OLDHAM ADULTS SAFEGUARDING BOARD

Safeguarding Adults Review Executive Summary: Jessica

July 2020

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1.0 Introduction

1.1 Jessica (not her real name) died in hospital in June 2019. She was 28 years of age. She had been quadriplegic since sustaining a spinal cord injury in a road traffic collision at the age of nine. Following the settlement of her personal injuries claim some years later, Jessica's day to day care was privately funded in the home she shared with her parents and a sibling. Her mother had given up her employment as a midwife to care for her daughter and remained closely involved in her care after the privately funded care commenced. Jessica received pressure ulcer care from the District Nurse and Tissue Viability services during the eight months prior to her death. During this period her wounds deteriorated and she developed sepsis which led to hospital admission shortly before her death.

1.2 Oldham Safeguarding Adults Board decided to undertake a safeguarding adults review (SAR) on the grounds that neglect may have been a contributory factor in Jessica's death and there were concerns that partner agencies could have worked together more effectively to safeguard her. This report is an executive summary of the full SAR report. A description of the process by which this SAR was conducted is shown at Appendix A.

1.3 David Mellor was appointed as lead reviewer for the SAR. He is a retired chief officer of police and has eight years experience of conducting statutory reviews. He has no connection to any agency in Oldham. He also co-chaired the Panel established to oversee the SAR. Membership of the SAR Panel is also shown at Appendix A.

1.4 An inquest will be held in due course.

1.5 Oldham Safeguarding Adults Board wishes to express sincere condolences to the family and friends of Jessica.

2.0 Terms of Reference

2.1 The review considered the contact partner agencies had with Jessica and her family from the point at which she transitioned from children's to adult services in 2009 until her death in June 2019.

2.2 The key areas of focus for the review are:

- How effectively was Jessica's transition from children's to adult services managed? How effectively were Jessica and her family supported through this process?

- What was the impact of Jessica's care being self-funded? What was the care and support provided to Jessica by publicly funded agencies? Did she have regularly reviewed care and support assessments? How did practitioners assure themselves that all aspects of the care provided to Jessica by her family and privately funded carers met her needs? Is there anything that could have been done differently?

- Was appropriate support offered to Jessica's mother and other family members involved in her care? Was mother offered a carer's assessment?

- How effectively did practitioners work with Jessica's mother in her role as her daughter's primary carer?

- What pressure area care did Jessica require? What care was in place?

- Were there any concerns about the care provided to Jessica, and if so, was there appropriate professional challenge? Is there anything that could have been done differently?

- When adult safeguarding concerns arose, how effectively were they addressed? Were there any concerns about the care provided to Jessica, and if so, was there appropriate professional challenge? Is there anything that could have been done differently?

- Was there a question about Jessica's mental capacity to make a decision? If so, when was this questioned and what action was taken, e.g. were decisions made in Jessica's Best Interests?

- Did the fact that Jessica no longer resided within her GP's catchment area affect the health care she received?

- Did the principles of Making Safeguarding Personal inform the care provided to Jessica?

- How effective was multi-agency working and information sharing in this case?

- Were Jessica's equipment needs addressed appropriately? In particular, were arrangements made to replace her ventilator when necessary? Did Jessica have access to the necessary pressure relieving equipment?

- Consider Jessica's lived experience

3.0 Glossary

Aseptic Non-Touch Technique (ANTT) procedure:

- Clean hands with soap and water or alcohol gel using six-step hand washing technique.
- Clean tray/trolley with detergent wipes.
- Gather equipment and place around blue ANTT tray or on the bottom shelf of the trolley.
- Clean hands thoroughly with soap and water or alcohol gel. Apply apron and non-sterile gloves. (Sterile gloves must be worn if you cannot avoid touching key-parts and/or key sites or you do not feel confident to carry out the procedure without touching the key parts or key sites).
- Perform procedure, protecting key-parts/key sites using non-touch technique. Safely dispose of used equipment, including sharps.
- Clean tray/trolley, remove apron and gloves, and dispose of appropriately.
- Clean hands with soap and water or alcohol gel.

Best Interests - if a person has been assessed as lacking mental capacity for a specific decision then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

A **Child in Need (CiN)** is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.

Independent Mental Capacity Advocate (IMCA) - The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

NHS continuing healthcare (CHC) is a package of care provided outside of hospital that is arranged and funded solely by the NHS for individuals aged 18 years and older who have significant ongoing healthcare needs. When someone is assessed as eligible for CHC, the NHS is responsible for funding the full package of health and social care.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working

alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and empower those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

Pressure ulcers are areas of localised damage to the skin, which can extend to underlying structures such as muscle and bone. There are four categories of pressure ulcer severity ascending in seriousness from category 1–4.

A **category 2 pressure ulcer** is defined as partial thickness skin loss involving epidermis (the upper or outer layer of the two main layers of cells that make up the skin), dermis (the thick layer of living tissue below the epidermis which forms the true skin, containing blood capillaries, nerve endings, sweat glands, hair follicles, and other structures) or both.

A **category 4 pressure ulcer** is defined as extensive destruction, tissue necrosis (localised death of living tissue), or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

Section 42 Care Act 2014 Enquiry by local authority
This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Self-neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

4.0 Chronology of Key Events

January 2001	At the age of nine, Jessica sustained a spinal injury in a road traffic collision, resulting in quadriplegia (paralysis of all four limbs – although she had limited movement in one arm) requiring continuous ventilation, catheter care, tracheostomy care (incision on the front of the neck and opening a direct airway in the trachea (windpipe)), nephrostomy care (surgery to make an opening between the kidney and the skin to allow for urinary diversion directly from the upper part of the urinary system (renal pelvis)) and pressure area care.
November 2002	Jessica was discharged from hospital and received care within the family home from the Children's Home Ventilation and Complex Needs Team which was funded through NHS Continuing HealthCare (CHC).
July 2009	Jessica transferred to adult services and NHS CHC funded care was provided by the NHS Long Term Ventilation and Complex Needs Team.
March 2011	The district nurse service made a safeguarding referral in respect of Jessica over concerns that she was declining more frequent district nurse visits and their advice to have more bed rest and less time in her wheelchair. No further action was considered necessary.
December 2011	Jessica's care began to be delivered by a private provider after her personal injuries claim arising from the 2001 road traffic collision was settled.
September 2012	Jessica's case was closed to the CHC team 'from a care point of view' although 'consumables' - such as suction tubing and suction catheters - would continue to be funded. No further assessment of Jessica's needs were carried out by the CHC team.
2014 onwards	Jessica began attending Oldham College completing Maths and Accounting qualifications and in 2018 began studying for FdA Accounting and Financial Services at the University Campus Oldham, which is the Higher Education faculty of Oldham College.
December 2015 – March 2016	Having been known to the district nursing service for wound and pressure area care for several years, Jessica was referred to the Glodwick district nursing team by her mother for pressure damage and remained on their caseload for four months. On discharge her wound, though unhealed, was improving. Her mother continued to manage and dress the wound and Jessica was discharged from the district nurse service.
March – September 2017	Jessica was again referred to the Glodwick District Nursing team by her mother following a recurrence of a pressure ulcer in the same area as before. The wound had deteriorated and increased in size. She was also seen by her GP who noted that the pressure ulcer had seemed infected but had since 'returned to normal'. She remained on the District Nurse caseload until September 2017.

November 2017	Jessica and her family moved to a new address which was outside their GP practice catchment area. Jessica was reluctant to register with a geographically closer GP practice and so her existing GP practice requested that she sign an Out of Area registration form, the effect of which was that the GP practice no longer had responsibility to complete home visits.
April 2018	Jessica reported a problem with her ventilator and breathing techniques when turning to her GP. She was given advice about getting a new ventilator.
12th November 2018	Jessica was referred back to the Glodwick District Nurse service by her mother as she had two pressure sores which were weeping and bleeding. District nurse 1 completed an assessment of Jessica's needs during which it was noted that she was unable to tolerate a dynamic air mattress. Her existing mattress was not considered adequate to meet her pressure relieving needs. She was noted to sit in her wheelchair for long periods whilst attending College. An examination of her wounds disclosed an unstageable (true depth cannot be determined until the slough (dead tissue) had been removed) and category 4 pressures ulcers on her left and right groins. A Waterlow (tool to assist in assessing pressure ulcer risk) score of 21 was recorded. A score of 20 and above indicates 'very high risk' of developing a pressure sore. A joint visit with a tissue viability nurse was to be arranged at the earliest opportunity in order to fully assess Jessica and complete a care plan.
23rd November 2018	There was a change in District Nurse service localities and Jessica's case was transferred to the East Cluster.
5th December 2018	Tissue viability nurse 1 visited Jessica and reviewed the pressure areas. All wounds were now assessed as category 4. No clinical signs of infection were noted.
10th December 2018	Jessica was visited by the district nurse caseload holder – who manages a team of district nurses. Her wounds were reviewed, measured and dressed in accordance with the care plan.
December 2018 and January 2019	Jessica was visited weekly either by a district nurse or tissue viability nurse. On 28th January 2019 tissue viability nurse 2 found the wounds to be greater in depth although it was noted that this may have been due to 'how the wounds were measured previously'. Alternative dressings were advised but Jessica and her mother wished to continue with the current plan (aquacel ribbon and mepilex border – an absorbent antimicrobial dressing).
February 2019	Weekly visits continued although one weekly district nurse visit did not take place due to service capacity issues. Jessica's mother was advised to dress her daughter's wounds less frequently than twice daily so as not to disturb the healing environment. Advice was provided on the importance of nutrition and pressure relief on wound healing and that sitting for long periods in her wheelchair at College was not helping. The

	tissue viability nurse suggested flaminal (a wound healing agent) in the wound cavities but Jessica and her mother declined this suggestion.
March 2019	Only one visit – by the tissue viability nurse – took place during March 2019, when a wound to Jessica's left groin was noted to be larger whilst the other wounds had reduced although their depths were static. Jessica and her mother were willing to try flaminal on the pressure ulcer in the left groin only. During the month, one district nurse visit was cancelled by mother and a further district nurse visit did not take place for undocumented reasons. A second tissue viability nurse visit did not take place due to staff leave.
April 2019	Two tissue viability nurse visits took place but both scheduled district nurse visits were cancelled as 'no longer required'. Jessica's wounds were inspected by the tissue viability nurse for the first time in a month and were found to be static although a new wound had developed. Jessica's mother said that the flaminal had made her daughter's wounds bleed. The application of a PICO dressing – which are recommended where there is a high risk of developing infections - to Jessica's sacral wound was agreed. However, loose stools were said to have adversely affected the PICO seal and so Jessica had decided to discontinue using PICO for the time being. There was said to have been no increase in bed rest during the Easter holiday from College.
7th May 2019	Tissue viability nurse 2 visited Jessica and found that her sacral wound was static but the other wounds had deteriorated. A change to the treatment plan (to cutimed sorbact (a dressing which reduces the bacterial load in a wound)) was suggested but Jessica and her mother were reluctant. Jessica said she would try PICO again when College ended for the summer. The tissue viability nurse concluded that her deteriorating wounds, her wish to continue with aquacel (wound dressing) and her declining the checking of equipment by the wheelchair service necessitated a band 6 (district nurse case holder) review and to this end, a visit by the case holder was scheduled for the week commencing 14th May 2019, although a band 6 visit did not take place.
14th May 2019	District nurse 6 visited Jessica and observed mother dressing her wounds, which she continued to do twice daily. 'No ANTT' (Aseptic Non-Touch Technique - a procedure which aims to protect patients from infection) was documented. Jessica's temperature was high which was discussed with her mother who 'declined any action'. Her wounds were deteriorating which prompted contact with the case holder immediately after the visit. The district nurse's concerns were also discussed with a senior practitioner. A case holder risk assessment was to be requested.
21st May 2019	Tissue viability nurse 2 visited Jessica and put a care plan in place in respect of temperature control. The tissue viability nurse discussed repositioning and the effect of this on wound care. Jessica declined an airflow mattress and continued to state that she was unable to lie on her side. She also declined a referral to wheelchair services and further

	pressure mapping. A swab was taken from the wound in the right groin as odour was noted as was an increase in pain. The tissue viability nurse discussed the case with the East Cluster lead who advised the offer of out of hours visits. The tissue viability nurse considered a capacity assessment in order to check that Jessica had the mental capacity to make decisions about her care against advice but after consulting the East Cluster lead, it was decided that there were no reasons to doubt that Jessica had capacity. The tissue viability nurse was to share the concerns about Jessica's deteriorating health with her GP, a risk assessment was to be requested and a visit by the district nurse case holder was to be arranged for the week commencing 27th May 2019.
21st May 2019	Jessica's GP received a letter from the tissue viability nurse sharing concerns about deteriorating category 3 pressure ulcers and stating that Jessica had declined pressure relieving equipment and input from wheelchair services. The GP chronology states that the expectations of this letter were unclear as were any actions which required to be taken.
22nd May 2019	Tissue viability nurse 2 sought advice from senior colleagues over any additional action which could be taken and was advised that, if the wounds continued to deteriorate, Jessica should be asked if an MDT could be held in her home.
28th May 2019	District nurse 6 visited Jessica and documented the following – 'Very concerned re Jessica's welfare; wounds deteriorated significantly since last visit two weeks ago, requested a senior nurse to visit following contact on 14th May 2019 to review and complete a risk assessment, also raised with tissue viability nurse and at handover. Mum is taking care of wounds on a daily basis. Jessica has capacity and expressed her wish for mum to continue with wound care. Jessica has declined any further intervention re pressure area equipment and is non-complaint with pressure area relief. Following the visit today contacted tissue viability nurse who has said she will speak to the senior practitioner and will also raise again at handover'. A Waterlow score of 25 was recorded. On the same date Jessica's GP notes record that a swab had been taken, that an unspecified pressure sore was not improving and metronidazole (an antibiotic used to treat bacterial infections) was prescribed. Around this date tissue viability nurse 2 had a conversation with a social care practitioner to discuss whether a safeguarding referral should be made and was advised that this was not necessary. There is no record of this conversation in the records of either agency.
30th May 2019	Jessica's GP had a telephone consultation with her mother who did not feel that the oxybutynin prescribed by her spinal consultant was working. Oxybutynin is used to treat symptoms of an overactive bladder such as incontinence. The GP advised Jessica's mother to contact the consultant's secretary to see if the medication could be changed.
3rd June 2019	The tissue viability nurse visited Jessica but was unable to see her as she was unwell. Later that day, Jessica's mother telephoned the GP to

	report a reaction to metronidazole and the GP prescribed co-amoxiclav (antibiotic used for bacterial infections) as an alternative.
11th June 2019	The district nurse case holder visited Jessica and expressed concerns over her deterioration and the consequent risks of infection, sepsis and possible death. A new SDTI (suspected deep tissue injury) was seen on her right leg. Jessica agreed to the provision of a dynamic mattress and an increase in district nurse visits to twice weekly. Jessica said she had College work to complete which would require long periods of sitting in her wheelchair with her pressure relief cushion. All wounds were cleansed, redressed and swabs taken. Mother was advised to use the Proshield system (prevents skin breakdown). A risk assessment was to be completed.
Friday 14th June 2019	Jessica's GP received wound swab results which identified moderate mixed bacterial flora and moderate mixed anaerobes. Oral antibiotics were prescribed. Jessica's mother was advised to ring 999 or take her to hospital if her symptoms worsened. On the same date the district nurse case holder visited Jessica and redressed all wounds. Deterioration was noted to the 'right leg' and the SDTI wound to the same leg was documented to be unstageable. A further letter was sent to the GP requesting an MDT which the GP documented was to be arranged.
Sunday 16th June 2019	At 11.07am the ambulance service received a 999 call from Jessica's mother as her daughter was feeling unwell and was less responsive than normal. The ambulance crew saw Jessica in bed. She was noted to be fully alert. A raised heart rate was documented. A medical history was obtained including the fact that she was taking antibiotics for treatment of pressure sores. She was advised to attend hospital but was unwilling to do so, stating she preferred to receive treatment at home. The crew consulted the North West Ambulance Service (NWAS) Clinical Support Hub, and Jessica was again advised to attend hospital. A Senior Paramedic Team Leader (SPTL) attended and spoke directly with Jessica and it was documented that she and her parents wanted treatment to be brought to her at home as she found that going to A&E was not easy for her as she was reliant on a ventilator and a previous attendance at A&E had been problematic. It was documented that Jessica had capacity to make decisions in relation to her care. The SPTL liaised with the District Nursing service which agreed to visit Jessica at around 2.30pm. The ambulance crew left at 2.04pm. The district nurse case holder and district nurse 6 visited Jessica and decided to call NWAS again due to tachycardia (heart beating much faster than normal). The district nurse case holder contacted the senior practitioner, following which she rang 999 to arrange a ventilation bed to enable Jessica's hospital admission. On ringing 999, the case holder was advised to contact the hospital direct when she discussed Jessica's extensive pressure ulceration with the A&E sister advising that she

	required pressure relieving equipment upon arrival but that she would be attending *with* a ventilator. The ambulance service received a 999 call from the District Nurse service at 3.41pm when it was stated that Jessica may have sepsis. The crew noted that Jessica had a raised pulse rate and slightly low blood pressure. Jessica, who was said to have 'full capacity', was advised that it was possible she had sepsis which needed to be treated in hospital and that if she remained at home it could lead to a deterioration. NWAS documented that she was well aware of the consequences but still wished to stay at home. At 4.21pm the District Nurse service then contacted the Out of Hours (OOH) service (GTD Healthcare) to request an urgent prescription for intravenous antibiotics in the home environment as Jessica was refusing to go to hospital. An OOH GP spoke to the paramedic in attendance who considered the situation critical. It was established that the ambulance crew had inserted a cannula which would be left in situ. The OOH GP was unwilling to prescribe intravenous antibiotics for community administration without a face-to-face medical assessment as the GP felt that this would be unsafe. Jessica had had no previous contact with the OOH service. The outcome of the discussion was that the paramedic would request A&E to fax a prescription directly to the IV team and that the OOH GP would carry out an urgent home visit. The ambulance crew departed at 6.07pm. At 7.28pm the OOH GP visited Jessica and documented that she had been generally unwell that day, more drowsy than usual but no vomiting, with reduced appetite and hadn't been drinking as much. Jessica described pain around her perineum (area between anus and vulva) and at the site of the pressure ulcers. She had MRSA (a strain of antibiotic resistant bacteria) in one of the wounds. Since the original call, Jessica was documented to be seeming brighter, was drinking and 'looking more like herself'. However, during what was documented to be a 'very long chat', the OOH GP advised Jessica and her family that it would appear that oral antibiotics were not working and she would ideally benefit from hospital treatment in view of low BP and tachycardia which suggested sepsis. Jessica and her parents were documented to be aware of the risks but preferred Jessica to be monitored at home and would call an ambulance if she deteriorated. Mother also reported that Jessica's pulse/BP was very liable to change. The OOH GP telephoned the IV team who were unable to visit Jessica at home to administer the IV until 8am the following morning and had no clindamycin (which is used to treat certain kinds of bacterial infections)

	in stock. The OOH GP also spoke to the on call microbiologist who advised on IV antibiotics options. The OOH GP also spoke to the hospital medical registrar who confirmed that no critical care bed was available for Jessica but recommended admission via A&E in order to stabilise her condition. The OOH GP also contacted her spinal team in Sheffield which advised local hospital admission. The OOH GP shared information from the above conversations with Jessica and her family and advised that all those the OOH GP had consulted recommended hospital admission. Jessica and her family stated that they continued to prefer to monitor her at home. It was documented that Jessica was 'judged to have capacity' to decline hospital admission. The family raised concerns about a critical care bed not being available which would require transfer to another hospital. They were also concerned about long waits on a trolley in A&E. Additionally Jessica's grandmother's funeral was due to take place at 2pm the following day. The family would liaise with their own GP the following morning. On the same date the District Nurse service made a safeguarding referral to Adult Social Care to which the latter service responded the following day, documenting that a protection plan was put in place, no details of which have been shared with this review, whilst more information was gathered.
Monday 17th June 2019	Jessica's GP discussed her case at a MDT meeting at which concerns were expressed regarding her mother's reluctance to take her daughter to hospital or to accept advice or care despite the severity of her pressure ulcers. Both the GP and district nurse team had stressed the importance of a hospital admission and mother had promised to take Jessica to hospital after she had attended the funeral that day. It was documented that if Jessica was not taken to hospital this would be a safeguarding issue. NWAS attended Jessica's address at 3.52pm following a call from the District Nurse service. Clinical observations of Jessica found her to have deteriorated since the previous day. The crew started treatment for red flag sepsis (a time critical condition in which it is assumed that severe sepsis is present) and gave fluids through a cannula. Jessica was noted to have capacity, consented to the care provided and agreed to attend hospital. A pre-alert was sent to the hospital. Jessica (escorted by both parents) was transported using blue lights and sirens, arriving at 5.16pm. (Time stated to be 5.55pm in hospital letter to GP). Following Jessica's arrival at hospital, the A&E consultant was unable to cannulate her and so the only current access was the yellow cannula inserted by paramedics. She was reviewed by the ICU team who advised that Jessica could be cared for on the acute medical unit (AMU) with her

	carers managing her ventilation. Sepsis, secondary to vulval sores was considered likely. A large sacral pressure sore with areas of necrotic skin was noted.
Tuesday 18th June 2019	The collective opinion in the hospital A&E was documented to be that should Jessica deteriorate, she lacked the functional reserve to survive a critical care admission. A discussion took place with Jessica's parents during which they were informed that it was likely that she would die without surgical debridement (removal of non-viable tissue from the wound bed to encourage wound healing) but that operative intervention was very high risk and that she may die even with this. It was documented that Jessica appeared to lack capacity, in that she was noted to be less responsive than she had been earlier. It was documented that the collective view was that surgery would not be in her best interests. At 2am Jessica was transferred to the AMU. She required a blood transfusion to which it was documented that mother 'consented'. At 1.30pm Jessica was reviewed by the Hospital Critical Care Outreach team who noted that her nephrostomy had been due to be changed by the Sheffield team two weeks earlier and was now overdue. A safeguarding referral in respect of pressure damage was advised at this point. At 2.10pm Jessica was reviewed by a microbiologist who diagnosed necrotising fasciitis (acute disease in which inflammation of the fasciae (band or sheet of connective tissue, primarily collagen, beneath the skin that attaches, stabilises and encloses and separates muscles/ other internal organs) of muscles or other organs resulting in rapid destruction of overlying tissues) until proven otherwise. When seen for anaesthetic review at 2.55pm, Jessica was documented to have capacity although there is no indication that a formal capacity assessment took place. Surgical and orthopaedic reviews took place in the late afternoon at which it was noted that a CT scan and a pelvic x-ray were awaited. The outcome of Jessica's CT scan was received at 11.05pm and indicated worsening necrotising fasciitis. The possible plan was for her to go to theatre overnight with joint care from Gynaecology, General Surgery and Orthopaedics. During the day Adult Social Care received legal advice that Jessica's capacity should be assessed and she should not be discharged from hospital without a safeguarding meeting taking place. Adult Social Care

	made contact with the doctor treating Jessica in hospital who was documented to believe that she had capacity. Also during the day the hospital A&E referred Jessica for a social work assessment as a result of concern for her welfare due to pressure ulcers. A referral for a tissue viability nurse was also made and an incident form completed on which the question 'Is this a safeguarding issue?' was answered in the negative.
Wednesday 19th June 2019	At 12.30am an intensive care medicine (ICM) consultant review took place. It was documented that Jessica appeared to lack capacity. The consultant felt that surgery would not be in her best interests and a discussion with her parents and the full medical team was to take place. An orthopaedic consultant and ICU consultant review took place ten minutes later followed by a discussion with Jessica's parents at which the extensive surgery required and the likelihood of success was discussed. It was documented that a decision was made, in Jessica's best interests, not to undertake surgery and manage her conservatively with antibiotics, regular dressings, analgesia and comfort care. The ICU consultant signed a DNACPR (do not attempt resuscitation) at 12.50am. Jessica was described as settled overnight with two carers present. A discussion took place between a nurse and the family over Jessica's understanding of why the proposed surgery had not taken place. Jessica was documented to be aware that surgery had not taken place. At 10.30am a tissue viability nurse review took place and a detailed care plan was put in place for treatment of her ulcers. The family requested that Jessica was transferred to a static foam mattress due to difficulty in repositioning and comfort. At 11.50am a safeguarding referral was made by the AMU. At 1.05pm Jessica was transferred to Ward F7 and a referral to palliative care made. During the day screening for MRSA was positive.
Thursday 20th June 2019	At 9.30am a safeguarding strategy meeting took place at which concerns that Jessica may have been neglected were discussed. Jessica was said to have had capacity to make decisions in respect of her care although the extent to which she made independent decisions was documented as not being clear. Concerns were expressed by the district nurse and tissue viability nurse services that decisions taken by Jessica, which may have been unwise, were influenced by her mother. The minutes of the meeting were unclear in which specific safeguarding

	categories of abuse, enquiries were to be made. As a result of the information presented at the strategy meeting, the matter was allocated to police constable 1 for further investigation. No advocate or representative of Jessica or her family was present at the meeting. At 11.40am a discussion took place between a consultant, Jessica and her mother in respect of her treatment plan and prognosis. It was documented that Jessica was alert, understood the discussion and had mental capacity. Supportive care was to continue, contact was to be made with Sheffield in respect of the ventilator settings and an urgent dietician referral was to be made. During the day Adult Social Care made contact with Oldham College to establish whether any concerns about Jessica's health or wellbeing had arisen. They were advised that no concerns had been raised by her tutor. At 2.05pm a health care assistant documented that Jessica's family had refused all aspects of care repositioning and skin inspection throughout the day. The ward sister was informed.
Friday 21st June 2019	Police Constable 1, accompanied by a second officer visited Jessica on Ward F7. It had been decided that this visit should take place without delay as Jessica was on the end of life pathway. The ward manager consented to the visit. As a result of this visit, police constable 1 determined that there was no further investigation required by GMP and a crime was not recorded. The officer documented that Jessica had been cared for by her mother for nineteen years 'with no complaints from any agencies' until the recent safeguarding referral and that her mother had actively sought help from agencies when she struggled to care for her daughter's pressure sores. Jessica was documented to have 'full capacity' and made no complaint about the care received from her mother or from agencies. The officer added that 'bothering her during the end stages of her life was disproportionate, unwarranted and unjustified'. The officers had been unable to record contemporaneous notes of their conversation with Jessica, as because of her infections, they were not allowed to take writing materials into her room and also wore protective clothing. At 4.15pm nursing staff documented that the family had refused all aspects of personal care, repositioning and skin inspection. Jessica was said to have been settled during the day. During the night, nursing staff reported that Jessica's parents and carers were tending to her personal cares.

Sunday 23rd June 2019	Jessica died at 4.30pm. The cause of death was documented as necrotising fasciitis.

5.0 Views of Jessica's Family and Friends

5.1 Jessica's family decided not to contribute to this safeguarding adults review. There is no obligation on them to do so.

6.0 Review of Jessica's Care Plan

6.1 Jessica had very substantial treatment, care and support needs which were largely, but not entirely met by her privately funded care package. She continued to need to access NHS commissioned services such as GP, District Nurse and Tissue Viability Nurse services locally and specialist support from the Princess Royal Spinal Injuries Centre in Sheffield. There is no indication that any annual CHC review of Jessica's needs or care plan took place after 2011. This was unhelpful and NHS Oldham Clinical Commissioning Group's (CCG) CHC team has concluded that should they have a client with similar needs to those of Jessica in the future, they will ensure that an annual review is undertaken as good practice.

6.2 However, the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care [(1)] provides no guidance on whether annual reviews should continue in such circumstances. The National Framework refers to privately funded care only as 'additional', whereas in Jessica's case, it was her core care which was privately funded. There may therefore be value in bringing this case to the attention of NHS England so that they can consider whether the National Framework needs to be reviewed.

Recommendation 1

That Oldham safeguarding Adults Board brings this case to the attention of NHS England so that they can consider whether the National Framework for NHS Continuing Healthcare needs to be reviewed.

Review of Care and Support Needs

6.3 Adult Social Care had no statutory duty to review Jessica's care and support needs as she was not in receipt of any commissioned services from the local authority. However, one of the key principles of the Care Act 2014, which a local authority must have regard to, is the importance of preventing or delaying the development of needs for care and support [(2)]. The statutory guidance which accompanies the Care Act states that 'at every interaction with a person, a local authority should consider whether or how the person's needs could be reduced or other needs could be delayed from arising' as 'effective interventions at the right time can stop needs from escalating, and help people maintain their independence for longer'. In Jessica's case, her needs as a quadriplegic person were likely to change over time and she could need support to avoid social isolation, engage in work or volunteering, make use of community services or engage in recreational activities for example.

6.4 Adult Social Care did have pre-Care Act contact with Jessica for moving and handling assessments and at the time of the 2011 adult safeguarding referral, which represented missed opportunities to robustly screen her case and consider offering a statutory review of the services Jessica was receiving at that time. This could have helped build relationships and provide some oversight of the support being provided.

6.5 It is therefore recommended that when the learning from this Safeguarding Adults Review is disseminated, the need to consider a review of care and support needs of people not in receipt of commissioned services at any interaction with them is highlighted.

Recommendation 2

That when Oldham Safeguarding Adults Board disseminates the learning from this Safeguarding Adults Review, the need to consider a review of care and support needs of people not in receipt of commissioned services at any interaction with them is highlighted.

Transition from Children's to Adult's Services

6.6 Although the Safeguarding Adults Review does not have a complete picture of the management of Jessica's transition from children's to adults services, Adult Social Care has advised this review that no transition to their service from children's social care was completed, which suggests that the focus of services during Jessica's childhood may have primarily been on her health needs. Had a well-planned holistic transition taken place, this could have supported relationship building between agencies and the family and enhanced subsequent engagement with services.

6.7 The absence of involvement of Adult Social Care is of concern. The subsequent duty placed on local authorities under Sections 58 – 66 of the Care Act 2014 to carry out a Child's Needs or Transition Assessment if there are likely to be care and support needs post 18 may have made it less likely that Adult Social Care would be largely unaware of a child with the substantial needs of Jessica who was transitioning to adult services. However, Oldham Safeguarding Adults Board may wish to seek assurance that the Transition Assessment process is an effective mechanism for picking up on cases such as Jessica, where the primary focus appeared to be on her health, as opposed to social, needs at transition.

Recommendation 3

That Oldham Safeguarding Adults Board obtains assurance that the Transition Assessment process is an effective mechanism for picking up on children with substantial needs when transitioning to adult services.

Carers assessment

6.8 There is no record of Jessica's mother being offered a carer's assessment. She was directly involved in her daughter's care from the point at which she was discharged from hospital in November 2002 until Jessica's death in June 2019. This was undoubtedly a very substantial, long term and intensive responsibility. She was a reserve carer on the rota of private carers for many years but in 2017 the senior carer stepped back from her role and was replaced by Jessica's mother. It is understood that the reason why the senior carer relinquished her role was because Jessica and her mother were making key decisions about the former's care and the senior carer sometimes found her decisions over ridden. The Care Act statutory guidance states that 'where an individual provides or intends to provide care

for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment' [3]. Whilst Adult Social Care had limited involvement with Jessica prior to her hospital admission in June 2019, the GP practice, District Nursing and Tissue Viability services had substantial contact and could have suggested a carer's assessment.

6.9 Oldham Safeguarding Adults Board may wish to request Adult Social Care to promote Carer's Assessments by advising partner agencies of the rights of carers to a Carer's Assessment and encouraging partner agencies to notify them of carers who need such an assessment.

Recommendation 4

That Oldham Safeguarding Adults Board request Adult Social Care to promote Carer's Assessments by advising partner agencies of the rights of carers to a Carer's Assessment and encouraging partner agencies to notify Adult Social Care of carers who need such an assessment.

Carer support and training

6.10 Training in wound care management could also have been offered to mother, as Jessica's primary carer, by the District Nurse/ Tissue Viability services. The Oldham Carer's Strategy 2018-2021 emphasises the importance of providing carers with the right support at the right time. It is therefore recommended that the Safeguarding Adults Board shares the learning from this SAR with Oldham Carers Partnership Board, which oversees the Carer's Strategy, so that the learning informs the implementation of the Carer's Strategy, particularly the aim of providing the right support to carers.

Recommendation 5

That Oldham Safeguarding Adults Board shares the learning from this SAR with Oldham Carers Partnership Board to inform the implementation of Oldham Carer's Strategy, particularly the aim of providing carers with the right support at the right time.

Pressure ulcer care

6.11 The Section 42 Enquiry in response to the safeguarding referral submitted by the District Nurse service on 18th June 2019 found that concerns regarding alleged neglect and acts of omission in relation to the management of pressure sores by the District Nurses/Tissue Viability services were substantiated.

6.12 The then providers of the District Nurse and Tissue Viability services, Pennine Care conducted a concise investigation review which highlighted the following concerns:

- The schedule of home visits to Jessica was not adhered to on several occasions. In particular, there were no District Nurse visits at all between 5th February and 14th May 2019.

- Home visits to Jessica should not have been deferred given the complexity of her needs and the risk of deterioration in her wounds.

- There was an inappropriate acceptance of the cancellation of home visits and requests to schedule less frequent visits by Jessica and her mother.

- Evening and weekend visits should have been offered much earlier.

- There was a lack of full holistic nursing assessments with evidence of largely task orientated work being completed.

- A full risk assessment was only begun on 11th June 2019 and never fully completed. This was a major omission given that the National Institute for Health and Care Excellence (NICE) guidance *Pressure ulcers: prevention and management* stresses the importance of carrying out and documenting an assessment of pressure ulcer risk for adults if they have a risk factor. Of the six risk factors given as examples in the NICE guidance, four applied to Jessica in that she had significantly limited mobility (for example, people with a spinal cord injury), significant loss of sensation, a previous or current pressure ulcer and the inability to reposition herself (4). Additionally sepsis arising from pressure ulcers is a leading cause of death for people with a chronic spinal cord injury (5).

- There was a lack of clinical oversight and leadership in the District Nurse service for much of the period the service was providing care to Jessica as one band 7 senior practitioner was covering two District nurse clusters between December 2018 and June 2019 as a result of the absence of a senior practitioner due to maternity leave.

6.13 The concise investigation report made a number of recommendations and an action plan was drawn up to implement them. The Section 42 Safeguarding Enquiry report also made recommendations in respect of the District Nurse and Tissue Viability services. It is therefore recommended that Oldham Safeguarding Adults Board request the Northern Care Alliance, which is now the provider of District Nurse and Tissue Viability nurse services to review and where necessary expand the action plan drawn up to address the concerns identified by the Pennine Care Concise Investigation report in the light of the learning from this Safeguarding Adults Review and the Section 42 Safeguarding Enquiry. The Northern Care Alliance should also provide the Board with assurances that the learning identified from the three investigation/ enquiry/review processes has been addressed.

Recommendation 6

That Oldham Safeguarding Adults Board request the Northern Care Alliance to review and where necessary expand the action plan drawn up to address the concerns identified by the Pennine Care Concise Investigation report to fully reflect the learning from this Safeguarding

Adults Review and the Section 42 Safeguarding Enquiry and provide the Board with assurances that the learning identified from all three processes has been addressed.

Multi-agency working

6.14 Multi-agency working was largely absent until a tissue viability nurse wrote to Jessica's GP a month before Jessica's death to share concerns. The letter was unsuccessful in prompting joint working although it provided an opportunity for the GP practice to review Jessica's case, but there is no indication that this happened. The District Nurse/ Tissue Viability service could have contacted Jessica's College to consider options for reducing the amount of time Jessica spent in her wheelchair without compromising her studies, such as making a bed available in which she could have rested during breaks between lectures and tutorials.

6.15 The absence of multi-agency meetings in cases in which concerns are escalating is a frequent feature of Safeguarding Adults Reviews completed by this independent reviewer. Having said that, had a safeguarding referral been made when the circumstances justified it, this would almost certainly have prompted a safeguarding strategy meeting which should have brought relevant agencies together.

Safeguarding concerns

6.16 There is no indication that the district nurses or tissue viability nurses logged incident reports on the Pennine Care safeguarding system as concerns about the deterioration in Jessica's pressure ulcers increased.

6.17 By May 2019 a safeguarding referral to Adult Social Care was justified on the grounds that Jessica's wounds were deteriorating, that she and her mother had not addressed the unsuitability of Jessica's mattress, that mother continued to dress Jessica's wounds twice daily against professional advice, that Jessica had not increased bed rest despite being away from College, that Jessica's mother had declined the checking of equipment by the wheelchair service and that Jessica's mother had cancelled district nurse visits and both she and Jessica wished the visits to be decreased.

6.18 There would be merit in raising awareness of the Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry published by the Department of Health & Social Care which provides guidance on when a safeguarding referral may be justified in respect of pressure ulcer care [(6)]. Additionally, Oldham Safeguarding Adults Board's multi-agency safeguarding adults policies could be developed to provide advice on when a safeguarding referral may be justified in respect of pressure ulcer care.

Recommendation 7

That Oldham Safeguarding Adults Board raises awareness of the circumstances in which a safeguarding referral could be justified in respect of pressure ulcer care by drawing

attention to the Department of Health & Social Care Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry and by developing the Board's multi-agency safeguarding adults policies to provide advice on when a safeguarding referral may be justified in respect of pressure ulcer care.

Safeguarding Strategy meetings

6.19 The safeguarding strategy meeting held following Jessica's admission to hospital in June 2019 did not appear to clarify the risks to which she was exposed, did not develop a plan for safeguarding her and documented no decisions. This lack of clarity was a factor in the ill-advised and insufficiently briefed police interview with Jessica whilst she was receiving end of life care. Whilst there is no reason to doubt that the police officers conducted this interview with Jessica sensitively and respectfully, it is difficult to disagree with the conclusion of one of the interviewing officers that 'bothering her during the end stages of her life was disproportionate, unwarranted and unjustified'. Whilst it is clear that the safeguarding strategy meeting took place in very challenging circumstances, this was all the more reason to work towards a clear plan.

6.20 It is not known whether the omissions apparent in this safeguarding strategy meeting were the product of exceptional circumstances or represent wider concerns about the conduct of these meetings. Oldham Safeguarding Adults Board will be in a better position to take a view on this than the independent reviewer, however the Board may wish to seek assurance that when *urgent* safeguarding strategy meetings are convened, there is clarity about the purpose of the meeting, that attendees prepare by obtaining information relevant to the meeting and where information is not readily available, as in Jessica's case, the need to obtain such information is clearly recorded as an action.

Recommendation 8

That Oldham Safeguarding Adults Board obtains assurance that when urgent safeguarding strategy meetings are convened, there is clarity about the purpose of the meeting, that attendees prepare by obtaining information relevant to the meeting and where information is not readily available, as in Jessica's case, the need to obtain such information is clearly recorded as an action.

Mental Capacity Act

6.21 Prior to her June 2019 hospital admission, practitioners did not doubt that Jessica had capacity but the series of unwise decisions made by Jessica and her mother to go against professional advice in respect of pressure ulcer care should have been challenged and enquired into. The Mental Capacity Act (MCA) Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character'. The Code of Practice adds that 'these things do not necessarily mean that somebody lacks capacity...but there might be need for further

investigation, taking into account the person's past decisions and choices'. The Code of Practice suggests issues worthy of further investigation might include whether the person is 'easily influenced by undue pressure' [7].

6.22 The question of whether Jessica was 'influenced by undue pressure' from her mother and possibly others involved in her privately funded care package received insufficient attention at the time. Jessica had been reliant on her mother as her primary carer for nearly two decades. Her mother had a professional background in midwifery and having cared for her daughter on a daily basis for such an extended period of time, would have become acutely aware of Jessica's needs. As such it would be surprising if Jessica didn't value her mother's advice and guidance. However, Jessica may have been over reliant on input from her mother - which is suggested by mother's assumption of the role of senior carer in the private caring arrangements since 2017 - whilst isolated from the input of others outside her cocoon of care.

6.23 In these circumstances practitioners could have considered one of the statutory principles underpinning the MCA which is that a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. In Jessica's case, 'all practicable steps' could have included the involvement of advocacy to support her in making decisions about her care. A referral for an Independent Mental Capacity Advocate (IMCA) could have been considered although this would have required a capacity assessment of Jessica to have been carried out. Alternatively, advocacy support could have been provided under the Care Act 2014 which states that local authorities must arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of their care plan, as well as in safeguarding enquiries and Safeguarding Adults Reviews if the following two conditions are met: (i) if an independent advocate were not provided then the person would have substantial difficulty in being fully involved in these processes and (ii) there is no 'appropriate' individual available to support and represent the person's wishes. Jessica could have been considered eligible for advocacy support under the Care Act to facilitate her involvement in reviewing the care plan drawn up by the Tissue Viability service or to facilitate her involvement in safeguarding enquiries had a safeguarding referral been made earlier.

6.24 During Jessica's hospital admission from 17th June 2019 until her death six days later, Jessica's capacity appeared to fluctuate. Decisions were subsequently taken in her 'Best Interests' not to undertake surgery. There is no indication that Jessica's capacity was assessed at this, or any other time during her hospital admission. Nor was there any indication that advocacy was sought for Jessica. As a result 'life and death' decisions were taken in respect of Jessica without the necessary legal underpinning.

6.25 It is therefore recommended that when Oldham Safeguarding Adults Board disseminates the learning from this review, issues to consider in response to a series of unwise decisions by a person who apparently has capacity should be highlighted. Additionally it is understood that the Safeguarding Adults Board is developing a risk

management protocol to guide practitioners in their approach to people with capacity who repeatedly make unwise decisions. It is also recommended that the Safeguarding Adults Board obtains assurance from the Northern Care Alliance NHS Group, as provider of the Royal Oldham Hospital, that they have policy, training and audits in place to ensure compliance with the Mental Capacity Act.

Recommendation 9

That Oldham Safeguarding Adults Board make use of the learning from this SAR to inform their risk management protocol which will provide guidance in respect of unwise decisions by people with capacity.

Recommendation 10

That when Oldham Safeguarding Adults Board disseminates the learning from this review, they ensure that issues to consider in response to a series of unwise decisions by a person who apparently has capacity are highlighted.

Recommendation 11

That Oldham Safeguarding Adults Board obtains assurance from the Northern Care Alliance NHS Group, as provider of the Royal Oldham Hospital, that they have policy, training and audits in place to ensure compliance with the Mental Capacity Act.

Out of Area GP patients

6.26 From November 2017 until her death in June 2019 Jessica was deemed by her GP practice to be ineligible for home visits after moving out of the GP catchment area. However, the GP practice had erroneously applied the 2015 NHS England guidance *Choice of GP practice: Guidance on the new out of area patient registration arrangements* [8] which allows GP practices to register new patients who live outside the practice area without any obligation to provide home visits or services out of hours when the patient is unable to attend their registered practice. Having allowed her to remain as a patient with the GP practice, the GP practice could not remove her right to GP home visits as the NHS guidance applies primarily to *new* patients. Nor was it a clinically appropriate or practical decision for a quadriplegic patient to be denied home visits. The absence of home visits adversely affected the care Jessica received and further contributed to her isolation from services.

6.27 It is therefore recommended that Oldham Safeguarding Adults Board request NHS Oldham CCG to audit the implementation of the NHS England policy on out of area patient registration arrangements by Oldham GP practices to ensure that the policy has been applied correctly and has not resulted in clinically unwise decisions.

Recommendation 12

That Oldham Safeguarding Adults Board request NHS Oldham CCG to audit the implementation of the NHS England policy on out of area patient registration arrangements by Oldham GP practices to ensure that the policy has been applied correctly and has not resulted in clinically unwise decisions.

Engagement of Higher and Further Education sector in Adult Safeguarding

6.28 Jessica was undertaking a higher education course at the University campus at Oldham College. The College has reflected that they need to be more involved in care planning for the self-funded care of higher education students. They could have played a valuable role in safeguarding Jessica had they been drawn into multi-disciplinary discussions. It is therefore recommended that Oldham Safeguarding Adults Board consider how to engage more effectively with the higher and further education sector in order to address any adult safeguarding issues which might arise.

Recommendation 13

That Oldham Safeguarding Adults Board consider how to engage more effectively with the local higher and further education sector in order to address any adult safeguarding issues which might arise.

Jessica's 'lived experience'

6.29 The 'lived experience' is what a person sees, hears, thinks and experiences on a daily basis which impacts on their wellbeing. The records of agency contact with Jessica generally provide very little information about her as a person. Whilst it was important for agencies to fully and accurately document their observations about her health needs and agency responses to those, it would also have been helpful for comments to have been made about, for example, her wishes, feelings, hopes, mood etc. This would also have helped practitioners to gain a more holistic understanding of her needs and ensure that they provided a more personalised service, particularly as Jessica was seen by quite a large number of different practitioners. It is therefore recommended that when Oldham Safeguarding Adults Board disseminates the learning from this review, they highlight the need for practitioners to ensure that they focus on the person and not just their illness or disability in recording their contacts with service users.

Recommendation 14

That when Oldham Safeguarding Adults Board disseminates the learning from this review, they highlight the need for practitioners to ensure that they focus on the person and not just their illness or disability in recording their contacts with service users.

References

(1) Retrieved from https://www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf

(2) Retrieved from https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-

(3) ibid

(4) Retrieved from https://www.nice.org.uk/guidance/cg179/resources/pressure-ulcers-prevention-and-management-pdf-35109760631749

(5) Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3184485/#scm-34-482C7

(6) Retrieved from https://www.gov.uk/government/publications/pressure-ulcers-safeguarding-adults-protocol

(7) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

(8) Retrieved from https://www.england.nhs.uk/publication/choice-of-gp-practice-guidance-on-the-new-out-of-area-patient-registration-arrangements/

Appendix A

Process by which safeguarding adults review (SAR) conducted and membership of the SAR panel

A panel of senior managers from partner agencies was established to oversee the SAR. The membership was as follows:

Role	Organisation
Co-Chair of SAR Panel	NHS Oldham Clinical Commissioning Group
Panel Member	Northern Care Alliance NHS Group (Community)
Panel Member	Oldham Adult Social Care
Panel Member	Northern Care Alliance NHS Group (Acute Hospital)
Panel Member	NHS Oldham Clinical Commissioning Group (Continuing HealthCare)
Panel Member	Greater Manchester Police
Panel Member	Oldham College (University Campus)
Safeguarding Partnership Co-ordinator	OSAB
Independent Reviewer and SAR Panel Co-Chair	David Mellor

It was decided to adopt a systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Reports which described and analysed relevant contacts with Jessica were completed by the following agencies:

- Greater Manchester Police
- GTD Healthcare
- NHS Oldham Clinical Commissioning Group (GP Practice)
- NHS Oldham Clinical Commissioning Group (Continuing HealthCare)
- Northern Care Alliance NHS Group (Acute Hospital)

- Northern Care Alliance NHS Group (Community)
- North West Ambulance Service
- Oldham College (University Campus)
- Oldham Council Adult Social Care

The SAR panel analysed the chronologies and identified issues to explore with practitioners and managers at the learning event facilitated by the lead reviewer which was well attended by representatives of nearly all of the various disciplines involved in this case.

As previously stated Jessica's family decided not to contribute to the review.

The lead reviewer then developed a draft report which reflected the chronologies and the contributions of practitioners and managers who had attended the learning event.

With the assistance of the SAR panel, the report was further developed into a final version and presented to Oldham Safeguarding Adults Board.