CONFIDENTIAL

Ealing Safeguarding Adults Board

Safeguarding Adult Report

Concerning the Death of 'MARTHA'

Version 3

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Martha is a pseudonym which is used to protect the identity of the subject of the review

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1. INTRODUCTION

1.1 This Safeguarding Adult Review, hereinafter referred to as the Review, is about Martha, a 76-year-old woman who died on the 31st May 2020 having been admitted to hospital on 22nd May 2020. Martha was admitted to hospital with a grade 4 pressure sore, the care prior to admission was described as poor. Her condition was assessed as terminal and she died in hospital as a result of complications relating to her pressure sore.

1.2 Martha had two children, a son, and a daughter. She had been widowed for a number of years and prior to her death had been residing in Ealing with her daughter and latterly with her son and daughter-in-law prior. There had been concerns regarding her ability to care for herself for some time and her family had found it difficult to care for her increasing level of need. Assessments had concluded that she had care and support needs that could be provided for her in the family home.

1.3 Adult Social Services had been commissioning the social care services that Martha required for about seven years until she died on 31st May 2020. A Care Agency named 'Lean on Me' was the domiciliary Care Provider throughout this time period. She had received a diagnosis of Dementia as a result of Parkinson's disease, and it was understood by everyone that her heath would continue to deteriorate. Social care agencies kept her care and support under regular review and adapted her Support Plans correspondingly, so that she received the appropriate amount of formal care that she required as her needs changed and increased over the seven-year period.

1.4 During the period of her receiving care the relationship between the family and the Care Agency was described as good, with good handovers of care and good communication. Martha's daughter-in-law described the relationship to Social Workers as positive. During the seven years of offering community-based services, no safeguarding concerns had arisen regarding the care offered to Martha, the exception being the day before she died.

1.5 In addition to the assessments of her care and support needs, there had been two other involvements from statutory agencies. These took place 2008 and 2012 and did not involve concerns relating to Martha's care, but related to the wider issues within the family. Both incidents stemmed from complaints regarding anti-social behaviour made by neighbours. They included concerns regarding the number of visits to the home being made by strangers, the possibility that drugs were being sold from the property and concern that the property was being used for drug taking. There was a police drugs raid associated with, and as a consequence of reports, no illegal substances were found at the time.

1.6 In 2012 Martha's daughter lived with her mother and was the subject of a Carer's assessment in relation to her care in 2012. Between 2012 and 2014, Martha had several hospital admissions and short-term residential care placements, but always returned to her home. Hospital records illustrate a steady decline in her health during this time. In an assessment dated 14th October 2014 Martha was described by health professionals as very immobile, generally bed or chair bound and unable to transfer without assistance.

1.7 There were concerns about Martha's daughter, following a police raid on the address which resulted in the arrest of four men on suspicion of dealing heroin, it is understood she moved out of the house and that Martha's son commenced the role of Carer. Adult social care undertook a Carers

Assessment of him as required and completed a Carer support plan in May 2017. A further Carers Assessment was undertaken in August 2019.

1.8 As an informal Carer her son lived with his mother throughout Ealing Social Service's involvement with Martha. He is one of the men arrested on suspicion of dealing heroin from the property referred to above.

1.9 During April 2020 it appears that the care offered to Martha stopped. There are differing views as to why this was the case - the Care Agency have reported that the family refused admission, the family have reported that the Care Agency were not attending. On the 5th May 2020, Martha's Daughter-in-law contacted Adult Social Care requesting that formal care be reinstated and logged a concern relating to a sore on Martha's bottom. Adult Social care made an immediate referral to a District Nursing service in response to the reported pressure sore and requested that the community provider recommence their care of Martha. On the 7th May 2020 care was reinstated and on the same day the Care Agency sent an email to Ealing Adult Social care advising that Martha had developed a Grade 4 pressure sore on her bottom.

1.10 There was intensive District Nurse intervention but the lack of healing through the home management of the pressure sore, led to Martha being admitted to hospital on the 22nd May 2020. She was admitted to Charing Cross Hospital, having been brought in by ambulance this was as a consequence of the district nurse becoming concerned regarding the grade 4 pressure sore. At the time of admission, she was also noted to have a urinary tract infection as a result of the sore. Concerns regarding her condition and general health, continued to escalate and on the 27th May 2020 the medical team discussed with her family end of life care. It was recorded that the pressure sore condition was severe and unlikely to respond to IV antibiotics. Martha died on the 31st of May 2020.

2. ESTABLISHING THE SAFEGUARDING ADULT REVIEW

2.1 The decision to Hold a Safeguarding Adult Review was taken at a Rapid review meeting held on the 22nd October 2020. This was convened following the late notification of Martha's death to the Adult Safeguarding Board. It must be noted that the death occurred during the Covid pandemic, when an exceptional set of circumstances were prevailing across the country and which impacted significantly on the provision of health and social care services. The impact of the pandemic in this case are considered in a subsequent section of this report as they are a significant event and likely to have some bearing on events.

2.2 Section 44 Care Act 2014 Safeguarding Adults Reviews says:
(1) An SAB must arrange for there to be a review of a 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) if-
(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) Condition 1 or 2 is met
(2) Condition 1 is met if-
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

2.3 On 22nd October 2020 the Rapid review meeting Board determined that the circumstances of Martha's death met the criteria for a Safeguarding Adult Review. There were a number of areas that the meeting wished a review to explore further. These resulted from gaps identified within the

meeting itself and from general concerns regarding the state of Martha's pressure sore at the point of admission to hospital. The meeting concluded from information obtained that Martha experienced neglect between 24th March 2020 and 7th May 2020. It appears that she did not receive any formal home care services during this period, from information at the Rapid review meeting a number of issues emerged

1. Discrepancies between the agency's reasons for not attending and the family's account.
2. A gap in understanding in respect of the pressure sore and understanding whether the pressure sore could have been avoided or prevented from deteriorating further.
3. Concerns regarding understanding the escalation process once the family raised concern re nonattendance
4. Concerns relating to the provider and the service delivery
5. Agencies highlighted some gaps and apparent confusion in the recording of vital information, including information relating to safeguarding and care logs

2.4 The commencement of an information gathering exercise as a formal part of the Safeguarding Adult Review process afforded an opportunity to gather additional information from agencies to fill the gaps above and to improve the chronology of care events during the months prior to Martha's death.

2.5 It was agreed that this review would be conducted locally, utilising independence and scrutiny from the Chair and the Director of Safeguarding from WLNHST, as neither had had any involvement with this case previously.

2.6 A number of agencies contributed to the Review process, this included

- Ealing Council Adult Social care
- Ealing Council Independent Living and Learning Disability Services
- Ealing Council Health and Provider Services
- Imperial College Hospital NHS Trust
- Metropolitan Police
- NHS Hammersmith and Fulham
- Central and West London CCG
- West London NHS Trust
- Community Care Provider- Lean on me

The family were invited to contribute to the Review process on two occasions but did not respond to letters sent by the Chair of the Safeguarding Adult Board. Their perspective on events surrounding their mother has only been obtained from records.

2.7 Unusually in this case a parallel process involving a review of the provider of care has been running throughout the duration of the review . It has been necessary for reasons outlined later in the report to draw upon information submitted by the provider to that forum.

3. TERMS OF REFERENCE

3.1 The Safeguarding Adult Review needs to determine whether any learning can be identified from the way agencies worked together prior to Martha's death and how effective such working was.

3.2 In addition the Rapid review meeting referred to at 2.1 above identified a number of issues that should be clarified in particular.

1. Discrepancies between the agency's reasons for not attending and the family's account.

2. A gap in understanding, in respect of the pressure sore and understanding whether the pressure sore could have been avoided or prevented from deteriorating further.
3. Concerns regarding understanding the escalation process once the family raised concern re nonattendance.
4. Concerns relating to the provider and the service delivery.
5. Agencies highlighted some gaps and apparent confusion in the recording of vital information, including information relating to safeguarding and care logs.

3.3 The Review seeks to understand, through the gathering of additional information and discussion where appropriate the following areas:

- How effective was the care Martha received at home in addressing her needs, including continence, skin, psychological and emotional needs, cognition, and medication?
- When her needs changed were her needs reassessed and care plans adapted appropriately?
- What happened with regard to the provision of care from the 24th March 2020 until Martha died?
- To what extent was the care package monitored by those commissioning her care?
- Were there any opportunities missed to raise a safeguarding alert and hold a strategy meeting?
- Were any concerns raised about the quality of care provided by the Care Provider?
- Were the views of Martha considered and did they impact on the actions taken?
- To what extent did the Covid pandemic and national arrangements impact on the care provided to Martha?

3.4 This Review considered agency involvement with Martha during the period in which the formal care provision stopped, which is understood to be on 24th March 2020, until the formal care provision was re-instated on 07th May 2020. It will also consider the statutory interventions and subsequent events that followed the reinstatement of Martha's formal care services on 07th May 2020, including her admission to hospital on 22nd May 2020, and her death on 31st May 2020.

3.5 The review will also set the context in which services were provided to Martha.

4. NOTABLE EVENTS AND KEY PRACTICE EPISODES

4.1 Set out in the table below are brief details of the notable events drawn from the management reviews completed by all agencies. They are summarised without comment and intended to be a synopsis of the key events. The analysis appears in section 5.

4.2 As the concern relating to this case is overlain by the timetable of UK national restrictions in response to Coronavirus, key dates are inserted into the notable events for ease of reference.

DATE	EVENT
Early July 2012	Martha referred to hospital by GP for consideration at the vascular clinic as a result of a worsening leg ulcer. Attending with her daughter, Martha expressed a view that her leg ulcer was improving. The clinician noted that the ankle brachial pressure was low in the leg affected by the ulcer and only marginally better in the other leg. Mobility at that time was reported as limited. A follow up appointment was offered but Martha did not attend.

16th July 2012	Outpatient letter back to GP, who had completed referral to hospital. Martha had attended initial appointment but declined any operative treatment suggesting she thought things had improved. Further follow up appointments were not attended.
6th September 2012	Ealing Hospital admission after running out of medication for Parkinson's disease. While at hospital a rash is noted to her leg which is diagnosed as cellulitis, oral antibiotics are prescribed. Martha reports feeling increasingly unstable on her feet and that she hasn't been walking using her Zimmer as a consequence of that. Martha reports not having walked at all in the preceding two days. Improvements noted as soon as Parkinson medication starts, and oral antibiotics start to work. Discharge home is completed the following day with appropriate referrals made for onward care to physiotherapy and to GP.
1st July 2013	Martha did not attend appointment with older care physician having been referred by her GP.
11th August 2015 – January 2016	Martha was an open case to the Cognitive Impairment and Dementia Team (CIDS). A referral having been made by her GP, Martha during this time refused to be involved and declined for any cognitive assessment to take place. The GP was advised accordingly.
27th March 2016	Referred to Charing Cross from the Emergency Department having been admitted with respiratory sepsis.
28th March 2016	Hospital assessment completed and recommended additional support at home with personal and physical care, support on management of incontinence and skin integrity.
5th April 2016	Discharged home with package of support in home to continue. There was a discussion with the family about other care options, including rehabilitative care to improve mobility, but this was declined.
10th September 2016	Hospital admission through Emergency Department following a cardiac arrest. The diagnosis is one of community acquired pneumonia, which required antibiotic treatment. An assessment was completed, and Martha was discharged home with the existing package of care, which was considered appropriate to meet her needs. No specialist follow-up with respiratory or cardiology was indicated following this admission though a 6-week post discharge chest x-ray was booked to determine any underlying cause of the pneumonia.
19th September 2016	Discharged home with continuing package of support and with liaison with the GP.
22nd December 2016	Hospital Admission as Martha found in bed having difficulty breathing and with secretions in her airway. The clinical diagnosis was of aspiration pneumonia and following antibiotics Martha improved.
23rd December 2016	Discharged home after treatment with the existing package of care in place.
22nd March 2019	GP refers Martha to Dementia support team because of concerns re her memory, this was the second referral, the first taking place in 2015 when Martha declined to cooperate.

11th June 2019	Martha was seen for an assessment by the Community Nurse. The delay was attributable to trying to agree a suitable date with the family who were away on holiday. A diagnosis of Dementia in Parkinson disease is recorded
12th July 2019	Psychogeriatrician visits Martha at home along with a Community Nurse to undertake a diagnostic and management review. Martha was described as being in a hospital bed in the sitting room of the sixth floor flat. While her son and daughter-in-law lived in what would have been the main bedroom of the flat. The door to the main bedroom was kept shut and had its own secure locks. The records note that the room in which the Martha stayed had one armchair which was placed on the other side of the room. There were no chairs near the bed, and it appeared that there was no space for someone to sit near Martha and to talk to her. There was no radio or television present in the room. Although conditions were described as 'grubby' Martha had clean nightwear and bed linen. The Doctor and Nurse noted the care package and reviewed the records of the visiting care staff. They were concerned that the 9pm medication from the dosette medication box had on two nights not been given and that the family had explained that this was because Martha was asleep. Because of concern regarding the quality of life for Martha a referral was made to the Ealing Safeguarding Team requesting that this be considered alongside a review of the package of care. They also requested the GP review the medication for Parkinson disease. At the same time Dementia concern were also asked to consider extra support to Martha and her family.
17th July 2019	Respite provision is discussed with Martha and her family, in order to undertake a review of Martha's medication and to stabilise her care, Martha declined this indicating a desire to remain at home.
22nd July 2019	Ealing Social Care allocate the case to the Locality team to keep under review in the light of the above events.
10th December 2019	A joint visit to the family home by a Social Worker and a Community Nurse from the CIDS team is conducted. Day centre support and support from Dementia concern are offered but this is declined by Martha. In reassessing the package Ealing Adult social care increase the package of support from three visits per day to four.
8th January 2020	The GP is requested by the CIDS team to commence Martha on medication to treat depression with a request that this is reviewed after two weeks and increased dosage given. This is confirmed in GP records.
Early March 2020	The CIDS team are largely redeployed to support Covid efforts on the wards, leaving only a skeleton staff. No new referrals are accepted and for existing patients the service is scaled down to shielding phone calls to those most vulnerable.
16th March 2020	The Prime Minister (PM) issues a statement stating that now is the time for everyone to stop non-essential contact and travel.
23rd March 2020	PM announces the first UK lockdown, ordering people to stay at home, the lockdown is due to come into force three days later. Key and essential workers are exempt from restrictions.
25th March 2020	Care log from provider, includes a daily progress report, that is largely as with other daily reports , but then also includes a large handwritten note "LAST DAY OF WORK". This is the last entry on care logs provided.

26th March2020	Lockdown measures come into force.
6th April 2020	The Care Agency email Ealing Council Homecare at 12:22pm saying that the family wish care to be suspended until the pandemic ends. Ealing Council Homecare at 12:24pm, email the Social Worker asking if the package should be suspended. The Social Worker agrees to check this out and to speak directly with the family of Martha. As agreed, the Social Worker speaks to the family who advise that the Care Agency hasn't visited since the 26th March. The daughter-in-law indicates that the family want the care to continue but that the Agency has advised lockdown has made this difficult for the Carer and there is no one else they can offer. She states they have been using the help of a neighbour, who has care experience, but that she and her daughter have to help and assist, as Martha needs two people to help turn her. She queries whether the neighbour could be paid for her support but is told that, as there is a contract in place, and that there is a pandemic, organising direct payments would be very difficult. It is suggested that it might be best to get the Care Agency visiting again. The daughter-in-law accepts this and welcomes getting the Care Agency back visiting, as it is a struggle for them. The same day the Social Worker updates Ealing Council Homecare of the family situation and the fact that they wish care to continue, he urges contact to be made with the Care Agency to clarify matters.
6th April 2020	Care Agencies carry out monthly telephone monitoring and report that in speaking to Martha's daughter-in-law, she indicates that she has stopped care because of fear relating to Covid. The report of the conversation records that the family have been providing care and that they wanted to be reimbursed. The manager asked why the Care Agency office had not been informed and was advised that the family had forgotten. The care workers confirm to the manager that they were asked by the daughter-in-law not to come back, as she fears Covid being brought into the house.
7th April 2020	An employee of the Care Agency makes contact via email, with Ealing Council Homecare and indicates that they have visited but that they have been turned away as the family are concerned regarding Covid. The email indicates the family have suggested they can organise the care themselves but would like to be reimbursed. This email was sent at 13:26pm The Social Worker follows up the original email and contacts the Care Agency direct, and the above account is repeated. It is noted that Martha has been supported by the same Carer for the last six years and that they have a good relationship. The Social Worker phones the family to discuss the above information and is told that the account of the agency is incorrect. Martha's daughter-in-law asserts that no one has visited them today and that instead she received a phone call this morning from the email author, suggesting that as the agency have no one who can care for Martha they are happy to pay the family for the informal care that is being offered. She maintains that no-one has visited since the 26th March 2020 as previously advised. The Social Worker explains that he is reluctant to seek alternative care as he is aware of the lengthy history of care and the positive relationship Martha has with her Carer. The

	family agree but also indicate they are struggling and that if changing Carers is a solution, they would accept that – going on to highlight some issues such as not cooking pork that they experienced from the Carer because of religious beliefs. There follows a series of emails between the Social Worker and Ealing Council Homecare, in which the Social Worker explicitly states that the package of care should not be suspended as the family still require formal care. He explicitly asks that the Care Agency are asked for care visit records and logs for the previous week in order to illustrate the pattern of visits. This request is made via email at 4:00pm. This is followed up by contact with the family who are advised the care package is to continue and that they should expect a visit later in the day. The Care Agency Management review suggests that Carers went to the property for a lunch time call to offer care for Martha and were allowed access and that it was at this visit they observed a pressure sore. The report continues to say that they discussed this with the daughter-in-law of Martha and understood she had called the GP. (Note this entry does not tally with another agency information and information below).
8th April 2020	Martha's daughter-in-law contacts the Social Worker to advise that no one visited yesterday as suggested but that this morning someone turned up requesting copies of the care records and logs. Despite initially resisting this request she advised she handed the records over after taking photographs of them. On the same day the Care Agency contacts Ealing Council and indicate that they are struggling to send records requested because of problems with their scanner. The email suggests that this will be rectified today.
9th April 2020	Care Agency issues a verbal disciplinary letter to employee for failing to communicate regarding Martha's care.
16th April 2020	Lockdown extended for at least three weeks.
22nd April 2020	A shielding phone call is made to check up on Martha by the CIDS team. Martha's son is spoken to, who reports no problems.
5th May 2020	Martha's daughter-in-law again contacts the duty Social Worker, indicating that she is struggling with Martha's care, she repeats that the Carers stopped attending and that she does not understand why this was the case. She indicates that they want a new Carer as they cannot cope. The Social Worker emails the agency at 16:25pm and requests that they explain why they have not been attending for over a month. On the same day a staff member from the Agency responds saying that the provision of care was cancelled on the 24th March 2020 following requests by the family not to visit due to Covid. On receiving this information, the Social Worker again contacts the family and is advised that the Care Agency have missed calls, that they don't feed her the food she wants to eat on religious grounds and that the family want care from someone new. The Social Worker liaises with the Ealing Council Homecare and reports that the family have had no care since the 24th March 2020 and that they now wish a different provider to attend. Ealing Council Homecare clarify that

	there has been no suspension of care and indicate that while they will consider an alternative agency, they first need to address the issues with the provider already in place.
5th May 2020	GP took a call from Martha's daughter who is concerned regarding a sore that has developed on her mother's bottom. She reports to the GP that Carers stopped attending due to Covid. The GP refers to District Nursing for an assessment.
6th May 2020	The Care Agency email in response to a request from Ealing Council Homecare, confirming the package of care was stopped on the 24th March 2020. But state that no issue has ever been raised with them regarding food. On the same day Ealing Council Homecare ask the Social Worker to liaise with the family regarding a restart of services to Martha. The Social Worker actions this immediately and in a call to Martha's daughter-in-law it is confirmed that services will recommence. In this call Martha's daughter-in-law indicates a conversation with the GP, on the preceding day regarding a sore on Martha's bottom that she has become concerned about. The Social Worker follows this up with District Nursing who advise that they will be visiting the following day the 7th May 2020. On the same day Ealing Council Homecare advise the Social Worker that they have been in contact with the Care Agency who will be recommencing visits from the following day. In correspondence with the Care Agency, Ealing Council Homecare request that the agency confirm the suspension of care between the 24th March 2020 and 6th May 2020, this was retrospectively recorded and categorises the suspension as 'holiday'.
7th May 2020	The Social Worker receives an email from the Care Agency, sent via Ealing Council Homecare, indicating a high level of concern for Martha. The email states that they have observed, a type 4 pressure sore" and that 'Martha' "Is in need of urgent medical attention". The E-mail further adds that "The daughter has been calling the doctor and district nurses. Please advise as this needs to be seen to today".
10th May 2020	The Prime minister announces a conditional plan for lifting lockdown and says that people who cannot work from home should return to their workplace but avoid public transport.
13th May 2020	The Social Worker completes a telephone conversation with the District nurse who reports that Ms Pither has an unstageable pressure sore. The District nurses indicate that they will now visit Ms Pither three times per week. The District nurse enquires as to why care stopped and whether this was due to the pandemic or whether family suspended the provision of care. The Social Worker indicates that this was due to the family refusal to allow access, although it is also recorded that this is disputed by the family, records do not suggest this information was not imparted to the District nurse.
13th May 2020	GP records that the Tissue Viability Nurse has indicated that Martha has a pressure sore that is ungradable, and that Martha has also lost weight. Additional support has been put in place by District Nursing to include additional visits, dietician support and additional aids and adaptations.
22nd May 2020	Following a 999 call Martha is taken by ambulance and is admitted to Charing Cross Hospital. It was at this admission she was reported to have experienced a breakdown in the tissue of her sacrum which was noted to be stage 4 at the time of admission. Following admission, she was reviewed by tissue viability

	specialists, who diagnosed Sacral Osteomyelitis which was only likely to resolve with IV antibiotic treatment which was felt not to be tolerable by Martha owing to her poor physical health.
23rd May 2020	The Care Agency advise that Martha has been taken to hospital, she was admitted to Charing Cross. Upon admission the Safeguarding Nurse completes a safeguarding alert relating to the admission and indicating that a factor is poor care at home. This is forwarded by the Adult Social care team for Hammersmith and Fulham which covers Charing Cross. A Pressure Ulcer Support Tool is not included with the referral.
27th May 2020	Having been admitted on the 22nd May 2020, the care team decided that Martha was a candidate for end-of-life care pathway on the 27th May 2020, following a seizure (likely related to sepsis).
31st May 2020	Though she was on the fast track for a nursing home transfer so that she could receive end of life care, Martha was found unresponsive and was declared dead at 08:34am.
10th June 2020	Social care concluded that the referral from the hospital constitutes a safeguarding concern and initiate a section 42 enquiry. Seeking to understand the issue of possible neglect and to understand if the family position on care in the home had contributed to Martha's decline in health.
15th June 2020	Imperial college query via email if a safeguarding concern has been raised by Charing Cross as they cannot find this on the record system. The email also notifies Adult Social Care that Martha died on the 31st May 2020.
16th June 2020	Adult Social Care request a copy of the completed Pressure Sore Tool and the recorded details of the cause of death.
18th June 2020	Adult Social Care formally cease the package of care.
30th September 2020	Email to Ealing Council Homecare from Care Provider alerting to the sending of care logs requested in April.

5. ANALYSIS

5.1 In this section of the report the key areas of exploration are addressed in turn.

How effective was the care Martha received at home in addressing her needs, including continence, skin, psychological and emotional needs, cognition, and medication?

5.2 It has been challenging to review the effectiveness of care received by Martha as the Care Provider records and the information provided to this Review is poor. The Individual Management Review submitted by them came in late and is incomplete, it fails to give a full picture of care provided and contains information that by cross referencing to other information must be inaccurate. This includes inaccuracies regarding dates and of the care being given, one example is there are no care logs provided after the 25th March 2020, despite an entry in the Individual management report that suggests the Care Agency resumed care between the 7th April 2020 and May 23rd 2020. This, when cross referenced to the accounts of the family and of Ealing Social Care cannot be accurate. As the Provider is subject to a Provider Concern process involving the regulator and commissioners, additional material to support this review has been sought from that forum. This has been in an attempt to ensure consideration to all available material, however, that process has encountered very similar challenges in obtaining accurate information.

5.3 Care logs were requested in April 2019 and supplied in September 2019, they only cover the period 10th March 2019 – 25th March 2019, they are limited in their content and are handwritten. Indeed, many of the entries follow the same narrative. It is understood that an electronic recording system did not go 'live' at the Care Provider until April 2021.

5.4 It is clear from other agency records that the care of Martha at home was her desired wish and that until events in March of last year had progressed well. The relationship with her Carers was believed to be positive and because they had provided continuous care over a long period of time had a strong personal relationship.

5.5 It is not clear when the sacral ulcer first began to develop. On the 5th May 2020 Martha's daughter contacted the GP to express concern regarding the development of a sore on Martha's bottom. At this point she reported to the GP that a Carer hadn't been into the house since the 26th March 2020. The GP referred the matter to the District Nursing Team. This contact coincided with the Ealing Council Social Worker following up the issues relating to provision of care and engaging the family in discussion. It was in a call on the 6th May 2020, that Martha's daughter-in-law advised the Social Worker of her concern relating to Martha's sore bottom and the contact that she had initiated with the GP.

5.6 The Social Worker was proactive in speaking to the District Nursing Team and in asking that he is kept appraised of their assessment of the ulcer. On the 7th May 2020 the Care Provider emailed the Social Worker indicating their concern regarding the sore and suggesting that urgent treatment is necessary. This date fits with the Care Agency resuming their care responsibilities on the 6th May as opposed to the 7th April 2020 date set out in the Individual management report. That report completed by the Care Agency in response to this review argues that they were the organisation first alerting Ealing Council Homecare to the presence of an ulcer on the 7th April 2020. This has to be an error for reasons outlined above. All of the evidence in other agency reports indicate this inaccuracy. In fact, as the above chronology, illustrates it was the family who raised alarm to the GP and to Ealing Council and who triggered the involvement of District Nursing intervention and this correctly occurred on the 6th May 2020.

5.7 The evidence available from all agencies in this case suggest that Martha and her family were without commissioned care and support from the 26th March 2020 until the 7th May 2020. The family did indicate that they were using a neighbour who was experienced in providing care and support in a call with Ealing Social Care on 6th April 2020, but that this was a measure implemented as a consequence of the Care Agency not turning up. There are clearly issues that emerge in the evidence presented that highlight differing views as to the reasons why the Care Agency didn't deliver commissioned care and these are explored later in the report.

5.8 Following the identification of the sacral pressure ulcer, the District Nurses took appropriate steps to treat it. Guidance was provided to the Carers on the need for repositioning. NICE clinical guidance on *Pressure ulcers: Prevention and management* advises that where a person is assessed as being at high-risk of a pressure ulcer they should be encouraged or assisted to change position frequently. It is clear that Martha's ulcer was at an advanced stage when the District Nursing team became involved. Treatment and care plans were adjusted in response and District Nursing visits intensified in order to manage the ulcer in the home environment.

5.9 On the 13th May 2020 the sacral ulcer was described as ungradable and the further assessment by the District Nurse and Tissue Viability Nurse led to the delivery of additional support through the supply of aids and adaptations and dietician advice as well as increased visits, Martha was losing weight. Given her ill health and the additional support needed with feeding as identified in her care

and support plan this is understandable. By the time Martha was admitted to hospital on the 22nd May 2020, her nutritional intake had become extremely poor, and her weight loss was significant. **When her needs changed were her needs reassessed and care plans adapted appropriately?**

5.10 The last review of Martha's care and support needs were completed by Ealing Adult Social Care service on 10th December 2019. This also resulted in in the development of a Care and support plan setting out how her needs were to be met. Before this review Martha had been involved with services for 12 years prior to her death and was assessed as having care and support needs for 7 years due to declining health. The Council took responsibility for managing her care through the contract with and external Care Provider, commissioned to provide services in accordance with the care plan in Martha's home.

5.11The review in December was prioritised and brought forward following concern that Martha was struggling more with her health and concerns expressed by the Cognitive Impairment service following a visit, in which they raised some concern regarding Marth's situation. There was some delay in allocating the case for a locality review. The statutory review was due to take place in March 2020 but was prioritised following receipt of the new information and as a result of the December review Martha's daily visits were increased from three to four.

5.12 Prior to the review in December Martha's care was reviewed in line with statutory requirements on the 20th March 2019. Martha was present and contributed to that review. Also present was her son and daughter-in-law. The family indicated that the current arrangements were positive and generally worked , Martha stated that the arrangements worked for her and that she was happy with the care provided and with the support of her family. In discussion Martha and her family spoke about the reduced mobility of Martha, who was at this stage bed or chair bound. The support required was assistance in personal care and hygiene , managing incontinence , alongside managing transfers, feeding and medication.

5.13 Martha presented as fiercely committed to remaining at home and in her local community. The care support plan notes the need to break down information into simple language to help Martha reach decisions and emphasises the ability of Martha to articulate her needs, throughout the review she remained committed to living at home. Options such as respite, day centre provision and nursing care were explored but all declined by Martha, who was clear in her wish to remain at home with her family.

5.14 Ealing Adult Social Care regularly reviewed Martha's case in line with the statutory requirements and appropriately brought forward the review prior to her death when her care and support needs changed. The plan for her care and support being adapted accordingly and additional visits arranged.

5.15 An area of some consideration in this review was the role that Martha's family played in her care and whether it was understood by those assessing her needs, whether the family had capacity to care for her in the absence of formal care. What is clear from the paperwork submitted was that Martha's family were committed to continuing to reside with her and to engage in key planning and review discussions. What is less clear is the extent of difficulties they experienced when care stopped. In discussions with Ealing Homecare on the 6th April 2020, it is clear that the family had sought additional support from a neighbour with care experience, to assist in supporting them with Martha's care when the agency had not sent staff. They had initially wanted Ealing Homecare to reimburse the neighbour, but were advised that this wasn't possible, due to the nature of commissioning formal care, the requirements for commissioned staff to be checked etc and because

an agency were already contracted to provide this service. It is less clear whether the neighbour stopped helping because the family couldn't pay for the support.

5.16 There was also information shared with this review relating to potentially criminal activity at the household Martha shared with her family. It is unclear as to how this was considered in the context of Martha's needs and any risk that such activity posed at the time. It is important to note that there was no suggestion that Martha was at any immediate risk, but the wider implications of living in a household where criminal activity was being investigated was never explored. That said Martha remained very vocal in her desire to remain at home.

What happened with regard to the provision of care from the 26th March 2020 until Martha died ?

5.17 It is clear that the care and support plan which formed a pillar of the Local Authorities commissioning arrangements with the Care Agency set out an expectation of 4 visits per day, which were required as part of the contract to supply services to Martha. This was reviewed in December 2019 as set out above. The care plan is a tool used to instruct and inform the Carers what kind of care and support they should provide; it formally sets out the needs of Martha and how the Care Agency is expected to deliver.

5.18 From the information provided to this review Martha was without care at home from the agency contracted to provide care between the period 26th March 2020 (the last visit recorded in the care logs as the 25th March 2020 at 1:00pm) and the 7th May 2020. The family had put in place some temporary arrangements from a neighbour.

5.19 The reasons behind this failure are unclear and there are differing views that should be explored.

5.20 The position of the Agency is that the family turned away Carers as a consequence of growing concern relating to Covid. There is a suggestion in the Agency information presented by the Care Agency that the family were concerned regarding the transmission of Covid through the clothing worn by the care staff.

5.21 The position of the family is that the Agency simply stopped attending. This was repeated to Ealing Social Care staff on a number of occasions as set out in the chronology.

5.22 Both of these positions should be explored by considering the evidence presented as part of this review process. The care logs providing a record of care include a large handwritten statement on the 25th March 2020, stating LAST DAY OF WORK. Those provided to this review only cover a short window of care from the 10th March 2020 to 25th March 2020, they have been written by the Carers. There are no entries in that period referring to interactions with the family relating to concern regarding Covid and care staff visiting. The quality of recording is poor, with largely repetitive entries, however it is reasonable to expect that if a family were concerned regarding the issues around Covid, particularly given the news coverage and concern re Personal Protective Equipment being echoed in the media, that any concern would have been discussed with the Carers visiting daily and appropriately recorded by them. In addition, no evidence was presented to this review relating to action the agency took in line with government advice to ensure staff were appropriately trained and aware of how to handle and alleviate any concerns families might have expressed.

5.23 On the 6th April 2020, the Care Agency has submitted to this review a handwritten recording of a telephone spot check, management oversight report. This report sets out details of a conversation with Martha's daughter-in-law in which the family made it clear they did not wish care to be offered because of Covid. The report indicates that the family have decided to offer care to Martha themselves. The Manager then suggests that the family could have told them (the Care Agency) of their decision.

5.24 By the 6th April 2020 Martha had already been without contracted care for 12 days. From the evidence presented to this review the Care Agency have supplied a copy of a disciplinary letter dated the 9th April 2020 inviting both Care Workers to a disciplinary meeting to be held on 15th April 2020 with regards to failure to communicate with the office regarding the care of the Service User. This Review has not been made privy to the investigation or disciplinary interviews but notes that the letter has been signed and dated by the employer on the 15th April 2020 and the employee on the 20th April 2020. The letter suggests that the family want care to be resumed and that the Supervisor will now be joining those visits.

5.25 Following the telephone call of the Manager to the family on the 7th April 2020 the Agency alerted Ealing Homecare regarding the family situation, indicating that they have visited and been turned away. The Social Worker contacts the family to explore the position and is advised that no visit has taken place that day and reemphasising that the family need help to care for Martha. The Social Worker clarifies the position of the family and requests information relating to the care logs to clarify the position on visiting arrangements.

5.26 The information presented to this review by the agency regarding events of the 7th April 2020 are inconsistent. In an email sent to Ealing Homecare by the agency on the 7th April 2020 it states that Carers attended and were refused access, however in the Management Review it suggests that as instructed they went into the home and went in to provide care which is when they noticed the pressure sore. This account is inconsistent with other Agency reports which indicate the pressure sore became apparent and problematic in early May, indeed the Agency themselves sent an email to this effect on the 7th May 2020.

5.27 On the 8th April 2020 Martha's family contact the Social Worker to advise that no one turned up from the Care Agency to provide care as promised on the preceding day, but that someone turned up this morning requesting the family copy of care logs. These were requested by Social Care on the preceding day from the Care Provider, who should retain a record of the care they are offering, the visit requesting logs must be linked to the request for them to provide logs to the commissioner. A subsequent email from the agency suggests that they are having difficulty sending the logs as their scanner is not working.

5.28 The Ealing Homecare service recorded that care recommenced on 6th May 2020. Regardless of the reasons as to why formal care to Martha stopped it is the contractual obligation of the formal provider to inform the Council.

To what extent was the care package monitored by those commissioning her care ?

5.29 Prior to the concerns regarding Martha and the provision of care from the Agency in this case, Ealing Social Care services had no general concerns over the quality of care provided by this Agency. As is the case in many Social Care Services the route to generally monitor care provision is via the annual review process.

5.30 From information presented to this review monitoring of Martha's care and of her care and support plan was undertaken in accordance with the statutory framework, however when it became apparent that there was a communication breakdown between the family and Care Agency between 25th March 2020 and 7th May 2020, more could have been done. It became clear that the family view and the view of the Agency were different in relation to the provision of care to Martha. From evidence presented, the Ealing Homecare Service and the Social Worker attempted to broker a solution on each occasion that the family confirmed a failure in the package of care being delivered. This was followed up and the Social Worker appropriately contacted both parties. On the 7th April 2020 asking Homecare to instruct the Care Agency to resume visits and to supply copies of logs recording the care they offered.

5.31 On the 22nd April 2020 in a shielding call to the family made by the Cognitive Impairment and Dementia team the family reported no problems, suggesting that all was well with the care being provided. The family make no further contact with Ealing Social Care until the 5th May 2020 when they again report that no formal care has been in place since the 26th March 2020. It is reasonable to assume that the call on the 22nd April 2020 provided some reassurance that all was well, however there were concerns that should have escalated further enquiry and a safeguarding alert.

5.32 By the 7th April 2020 it was already apparent that Martha had received no formal care for 12 days, this in itself should have triggered a safeguarding alert and further investigation. In addition, the agency had been asked to supply copies of records, which were not readily to hand and which they got copies of from the family. These factors should have triggered more professional curiosity as to the events surrounding Martha.

Were there any opportunities missed to raise a safeguarding alert and hold a strategy meeting?

5.33 There were opportunities to consider making a safeguarding referral as highlighted above and to bring professionals together, albeit virtually to discuss Martha's care. This may have provided an opportunity to consider Martha's vulnerability in its widest sense, including her immobility and isolation, this could have included the issues outlined at 5.14 and suggestions of criminal activity from the property.

5.34 In fact a safeguarding referral wasn't formally raised until Martha's admission to hospital and in line with the concerns relating to skin damage as a result of a pressure ulcer. While completed appropriately this was submitted without the necessary Pressure Ulcer Decision support tool to support effective consideration.

Were the views of Martha considered and did they impact on the actions taken?

5.35 From the information shared with this review Martha's wishes and feelings are clearly recorded in her interactions around the identification and assessment of her care and support needs. Professionals recognised her declining health and cognitive difficulties but were sensitive to adapting the approach to glean from her how she was feeling and what her wishes were. Martha was supported in engaging with these processes by her daughter and then by her son and daughter-in-law. Martha's daughter-in-law accompanied her to appointments when she was able to get out and either she or Martha's son were present when meetings took place. What is less clear is whether those providing services and making decisions really considered the 'lived experience' of Martha and the quality of her life.

5.36 There is a significant gap in the quality of records from the Care Agency, the log entries give little sense of Martha, recording instead the process of delivering care and many of the entries are the same with no differentiation.

To what extent did the Covid pandemic and national arrangements impact on the care provided to Martha?

5.37 The timeline of the National announcements in relation to the management of the Covid pandemic are highlighted in the chronology of care in this case. There is no doubt that the impact of the Covid pandemic was unprecedented particularly in the health and care sectors. It is clear from all the evidence that care to Martha stopped on the eve of the introduction of national lockdown measures and yet there is no preamble in the records provided by the Care Agency of the family views on Covid and its impact in the weeks preceding measures coming into place.

5.38 Nor is there any evidence of proactive measures being taken by the Care agency to advise and inform families whose loved ones were in receipt of care as to what they might expect from Carers during this period. This has to be recognised as an incredibly difficult and stressful period for health and care staff, but for the most vulnerable there remained a need to deliver services safely.

5.39 The time period around this case was a time of unprecedented pressure in Health and Adult social care services, documented and considered nationally. It was also a time of reduced regulatory activity by the Care Quality Commission, who have responsibility for oversight of providers and their quality. The pandemic resulted in a much-reduced inspection programme.

6. NOTABLE GOOD PRATICE

6.1

- The GP and District Nursing services responded effectively to try and improve Martha's condition at home. This was monitored regularly, and the intensity increased when the response to treatment was slow.
- Adult Social Care prioritised the review of Martha's care and support package in December 2019 to respond to concerns relating to her quality of life and deteriorating condition.
- The social worker was tenacious in pursuing agencies and in following up concerns.

7. ANALYSIS

7.1 This is a case involving the care and support to Martha and sheds some light on the challenges of commissioning external services to support and safeguard services for people with complex needs who are being supported to live at home.

7.2 There is considerable information that supports the view that Martha was left at home without formal care for a considerable period of time, whether this was for 12 days, as is asserted by the Care Agency or for six weeks as is indicated by the evidence of the family and other agencies. During this time, she developed a sacral ulcer so severe that she did not respond to treatment at home or in hospital.

7.3 Martha was frail and had a variety of health needs including incontinence, feeding difficulty, Parkinson disease and some cognitive impairment, her mobility was severely restricted, these were all identified in her care and support plan. The absence of formal care and the ability of appropriately trained Carers to transition and turn Martha will have impacted on the development of the ulcer.

7.4 The family first alerted the GP to the sore on Martha's bottom on the 5th May 2020 and at this point action was taken to ensure that appropriate services were offered, it was at this stage graded as a level 4 ulcer so already very severe.

7.5 The failure of formal care during the extended period is obviously a factor in the ulcer developing to such a severe point before treatment could be offered.

7.6 The presence of National restrictions relating to Covid is also a factor that led to the 'system' being under strain but does not adequately explain the failure to deliver care, or to advise the commissioners that the service was not being delivered in accordance with the care and support plan.

7.7 The agency concerned in this case presented no evidence to the review relating to their preparedness in relation to Covid. The review saw no evidence of information being shared with Martha or her family, no evidence of staff training in relation to the exception sequence of events and if such information and planning had been in place it was not reflected in the records presented or in the daily care logs.

8. CONCLUSIONS

8.1 It is the conclusion of this Safeguarding Adult Review that while not predictable, Martha's death may have been preventable.

9. AREAS FOR THE SAFEGUARDING ADULT BOARD TO CONSIDER

1. The arrangements for commissioning care and support from external agencies should be considered by the Ealing Homecare service, to include the expectations placed on providers for effective communication. This includes a minimum expectation on the standards for record keeping and those records should include a degree of personalisation to the service user.
2. Before commissioning care an agency should be required to submit evidence relating to staff training and awareness raising, not just in relation to safeguarding, but in the key elements of providing care to adults living in their home setting. The commissioning agency should be assured of the senior leadership commitment to discharge the effective supervision and support of the workforce.
3. The recording of reasons for care stopping also need to be clear and explicit – recording a reason as 'holiday' for example is not acceptable when a service is a commissioned service.
4. When a complaint is logged by a family relating to care provision not happening in accordance with what is agreed, Ealing Homecare should consider how they can ensure a service is maintained until ALL concerns with the existing provider are resolved, this may include commissioning a standby or emergency service.
5. All staff need to be reminded of the threshold relating to raising safeguarding concerns.

6. Consideration needs to be given to communicating that pressure ulcers can be an example of acts of omission and neglect .
7. For Service Users living in high rise accommodation with mobility issues consideration should be given to evacuation in an emergency as part of the care and support plan Although not necessarily a finding of this review it represents good practice.

The contents of this report have been shared with all parties who contributed information.