but there seemed to be pressure from more senior managers to start the service despite the resource concerns.

Staff and Managers interviewed described their frustrations with the service and the problems delivering this service within the constraints at that time.

There was evidence of caring and compassionate responses by staff, but they seemed powerless to be able to escalate their concerns.

There were assumptions made that by recording concerns in SWIFT it would trigger a response from the First Response Team, some concerns were escalated to making phone calls to First Responses, but there were a number of comments about the difficulties in getting through on the phone. There was an over reliance on the electronic records as a form of communication.

Reablement Team Leaders were receiving at this time group supervision from a Senior Social Worker, but records and interviews would suggest that the concerns about Mr W were not brought to these supervision sessions. These were missed opportunities to have not just presented the concerns, but to have discussed possible interventions.

When the safeguarding concern was raised by the District Nurse Team Leader the allegations were that Mr W had been neglected by the Reablement Service. During the first safeguarding meeting the managers attending from Reablement felt that this meeting focused on the blame sitting with their service. During the interviews with a manager and senior manager from this service there were strong feeling that the meeting was confrontational and adversarial.

The evidence would suggest that given that Mr W received regular visits from the Reablement Service and the District Nursing Service, both agencies had a part to play in sharing information and taking action to have safeguarded Mr W.

## G. General Practitioners and District Nursing

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| Mr W had regular visits/contacts from the District Nurses and GP's during the period under review.<br><br>It is not possible to comment further about the District Nurse involvement as despite repeated requests the notes were not made available. | |
| **Judgements of Practice** | **Contributory Factors and related questions** |
| **17 April 2013** Cooking fire in Mr W flat and admitted into hospital. | Would a GP Practice not be informed that a patient was in a house fire at the time or during their admission?<br><br>The GP was not aware from the discharge summary of the fire and smoke inhalation.<br><br>Given that Mr W was being treated for depression and was experiencing bereavement should this have triggered a capacity assessment to assess his decision making in term of cooking meals and understanding the fire risks? |
| The GP was attentive to his patient and when visiting did discuss with Mr W how he was coping, Mr W frequently stated that he was coping, cooking for himself, fully mobile, taking his medication and receiving some help at home from social services and that he had someone doing his shopping for him. The GP was aware that District Nurses were going in.<br><br>The GP therefore had no reason to be concerned. | The GP did not have access to all the facts, he was not informed of the repeated concerns being expressed by Reablement Staff, the calls that were made to the District Nursing Service reporting concerns about his leg dressings.<br><br>What systems were in place to ensure that all information is shared with GP's and if so why did this not happen?<br><br>Are there no systems in place to ensure that information is shared? |
| **30th April 2013** the GP carries out a routine visit following hospital discharge. | The facts that Mr W had been admitted into hospital following a |

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| The GP found Mr W to be generally well and alert. Mr W said he was having carers three times a day.<br><br>An interview with a GP did indicate that Mr W used to visit the surgery before his sister died, she did a lot for her brother and looked after him very well. After her death he seemed low in mood and he was referred to Mental Health Services, he was a loner, a proud man who did not want people coming to his flat.<br><br>The GP did visit at home and would check that he was taking his medication, the GP talked to Mr W about having help at home, but Mr W said he did not want any and would phone 111 or 999 if he needed any help.<br><br>The GP was only aware of the fire in Mr W flat when reading the discharge notes. | cooking fire, seemed to be information that was only known by the Fire and Rescue Service and the Hospital and was not shared with the GP or the Hospital Social Worker.<br><br>The GP showed concern for their patient and knowing their patient when his sister was alive helped to GP to understand the needs of their patient and ensured that home visits were undertaken to monitor Mr W.<br><br>This monitoring was done in isolation of the concerns that were held by the Reablement carers. The GP was unaware initially that this service was going in. |
| The GP visit at the end of May 2013 saw Mr W as '*generally well'* with no signs of '*infection or inflammation'* and advice was given.<br><br>During April and May 2013 the GP was of the opinion that Mr W '*was mobile, giving the impression that he was ok, although there were episodes of sadness and loneliness after his sister's death.'* | The GP did speculate that it may have been the case that when he visited Mr W it was after the District Nurses had visited and dressed his legs, hence why he did not observe any weeping/smell coming from his legs. |
| The GP described his visits as just a '*snapshot'* of the day.<br><br>The interview with the GP stated that he would have expected that with regular District Nurse visits that any concerns would have been brought to his attention.<br><br>In his interview the GP stated that the | This '*snapshot'* was not a true reflection of Mr W day and the GP had no records or recollection of these concerns being brought to his attention and assumed that as the District Nurses were visiting every other day he had no reason to be concerned.<br><br>If the GP had been made |

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| District Nurses, '*do not automatically share their notes, we don't have access, if they are not happy they would ring'* | specifically aware of the ongoing concerns including the weeping and smells coming from his legs might he may have investigated further?<br><br>What systems are in place for District Nurses to feedback to GP's following their visits?<br>What is the rationale for District Nurses not sharing their notes or GP's having access to them?<br><br>There seems to be a reliance on feedback from District Nurses. |
| The District Nurse Team Leader, in her interview stated that Nurses were feeding back concerns to the GP about Mr W's legs. | GP records do not reflect this level of concern. |
| During **June 2013** and early **July 2013** concerns escalated with reports from Reablement that Mr W was removing dressings from his legs, not eating properly, blisters on his body, refusing to have cream applied to his skin, accusing neighbours of taking his money, legs weeping and smelling bad, not allowing carers in and sleeping in a chair. | The GP was unaware of these concerns, despite reports from the District Nursing Service that they had telephoned the GP.<br><br>Whilst Social Care records highlight the concerns there is no evidence of any decision by Adult Services to make direct contact with the GP until the crisis point on the **16 July 2013** |
| **16 July 2013** the District Nurse Team Leader visits Mr W flat with Care Manager from First Response.<br><br>GP contacted by Care Manager to request an urgent home visit. GP agreed to visit the next day | Mr W stating '*he was hungry and wanted to die'*, leaking legs, little evidence of any food and Mr W reporting that '*he was hungry, risk of dehydration, carpet and flooring covered in dead skin, 'flat very hot and oppressive'*<br><br>Adult Social Care records state that the District Nurse Team Leader reported that Mr W's heating had been on full blast for 3 weeks and that nurses were coming out sweating and very concerned.<br><br>Without the District Nurse notes we |

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| | cannot say whether this was recorded in their notes/reported to the GP, but adult social care records show no reports of such concerns.<br><br>The Care Manager looked at the Reablement diary log which was found in Mr W flat, there were no record of any of the concerns recorded in the adult social care electronic records, other than 1 comment on how hot his flat was. |
| **16 July 2013,** locum GP visited Mr W | GP notes state patient '*alert and oriented'* his legs had recently been dressed. Mr W complained about lack of support and needing help with shopping. States that his sister had died recently. GP was of the view, having consulted with the District Nurse Team Leader and that Mr W had the capacity to make a decision about paying for his care.<br><br>Given the presenting risks with the main concerns about his ability to meet his nutrition and personal care needs, the question of his capacity to decide about whether to pay for care or not was the wrong decision to focus on in respect of his capacity. |
| **17 July 2013** the GP secured a GP in a residential respite service. | |
| **17 July 2013** The District Nurse team Leader raised a safeguarding alert. | Given that the District Nursing and the Reablement Services were going in to see Mr W regularly and the Reablement Service were repeatedly recording concerns and expecting Adult Services to respond and the District Nurse Team Leader sated that District Nurses had been concerned for 3 weeks about his heating been on full blast, (the |

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| | weather was hot), the flat was oppressive.<br><br>Should such concerns have triggered a safeguarding alert by the District Nurses earlier? |
| **19 July 2013** Mr W received his first visit from the District Nursing Service to dress his leg ulcers and subsequent visits continued until the **14 August 2013.** | Again these records were not made available, the only records available recorded that Mr W was seen **11 times between 19 July and the 14 August** for bilateral leg dressings.<br><br>During this time, the Assistant Manager of the Care Home stated in her interview that she had personally called the GP on several occasions because of concerns about his legs, the deterioration in his mobility and concerns that this placement was not suitable as he needed more care.<br><br>During this period, 31 July, the Social Care Officer visited and noted that there was an odour coming from his legs and they were seeping. He was incontinent of urine and faeces and had a yellow tinge to his face. The Social Care Officer spoke to the Assistant Manager to request a GP visit.<br><br>The records and the recollections from the care home assistant manager indicate that they were concerned that his health was deteriorating was not eating well and loss of mobility.<br><br>It is difficult to see what else social care staff could have done other than refer to the GP.<br><br>As Mr W was in a residential care home, the staff who are not nurses, |

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| | are reliant on the primary healthcare colleagues' assessments, outside of a view that an emergency response is needed.<br><br>Without the District Nursing notes it is impossible to know what their assessment was of his physical condition or what feedback they provided to the GP. |
| When Mr W moved to the care home on the 18 July 2013, he changed GP practice. | The new GP practice did not have full notes for Mr W and their records only show 4 visits to the care home to see Mr W.<br><br>This GP practice were unaware of the safeguarding alert.<br><br>Safeguarding procedures at that time would require all agencies involved with the adult at risk to be made aware of any safeguarding concern and where appropriate contribute to any further enquiry. |

**Review of Practice**

The interview with Mr W's GP shows a good rapport with Mr W and that perhaps Mr W had greater trust in the GP than of other professionals. The GP did describe Mr W as a '*very nice man'* who could be '*secretive'* and described that whilst his sister was alive she would do a lot for him and after her death he was lonely.

Mr W's GP recognised the difficulties he was having with coping with the death of his sister and referred him to mental health services and a Community Psychiatric Nurse was allocated. The GP started to visit Mr W at home when he realised that Mr W had problems with attending the surgery.

The GP was not aware of the fire in Mr W's flat and only received this information in the discharge summary from hospital but there was no reference to smoke inhalation.

The snapshot the GP had of Mr W circumstances was based on isolated visits and the GP was unable to see any bigger picture as the concerns from other professionals were not shared with the GP.

GP's only get a snapshot of a patients day, when they visit, so in particular for patients who are experiencing depression and who have a variety of health and social care needs and multi-agency involvement, there is a need for high quality care that is supported by a planned system of collaborative care that involves case management, systematic follow-up and improved integration of working between primary, secondary care and social care.

In today's world general practice should play a pivotal role in the delivery of high-quality care to people with long-term conditions as part of a shared care model in which responsibility is distributed across different teams and settings. Currently, quality of care remains variable. This might be significantly improved if a more proactive approach to multi-disciplinary care management were adopted.

The absence of District Nursing Records made it very difficult to know what care Mr W would have been receiving and whether any concerns were being reported by District Nursing staff, before the safeguarding concern that triggered the contact with Adult Services First Response and the joint visit with the District Nurse Team Leader.

GP's are reliant upon feedback from District Nurses if they have any concerns about their patients. In the case of Mr W there seemed to be inconsistencies in views about his health and living conditions between agencies, with the GP not seeing any specific concerns about his health or his living conditions.

During the interview with the District Nurse Team Leader they described the inadequacies of the service during this period, this was reflected in a CQC Inspection who commented that '*In adult community services, district nurses worked as lone workers from 8pm to 8am, and were at risk in terms of protection and security. This issue has been highlighted as a risk, but no action had been taken. The nurses were also identified as recently qualified or inexperienced (Band 5) nurses, who did not have the appropriate experience and skills for the decisions that they were being asked to make, such as to triage patients, and determine appropriate levels of care. The trust informed us that they had introduced an on-call senior district nurse and hospital at night team support for the district nurse on-call. During our unannounced inspection, we found that there was no district nurse on-call, and ambulance staff had only been informed at 8pm that night. There was no senior nurse on call, and the hospital at night team were not aware of the support they should be providing to the district nurse service. Patients who could be treated in the community, had delays to treatment and had to attend A&E*'.

At the time of interviewing the District Nurse Team Leader, she referred to having been chronically understaffed for the last 2.5 years and current down 236 hours a week of nursing time. '*You can keep beating the Nurses, but they need time to do their jobs*'

Whilst the notes were not made available to the Review Panel, the Team Leader said that the District Nurses were not aware that the Reablement Service were

visiting Mr W. Their knowledge of what this service was providing at that time was limited as they were rarely aware when carers were going in to see their clients, unless there were particular problems. If concerns were raised to District Nurses via the Reablement Service, then they may have been at weekends when it would have been and out of hours Nurse from the Hub.

Mr W would have received 3 calls a week, from unqualified staff (Healthcare Assistants) with every 3rd call from a qualified Nurse. She recalled reports from her staff that he was sometimes reluctant to have his leg dressings attended to and that they would smell.

She described Mr W as an interesting man who was reluctant to accept any help. She recalled meeting the neighbour downstairs, who was very concerned about the welfare of his neighbour and his living conditions.

The District Nurse Team Leader felt that as soon as Mr W was told that he would not have to pay for his care in the Care Home, this was a critical point and he seemed relieved and happy to accept help.

The District Nursing notes during Mr W period of stay in the care home were also absent so they is no further information available regarding his treatment and assessment of his legs and feet or any other healthcare concerns.

Whilst social care professionals were concerned about his deterioration and were reporting these concerns to the District Nurses and GP, what health care records the review panel have seen there is little to evidence to support concerns held by primary healthcare.

## H. Residential Care Home

**18 July 2013** Mr W is admitted to the residential care home, where he is transported by his neighbour, who offered in case Mr W changed his mind if had to wait for transport to be arranged.

Admission information:

- Bi-lateral leg ulcers
- Asthma and skin condition
- Risk of dehydration, nutrition neglect
- Not coping at home
- Hearing impaired
- Feet bandaged and doesn't wear shoes.

Request made by home for Encounter sheet to be sent regarding Mr W's medication.

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| **24 July 2013** Mr W should have attended St Mary's for a Dermatology appointment, records just state DNA. | It is not clear why Mr W did not attend this appointment, which would have been an opportunity to have reviewed |

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| The Assistant Manager, when interviewed stated that they were concerned about his skin condition and that Mr W was scratching and his skin looked very sore. He had diarrhoea and was prescribed Imodium by the GP. | his skin condition.<br><br>The Care Home were expressing concerns early on in his admission. |
| **31 July 2013** Mr W placement was reviewed by adult social care. Concerns being expressed about his skin condition and '*his legs were seeping and there was an odour*'.<br><br>Mr W was incontinent of urine and faeces and he had a yellow tinge to his skin and was often complaining of the cold.<br><br>The Social Care Officer spoke to the Assistant Manager to request a GP visit. | Given the level of his health care needs would Mr W have been more suitably placed in a Nursing Home? |
| **1 – 8 August 2013** the care home reported a significant deterioration in Mr W's health and the need for Nursing support, decline in mobility, loss of appetite, weight loss, increased incontinence, skin breaking down and he was not leaving his room. | During this period the care home state that the District Nurses were still visiting and there were records or recollection of any specific concerns being raised by the District Nurses.<br><br>This deterioration triggered a request from the Assistant Manager to Adult Social Care, for a Nursing home placement. |
| GP records state that Mr W had had several falls whilst in the care home and the GP felt that he needed a higher level of care. | |
| 9 August 2013 Red area on his bottom noted and the care home requested the DN to dress his legs and area on his bottom. | |

**Review of Practice**

At the time of his placement Mr W's circumstances were worrying and an urgent placement was required, this was seen as only possible via using a GP bed and to overcome the financial assessment required, knowing that Mr W was not prepared to pay for care, indeed he was relieved when told that he would not have to pay.

At the point of admission the care home had very little background information about his needs and initially felt able to meet these, knowing that his healthcare needs were being addressed by the District Nursing Service. They were unaware of the safeguarding alert having been raised.

The Care home took appropriate action to refer back to the District Nurses and or the GP when his health began to deteriorate. It was at this point that the care home began to question whether he may need nursing care, his deterioration was rapid and there was a reliance by the care home on the GP to judge his health care needs. At this point Mr W was attended by GP's and District Nurses that did not know him as he had moved area and a care home that did not have a full picture of his life and circumstances.

Whilst care homes do not provide nursing care they are responsible for overseeing the health and social care needs of their residents and need to work closely with Social Workers and health care professionals to ensure that a resident needs are coordinated and that information is shared between multi professional groups and with the adult and/or their representatives. It seemed that Mr W's health care needs were somehow separate and the care home had little or no idea of the input from the District Nurses nor did the District Nurses share their input with the care team. This lack of holistic approach may have led to Mr W's needs not being fully understood by either professional group along with Mr W's reluctance to allow care staff to assist with personal care, so any pressure areas may not have been visible/seen.

When his deterioration was noted the care home acted quickly to refer him to the GP and to Adult Social Care along with a request for a nursing home placement.

**I Nursing Home**

| **14 August 2013 – 15.8.2013**<br>**Admitted to the Nursing Home from the Residential Care Home.** | |
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| 10 August 2013 the Nursing Home Deputy Manager undertook a pre assessment visit.<br><br>The Deputy Manager asked to see records to obtain a clear picture of Mr W's needs. | Whilst this was a care home, it would seem important that they home maintain records of a residents health care needs and liaise regularly with GP's and District Nurses to ensure that they have up to date information. It is unclear as to whether the absence of this was just in relation to Mr W, due to |

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| Concerns were raised by the Deputy Manager of the Nursing Home that the Care Home, had little information available as to his tissue viability, staff were unaware of the dressings he needed and no body maps were available to show any wound areas. | the crisis nature of his admission or whether this is common practice?<br><br>If this was common practice, then such a weakness in the system could impact on the effective coordination and management of all residents with health care needs. |
| There were delays with the admission process due to transport problems. | There were no available records regarding Mr W condition during these 2 days prior to admission to the Nursing home. |
| Once residents have settled in, usually within 24hours, staff complete a body chart. | Given the concerns about Mr W's tissue viability, picked up by the Deputy Manager of the Nursing Home, should an assessment take place sooner to assess and record any wounds? |
| As soon as Mr W had been assessed by the Nurses, contact was made with the Care Home to find out if they were aware of the Grade 3 pressure wounds.<br><br>The Care Home were unaware of any pressure wounds as the District Nurses deal with this.<br><br>The Deputy Manager phoned the District Nursing Service on the same day about the pressure wounds, they were also unaware and said that they had had no reports from the Care Home. | The absence of District Nurse records make it impossible to understand what the assessments were of the District Nurses following visiting Mr W at the time of his stay in the Care Home.<br><br>It is impossible to know, without the records what treatment was being provided and whether District Nurses saw any pressure wounds?<br><br>The records available to the Nursing Home seemed incomplete, there was no record of Mr W having cellulitis? |
| Mr W has 2 falls whilst in the Nursing Home, when assessed by the Deputy Manager, he was ambulant although a little confused, although staff at the care home were surprised that he managed to walk to the transport, as he had not been ambulant days previously. | An impression would have been made that he was mobile and without the full picture from the care home, regarding changes in his mobility he may not have been seen as high risk of falls.<br><br>Both falls were unwitnessed. |

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| Mr W's condition deteriorated and his breathing became a cause for concern and GP was called.<br><br>GP arranged for Mr W to be admitted to Hospital, concerns re breathing, Infected pressures sores, increased confusion, itchy skin and a lump on his head. | The GP was shocked by his pressure sores. |

**Review of Practice**

At the time of the nursing home pre-admission assessment the assessor had limited information about Mr W's health care needs, at the time of the assessment Mr W may have presented a front, of being more able than he really was. He was often described as a proud man, reluctant to accept help.

The Deputy Manager was shocked when he saw Mr W's pressure wounds and equally surprised that the care home did not know about them, nor did the district nurses when contacted.

Given that Mr W was at the nursing home for so little time, the home acted quickly when his condition worsened and called the GP.

The Deputy Manager raised the safeguarding alert in a timely way and shared his concerns, including photographs with a representative from the safeguarding team.

## 6. Emerging Themes

### Communication, Collaboration and Multi-Agency Working

**Inadequacies in effective communication and multi-agency working were a key failure in the circumstances surrounding Mr W.**

The accepted pattern of care and support offered to Mr W became reactive, dealing only with the immediate concerns.

There was a lack of multi-agency discussion about Mr W's situation and ownership of how to try to address the choices he was making. There was also a lack of co-ordination of responses as his situation deteriorated and incidents occurred that could have been regarded as safeguarding alerts, none of which triggered a reassessment of his needs.

Each agency working with Mr W seemed to be working separately and there was little evidence of co-ordination. This was manifested in the manner in which concerns were dealt with or followed up on. Worries were regularly recorded on SWIFT but very little evidence of responses/actions arising out of the concerns. This failure may have been as a result of resource pressures, the skill mix of staff

available or the recording system that did not allow for a clear view of the overall patterns of contact. But this failure was not noted or followed up within the referring agencies. The case recordings were seen to be sufficient and that the concerns were passed on. There was little evidence that concerns were ever escalated and even where there was evidence of escalation this did not trigger an appropriate response. Each agency were of the opinion that they were communicating their concerns. The overriding view from those agency staff interviewed and from the records was that they were doing all they could do given the work pressures they were experiencing at that time.

There was no evidence of any robust assessment processes in place from any of the services going in and no evidence that safeguarding concerns were either being recognised or reported via the appropriate reporting channels.

There was a failure to collate single agency risk assessments into a holistic risk assessment to inform shared decisions and actions each agency .was working in isolation from each other. There was a tendency to attend to immediate support needs rather than managing the significant ongoing risks and seeing the patterns which were emerging, this lack of a systematic approach to risk assessment started at the point of engagement with Mr W whilst he was in hospital following the fire in his flat and continued during his time back at home and into residential and nursing care.

Staff at all levels in organisations should be engaged in a holistic approach in working with adults and other agencies in assessing and managing risk. There were issues about ownership of decisions as well as the need for professional challenge across agencies which required consistent input at a senior level. Consideration should be given to how agencies escalate critical risk issues and indicate how this should be done within formal policy frameworks. Services were not unaware of Mr W's needs nor were they unaware of aspects of his self-neglect or vulnerability, however they did not know what each other knew and therefore only acted upon what they knew. There were confusions about choice and risk. In the light of his clear and articulate resistance to receive help, his request for help with domestic tasks not acted upon agencies tended to work only in a reactive fashion.

There was no shared multi-agency assessment and discussion of his needs and the risks he faced. Without such a coherent and professional approach, there is no confidence that the manner in which Mr W was supported was not just a consequence of him being difficult to work with.

There was no one identified from the range of people supporting him who sought to work with him about his needs and choices. This is skilled work. It is not just about organising and delivering services. There was no overall ownership of Mr W's situation by those working with him. This was manifested in the manner in which referrals or actions on referrals were dealt with or followed up on.

Worries were communicated in the electronic social care records, to First Response who largely failed to react to these. This failure may have been as a result of resource pressures, the skill mix of staff available or the recording system that did not allow for a clear view of the overall patterns of contact. But this failure was not noted or followed up within the referring agencies. The recording of concerns were seen to be sufficient and the problem passed on.

Despite the number of professionals in contact with Mr W, no single agency ever had the full picture of his life. The consequences of not sharing information across agencies involved, not acting upon concerns, believing that someone else is responding, not following up or escalating concerns leads to greater costs later, risks and death to the adult, the intensity of intervention required, personal, professional and organisational costs in terms of finance, negative media, legal implications and reputational damage. Whilst meetings are often seen as time consuming, actual face to face meetings can achieve a better exchange of information and if meetings are well chaired, hidden agendas can be exposed, perceptions of risks can be seen more clearly and a change of direction can be achieved in a person centred way. The routine CQC Inspection carried out in June 2014, of the NHS Trust highlighted the following:

*Overall acute and community services were rated as 'requires improvement'*

*Overall, we found that staff were caring and compassionate, and treated patients and people using services with dignity and respect.*

*People who did not have the capacity to consent did not always have their needs considered in a safe and proportionate way, as not all staff were informed about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.*

*There was good multidisciplinary and integrated working, with GPs, community teams and social care teams, to support people at home, avoid admission to hospital, and support early discharge. There was also work with housing and employment teams, and with the police, in mental health services, to co-ordinate people's recovery, and support their independence and self-care. The trust was working to develop three locality-based integrated teams across the Island; teams and staff had said that this had already improved communication and joint working. However, community teams were under-resourced and there was ineffective caseload management and supervision; patients did not have appropriate assessment and care, and discharge was delayed for patients with complex needs.*

*The trust was developing IT systems towards an electronic records scheme. Where this was working well, it had a great impact, such as in A&E with GP practices. There was an ongoing programme to improve access and use IT across community services, and connectivity issues were a known challenge. Where*

*implemented, the IT system was still not fully functional in community services, and incomplete electronic records created a risk.*

*In adult community services, district nurses worked as lone workers from 8pm to 8am, and were at risk in terms of protection and security. This issue has been highlighted as a risk, but no action had been taken. The nurses were also identified as recently qualified or inexperienced (Band 5) nurses, who did not have the appropriate experience and skills for the decisions that they were being asked to make, such as to triage patients, and determine appropriate levels of care. The trust informed us that they had introduced an on-call senior district nurse and hospital at night team support for the district nurse on-call. During our unannounced inspection, we found that there was no district nurse on-call, and ambulance staff had only been informed at 8pm that night. There was no senior nurse on call, and the hospital at night team were not aware of the support they should be providing to the district nurse service.*

A Regulation 10 Notice (Assessing and monitoring the quality of service provision), was served on the Trust because there was a lack of effective implementation and monitoring of quality and risks in services.

Whilst this inspection was undertaken 10 months after Mr W death the above comments reported in this inspection reflect the practices identified by the review panel.

This review has shown how important it is that there are appropriate levels of knowledge, skills and protocols for staff to be able to recognise and respond to these more subtle and complicated scenarios. To achieve truly user led services that are committed to choice and control, while still providing older vulnerable people the services and safety they need, requires an infrastructure that encourages a culture of sharing and professional discussion and a multi-agency approach to risk assessment and risk management. It is hoped that the experiences of Mr W and how agencies responded to him will help us learn to achieve this as our patterns of health and social care in the 21st century develop.

**Engagement, Choice, Risk and Capacity**

**There was no shared multi-agency assessment and discussions about his choices and risks and no one from the range of agencies involved who sought to work with him about his wishes and choices. Any real focus on his capacity to make decisions and any associated assessment was missing.**

**An emphasis on engagement, developing relationships and building trust, should have been at the heart of the work of health and social care agencies, the compassion, concern and empathy shown by those working with Mr W was reflected in the interviews and in the case recordings but work pressure across all agencies make these principles of engagement just rhetoric.**

Exploring choice, decision making and capacity is skilled work requiring a skilled practitioner to engage and assess, it is not about organising and delivering services or personal care, without someone in the team surrounding Mr W working with his perspectives, choices and capacity, all interventions became essentially task driven.

The principle of presumption of capacity seemed to be followed without question. His decision making was problematic for him and he made a number of decisions which left him vulnerable. This should have led to a challenge as to his decision making (for example, to decide to decline support; to understand the risks associated with physical condition). His refusal of support/actions was consistently taken at face value.

This case is typical of many cases involving questions about individual mental capacity versus the wider duty of care. It highlights the complexity of working within the balance and judgement of being compliant with the Mental Capacity Act and responding to an adults wishes. Whilst recognising an adults right to refuse assessment/services is not an automatic right that is protected. Even where the adult is deemed to have capacity staff must consider the wider duty of care to assess and attempt to minimise risk to the person and others impacted by the lifestyle choices.

Good practice dictates that adults have the right to decide the pattern of services they need and want and the risks they wish to take in their lives. Everyone working with Mr W appears to have respected this either as a professional value, or because of their own powerlessness in the face of her apparent intransigence. But this sharing of power is complex. It is not about a "take it or leave it" strategy.

It is important that there are appropriate levels of skills and protocols for staff to be able to recognise and respond to these more subtle and complicated scenarios. To achieve truly person led services that are committed to choice and control, while still providing the adult with the services and safety they need, requires an infrastructure that encourages a culture of sharing of information and multi professional discussion that sit within a formal framework and the governance of this framework is monitored, reviewed and evaluated.

Working with Mr W reflects some of the complexities of mental capacity versus the wider duty of care. It highlights the complexity of working within the balance and judgement of being compliant with the Mental Capacity Act, responding to individual wishes, but recognising refusal of an individual to accept assessment/services is not an automatic right that is protected. Instead, persistence in following up and assessment of the life style risks is required, with the person's resistance being assessed by services. Even where the person is deemed to have capacity staff must consider the wider duty of care to assess and attempt to minimise risk to the person and others impacted by his life style choices.

Where an adult with mental capacity is resistant to intervention, and chooses to live in an unsafe way with risks to self and others, multi-agency professionals can feel disempowered and take no further action, in Mr W's case there is some evidence that some members of the Reablement service were very concerned and regularly recorded these concerns, others seemed less concerned/less aware of the risks and just saw Mr W as someone who was resistant to their input and therefore no longer needing their services. The regular attempts by Mr W to request help with housework and shopping was recorded but he never received an assessment to explore this need with him and the decision was made to reduce his service and then close him to Reablement.

Given the number of agencies involved with Mr W a multi-disciplinary approach to the assessment of his needs and risks would have helped all agencies see Mr W's life and choices more holistically, against the presenting risks.

**Self-Neglect**

**Whilst Mr W's circumstances were complex and challenged professional views it is important that such choices, decisions and risks are shared between all agencies involved in a timely way and that adults rights to live a chosen lifestyle are explored rather than assumptions made that if this is a person choice then no one should interfere.**

Gibbons et al (2006) defines self-neglect as 'the inability (intentionally or non-intentionally) to maintain a socially and culturally acceptable standard of self-care with the potential for serious consequences to the health and well-being of those who self-neglect and perhaps to their community

Self-neglect is reported mainly as occurring in older people, although it is also associated with mental ill health. Differentiation between inability and unwillingness to care for oneself, and capacity to understand the consequences of one's actions, are crucial determinants of response. Professional tolerance of self-neglect as lifestyle choice is higher than when it accompanies physical/mental impairment.

Where an adult self-neglects and is resistant to intervention, and chooses to live in an unsafe way with risks to self and others, multi-agency professionals can feel disempowered and take no further action, it would be wrong to suggest that professional did nothing, there were those that did report their concerns but felt unable to action these concerns.

The presenting information about Mr W's lifestyle and the choices he was making reflect some of the 5 areas in which people may self-neglect:

Psychological/Mental Health
Physical/Medical
Social/cultural/lifestyle
Financial

Environmental

And indicators of one or more of the 7 categories of self-neglect:

Hoarding
Nourishment
Medication and Treatment
Squalor
Administration (e.g. Utility Bills/services)
Refusing Help/Services
Hygiene

The research reflects a wide range of explanations:

**Self-neglect may be of physical and/or psychiatric aetiology: there is no one set of variables that causes it**,

**There may be underlying personality disorder, depression, dementia, obsessive-compulsive disorder, trauma response, severe mental distress, and/or neuropsychological impairment.** Mr W was experiencing bereavement and this was affecting his mental health and may have contributed towards his feelings of isolation and talks of ending his life. Some concerns were raised that he was drinking and that this may be affecting his self-care and or decision making, although this was not fully substantiated. There were also concerns about his cognition, associated with things like the cooking fire in his flat,

**It may be associated with diminishing social networks and/or economic resources** Following the death of his sister, to whom he seemed very emotionally and physically reliant upon, Mr W became more withdrawn, a factor that the GP took into account when deciding to undertake home visits to Mr W instead of relying upon him to come to the surgery.

It is not clear as to Mr W financial circumstances and there is conflicting information on the records as to his finances. Mr W was however reluctant to pay for services and this was a consistent message throughout his records.

His social networks consisted of his neighbours downstairs who were helping him and raising concerns, but also at times Mr W was distrustful of them accusing them of taking his money. His family were not on the Island and his niece who was in some contact with him she did express several concerns to adult services about her Uncles ability to cope at home and did describe him as mistrusting and that he could be outspoken and rude.

**Physical and nutritional deterioration is sometimes observed, but is not established as causal.** Mr W himself was asking for help with shopping, some carers reported that he had little food in his flat. Repeated concerns raised by Reablement staff that his leg dressings needed attention and that there were occasions when his legs were seeping with liquid. He repeatedly refused to allow Reablement staff to cream his back or to help him with personal care.

**It may reflect pride in self-sufficiency, sense of connectedness and mistrust.** Mr W did present as a proud man, although he was not without asking for help, which he did on a number of occasions, asking for help with shopping and cleaning. He was described as mistrusting of people, however, in particular the GP, one of the Reablement staff and the Social Care Officer were able to engage with him in a way that indicated some trust had formed.

**It may represent attempts to maintain continuity (preserve and protect self) and control.** Mr W's behaviour appeared to indicate a desire to remain independent, suspicious of others, refusing to pay for services and reluctant to accept the help he was being offered.

**IT Systems**

**A combination of poorly developed systems and an overreliance of IT systems impacted upon the professional responses to Mr W.**

The findings show that in adult services there was a reliance on the IT system to communicate, the electronic records system and emails were mainly used to raise concerns and assumptions that by recording and or emailing that this discharged their duty of care, when it was felt that concerns should be escalated there was no clear escalation process to follow.

From discussions with the District Nurse Team Leader the record systems within their service at that time we inadequate, exacerbated by workload pressures, poor communication systems and disjointed systems and processes between weekday and weekend district nursing staff.

**Safeguarding Adults**

**A series of CA12 about the same person should trigger an escalation of concerns and any patterns should be risk assessed by Adult Services and cross checks undertaken with other Emergency Services.**

**The Safeguarding Adults framework should have been an effective vehicle through which to have engaged multi-agency partners to more effective multiagency working. It should have facilitated agencies coming together to share responsibility for assessing and planning how best to re-assess the needs of Mr W and to manage the ongoing risks as well as examining the circumstances that led to the safeguarding concern.**

**Safeguarding adults' responses need to ensure a balance between the need to ascertain the circumstances surrounding the actions and inactions of agencies and the need to ensure a person centred approach to the wishes, needs and risks of the adult. The Care Act statutory guidance 2014, reminds us that the primary focus for adult social care should be on the wellbeing of the individual and that**

**responsibilities for quality, care governance, commissioning should sit with providers, contractors, commissioners, Care Quality Commission etc.**

**If safeguarding is to truly become everyone's business then all agencies across all sectors need to own their responsibilities.**

During the period in which Mr W's records have been reviewed there is evidence of missed opportunities to have raised Safeguarding Alerts. Some of those interviewed had not received safeguarding training nor had they attended any updates. Not all interviewed were aware that the Safeguarding Policy and Procedures had been updated in August 2013.

Despite some staff having an understanding of safeguarding concerns, they did not see that the information they had should have triggered a safeguarding alert. These alerts, which on their own present as low level the patterns of low level alerts should have triggered a safeguarding response.

All agencies should have systems in place to record low level alerts and systems to ensure that patterns are assessed and decisions to refer to the safeguarding teams are clearly recorded and decisions not to refer are also clearly recorded.

Ensuring that each agency has a designated safeguarding manager who can take ownership in an organisation/agency to oversee both low level concerns and all other aspects of their safeguarding responsibilities would be beneficial.

A safeguarding response should have triggered a multi-agency approach to gathering information, risk assessment and shared decision making and should have highlighted the pattern of safeguarding alerts, the concerns about his health and social care needs and his mental capacity. However a Social Care Assessment should have provided the same approach.

Some staff interviewed described when raising safeguarding concerns, they rarely received any feedback and this was unhelpful as the professional would not know whether the concerns were assessed as safeguarding and whether there would be a response under the procedures' and they rarely knew the outcomes of any investigation. Such practice can discourage staff from raising concerns when they do see the value of reporting.

The findings show a disjoint between understandings of safeguarding concerns, awareness of multi-agency procedures and roles and responsibilities, such a dissonance can only lead to a failure for systems to work reliably and effectively to safeguard adults.

The safeguarding alert triggered on the **17 July 2013** by the District Nurse Team Leader could have been triggered partly as a result of the shock of seeing Mr W's circumstances, this is reflected in the interviews statements by the District Nurse Team Leader and the Social Care Officer from First Response who were both concerned and distressed to see this man in such a situation.

The timing of the Strategy Meeting was not reflective of the timescales laid out in the Safeguarding Procedures at that time, particularly given that the safeguarding concerns had been assessed as a Level 1 (serious concerns requiring multi-agency involvement).

The safeguarding meeting held on the **15th August 2013** was not attended by the GP or by the District Nurse service, the latter who not only raised the concern but who were also providing a regular service to Mr W. There is no indication that they were even invited to attend the strategy meeting. The GP during their interview stated that they were unaware of the safeguarding alert.

There was no evidence in the records that between the alert being raised on the **17th July 2013** and the safeguarding strategy meeting held on the **15th August 2013**, some 4 weeks later, that anyone from the safeguarding team made any contact with Mr W to ascertain his wishes, to ensure that a full review of his current needs and risk and his care plan were undertaken and a medical review requested of his mental and physical condition. Whilst he was visited by the Social Care Officer there is no indication that any feedback was provided to safeguarding.

Whilst the safeguarding minutes give details of a range of actions as part of the safeguarding plan, there is not one mention of the current seriousness of Mr W physical health and how poorly he was and his admission to the Nursing Home.

On the day of the safeguarding meeting Mr W was admitted to Hospital by Ambulance and died on the **17th August 2013.**

The safeguarding meeting picked up on a number of key concerns:

- 14 SWIFT records detailing concerns about Mr W care and support needs
- Mr W often refusing care
- Lack of a full assessment of his needs and risk when he was in hospital following the fire in his flat
- Pressure from the hospital to discharge patients quickly which meant that not all assessments are through enough
- Was Mr W declining support whilst in hospital because he had to pay and because he may have felt this would have delayed his discharge if he said he needed help
- Safeguarding concerns recorded by Reablement were not referred using the right referral channels
- Reablement service under resourced
- First Response unable to deal with the amount of referrals they receive
- Failure by agencies to recognise possible indicators regarding capacity and to undertake decision specific capacity assessments
- The restructuring in adult services may have contributed to the pressures and capacity of adult services to have responded effectively
- Lack of communication between agencies

- Reablement staff do not see that assessing capacity is part of their remit and staff have little Mental Capacity Act training
- Health and safety checks not undertaken by the Reablement Service.

The focus of this safeguarding meeting seemed to have taken it as given that it was the Reablement Service that allegedly were neglecting Mr W, there is no evidence that any information was gathered prior to the Safeguarding meeting, in the 4 weeks prior to the meeting, from the District Nursing Service or the GP.

Those attending from the Reablement Service found the meeting adversarial and that they were to blame before any full investigation had taken place.

**Training and Staff Development**

**The lack of a joint up approach to the commissioning of a multi - agency training strategy has led to silo responses to the delivery of key training and skills development for staff across areas of person centred engagement, multi- agency assessments and risk assessments, capacity and safeguarding which leaves staff without the knowledge and skills to do their jobs effectively.**

Adult Social Care staff interviewed described the training and staff development process as somewhat random, with training courses being advertised on the Council website, but work pressures can make it difficult to regularly check the website, courses are not usually circulated directly to staff so if they do not check the website they do not know what training is being provided. They were not aware which training was mandatory and how often mandatory training was required.

Training available to District Nurses on adult safeguarding appears to be very limited and out of date, during the interview with the DN Team Leader, on the 24 November 2014, she was unaware that there were revised safeguarding procedures which came out in July 2013 and was unaware that concerns of self-neglect should be raised as a safeguarding concern. Recent workshops on self-neglect that has been made available by the safeguarding Adults Board have been very poorly attended by Health.

**Accountability**

**There was no overall ownership of Mr W's situation by those working with him. This was manifested in the manner in which referrals or actions on referrals were dealt with or followed up on.**

**With the Care Act and the Statutory Framework for Safeguarding Adults Reviews, the Safeguarding Adults Board need to pay urgent attention to their statutory responsibilities and have in place robust systems and processes, in particular how they intend to hold agencies to account to ensure that they can meet their Section 44 and 45 duties under the Care Act 2014.**

Concerns were communicated to First Response who largely failed to respond to these case recordings. This failure may have been as a result of resource pressures, the skill mix of staff available and the recording system that did not allow for a clear view of the overall patterns of contact.

## 7. Links to other Serious Case Reviews

A review of other Serious Case Reviews show that adults at risk who refuse services, or are reluctant to cooperate is a common theme.

Surrey Safeguarding Adults Board - involved an 81 year old woman known to adult social care and mental health services. "….*Both before and after her husband's death, she was offered services to address physical disabilities and dementia. Initially she accepted care worker support and a day centre, but subsequently declined. ……Refusals to accept services on several occasions did not prompt engagement with the individual and her daughters about her decisions, even when pressures on family carers were mounting and concerns about fire hazards were increasing*".

Cornwall Safeguarding Adults Board (2009) *JK* - JK was 76 years old when she died. She lived with her three dogs in rented accommodation. She was reluctant to leave her home and in the period leading up to her death was reported as spending most of the day on her bed with her dogs……"*JK was described as „reclusive", but made contact with a range of services as she felt she needed them. Two „core" assessments concluded that JK was able to manage her personal and domestic needs. JK's niece and nephew both expressed concern about her situation. People were unsure about her vulnerability and ability to manage. Her living conditions were unhygienic and unsafe, including dog faeces within the property, and she was not looking after herself adequately. Periodically, JK reported that she was being harassed, having money and medication stolen by people entering her home. JK was clear about not wishing to leave her home or change her situation. Everyone appeared to have attempted to persuade her to accept some help, which was consistently and coherently refused. All involved felt that JK had capacity to make these decisions. In the week before JK's death her health deteriorated rapidly but she refused hospital admission*".

Unlike these cases, whilst Mr W was reluctant and at times refusing care, health and social care staff were engaging with him and were aware of the increasing risk but these concerns did not prompt a reassessment of his needs and a multi-agency approach to assessing risk.

Warwickshire Safeguarding Adults Partnership( 2011) Serious Case Review in respect of the death of Gemma Hayter - "*No-one appeared to have explored her vulnerability with her and the report comments that a person's apparent choice should not be used as a rationale to ignore a professional duty of care…… No single agency had a full picture of her life. Risk assessments were not done to underpin decision-making, for example about case closure. Mental capacity*

*assessments were not completed. Gemma was assumed to have capacity and a right to choose risky decisions and her lifestyle."*

## 8. Conclusions

Present Government strategies and the thrust of adult care and support dictates it is for adults to decide the pattern of services they need and want and the risks they wish to take in their lives. Everyone working with Mr W seemed to have been powerless to create any change in action and when change did occur it was as a result of a crisis.

There is much discussion about the integration of health and social care and a focus on the outcomes that people want in their lives. Mr W's repeatedly asked for help with shopping and cleaning, he talked about this to different professionals, but it was never an outcome he achieved. He wanted to remain in his own home, but he did need support to do this, he needed help with shopping, he needed help to keep his flat clean and he needed to have access to good quality health care to maintain his physical and mental wellbeing.

There was no singular event that could be identified as a specific trigger which precipitated a decline in Mr W's health. Instead there was a combination of physical and mental ill health episodes over a prolonged period. In such circumstances identification of areas of risk and allocation of responsibility for monitoring and addressing these is crucial. This structured approach was absent throughout including within the safeguarding process.

Neither practice nor recording afforded clarity across agencies about the nature and the range of concerns; the necessary actions to address these; or who was responsible for those actions. A holistic assessment of the need and risks were never achieved or recorded. When organisations do not work together people do and will continue to fall through the net.

Practice in working with individuals who decline support and treatment cannot be based on generalised assumptions and must respond to personal circumstances, level of risk, and any issues in relation to mental capacity where there are indicators (as there were in this case) that these are a relevant and a necessary consideration.

Based on the information available, we can only conclude that the quality of Mr W's health and social care could have been improved and that there were missed opportunities to have intervened earlier to have improved his quality of life.