"*To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities*"

Thematic Safeguarding Adult Review (SAR) - Adults David, Fred & Emma

Names have been anonymised

Contents

1 Introduction- the legal framework.

1.1 The Care Act 2014 brought in a statutory requirement to undertake Safeguarding Adult Reviews (SAR).

1.2 Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Under section 44(4) a SAR can be undertaken in other cases concerning adults with care and support needs.

1.3 The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case, might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

1.4 The Thurrock Safeguarding Adults Board (TSAB) SAR Panel, including representatives from the 3 statutory partners, considered the case referral for Adults: David, Fred & Emma on 15 March 2022 and concluded that the Board will conduct a *Thematic Safeguarding Adult Review*. The recommendation to commission a SAR was subsequently approved by the TSAB Independent Chair.

1.5 Each individual referral alone was on the cusp of whether a Mandatory SAR (s.44(1)) needed to be commissioned because the concerns mainly related to a single agency. Given that the three referrals covered some similar issues and it was felt that there was potential learning it was decided that a discretionary (s.44(5)) *Thematic Safeguarding Adult Review* was commissioned. A *Thematic Safeguarding Adult Review* is able to consider all three cases and can draw out common themes relevant to the three people concerned and assume a degree of wider applicability.

1.6 In respect of all three adults, David, Fred and Emma, their families were supportive of this review and have written a little about their parents. This follows below. The author of this review has spoken to each of the daughters whose parents are concerned in this review. All three are caring and articulate and have pushed for a review like this. It is likely that the themes and conclusions from this review will apply to other people and that what happened was not limited to the three individuals involved.

1.7 This review had reached a point of conclusion before the case of one of the individuals, David, was considered by the Coroner. The Inquest concluded that David had died from natural causes, but that he had suffered neglect shortly

before his death. This review had to be partially rewritten to include this and also some information that had been made available to the Coroner but not, previously, to this review. Safeguarding is at its most effective when agencies are open to internal and external scrutiny. The information made available to this review from Mid and South Essex Hospital Trust was incomplete, it did not aid this review, nor did it help David's daughter come to terms with her loss. Most importantly it did not provide the hospital with an opportunity to learn and improve from some things that went wrong. This is addressed further later in the review.

1.8 This *Thematic Safeguarding Adult Review* will address the following areas:

- The whole care pathway from hospital admittance to discharge
- The Serious Incident process to include whether there is transparency in learning
- How well were concerns from family members managed?
- The impact of Covid-19 on the individuals involved

These terms of reference were amended in June 2023 by the Independent Board Chair in response to new information received at the Inquest of David to include:

- The identification and response to neglect, including learning from this
- The role family, friends and advocacy play in preventing a culture of poor care
- The openness of agencies to scrutiny and challenge

1.9 Every Safeguarding Adult Review concerns a person, or people. Where possible it is right that the review should contain their voice in some way. Below are short pieces written by family members of those concerned in this review. The author and Core Group members give their condolences to each of the family members involved and express our gratitude for the information they have provided.

1.9.1 Fred. Written by his daughter and family.

Our dad Fred was 85 years old when he passed away, he was married to our mother for 56 years when she sadly passed away from cancer in 2013. During their marriage they had 3 children and were foster carers, through this role they adopted one and provided a long term foster placement to another. All 5 children were lovingly cared for by our parents and all remain close to this day. Fred worked his entire adult life as an accountant and was a keen sportsman. When he stopped playing, he moved into managing children's football and cricket teams. He was well known and liked in our local community for these roles and was awarded the Jack Petchey Award for this work. Even though he was diagnosed with vascular dementia in 2017 he was able to live independently at home with the support of agency carers and his family. He

loved attending the local Day Centre, where he made lots of friends and would enjoy their day trips out. He was also supported to attend his weekly Table Tennis Club and he doted on his 6 grandchildren and great grandchild. Everyone who met Fred loved him, he had a way about him that made you feel at ease when talking to him, he was such a gently, kind soul and would never complain, he would be the first to help anyone who needed him. As children he would be the one to drop us off and pick us up from all of our activities (and there were many for 5 children) and as adults he would want to hear all about what we had been up to and would want to know how his grandchildren and great grandchild were doing. He was very proud of his family and would tell everyone all about what we were up to. Our father appreciated and would often thank everyone for the all the support he was given to enable him to remain living in the home he had resided in with our family for 33 years.

1.9.2 David: Written by his daughter

My dad worked from when he left school, he had already met my mum then. His last job was in the docks with his younger brother where he worked for over 15 years and his brother is still there now. He was known for always drinking a cup of tea and being the joker always taking the mick out of someone. He was the most supportive dad with anything that me or my brother wanted to do from being kids into adult life. He used to wind us up too especially when we had friends round but our friends always thought he was great! We could call him at any time day or night and he would be there he would moan but he would be there. If I had to find one word to sum up my dad it would have to be funny but he would also stand up for what was right and if we were wrong, he wouldn't be shy in telling us. He enjoyed riding his motorbike and loved his grandchildren dearly, they were the apple of his eye.

1.9.3 Emma: Written by her daughter

Emma *was an intelligent woman, she finished her degree in English literature in her forties and was an avid reader of just about every genre going. She was a daughter, sister, auntie, mum and grandma and every one of these roles she undertook with passion and commitment. She worked until retirement and generally led a very quiet and unassuming life. Mum was intensely shy and hated making a fuss or being centre of attention. She was independent and always wanted to be as neat as a pin, always taking care to be in some shade of pink - her favourite colour. Her health in latter years was complex, but she managed this with aplomb and knew exactly what was what. Until her fall she was still fully independent in her daily tasks and also loved to cook and bake for the family. She was loving being part of a bigger family having moved in with us and that was sadly stripped away. Her health, mobility and independence pretty much vanishing overnight - she went into hospital independent but obviously unwell, she came out subject to 4 times a day care package and lots of modified equipment. Sadly, it made the last year of her life hell.*

1.10 A SAR is about:

- Learning lessons for the future
- Making sure that Safeguarding Adults Boards get the full picture of what went wrong
- Improving the practice of all organisations involved
- Not apportioning blame

1.11 The Independent SAR Chair of the Panel, who is also the Overview Report writer, is a safeguarding consultant. He is a qualified Social Worker. He has held a number of safeguarding roles and was, from 2015 to 2018, the Independent Chair of the Walsall Safeguarding Children and Adults Board. He provided the safeguarding expertise into a review of safeguarding failures at the Royal National Institute for the Blind (publ. Charity Commission 2020) and is the Independent Safeguarding Chair for Dimensions UK. Apart from authorship of Safeguarding Adult Reviews and Domestic Homicide Reviews he has no connections with any agencies in Thurrock and does not live in the area. He is therefore independent of all agencies and people involved in this review.

2 Contributing agencies

- Alan Critchley - Chair/SAR author
- Les Billingham/Iyobosa Osunde - Thurrock Council
- Mohammed Shofiuzzaman – Mid and South Essex Hospital Trust
- Linda Moncur – Mid and South Essex NHS Integrated Care Board (ICB)
- Tendayi Musundire - EPUT
- Natalia Ross - Essex Police
- Neil Woodbridge - Thurrock Lifestyle Solutions (Independent)
- Sarah Dawkins - Legal advisor

3 This SAR

3.1 Information for this review has been received from Mid and South Essex Hospital Trust, Mid and South Essex ICB, Essex Police, EPUT, NELFT and Thurrock Council. Receipt of the agency information was coordinated by the Thurrock Adult Safeguarding Board. Further information was received from the daughters of the three adults concerned.

3.2 David, Fred and Emma were in three different wards on three different sites. All wards are the responsibility of Mid and South Essex NHS Foundation Trust, although Brentwood Community Hospital is the overall responsibility of NELFT (North East London Foundation Trust) responsibility for the ward that Fred was on transferred to Mid and South Essex NHS Foundation Trust just prior to his stay.

3.3 The story and timeline of the three patients covers the time of the Covid-19 pandemic and it is recognised that the care provided would have been atypical as agencies responded to the considerable demands of the pandemic.

3.4 The timeline for the review is 1 December 2020 to 5 August 2021 with individual timelines, for those involved as follows.

3.4.1 **David:** aged 55 at the time of his death. The timeline is 6 July 2021 to 5 August 2021. David was admitted to Mid and South Essex Hospital Trust on 6 July 2021 with shortness of breath, fever and a cough and one of his feeding tubes was "buried".

3.4.2 **Fred:** aged 85 at the time of his death. The timeline is 1 December 2020 to 28 December 2020. Fred was a patient in Bayman Ward, he had been admitted following a fall at his home.

3.4.3 **Emma:** aged 73 at the time of the incident. The timeline is 5 January 2021 to 30 January 2021. Emma was a patient in Bulphan Ward, she had been admitted following a fall at home.

4 Protected characteristics

4.1 Age and disability are relevant. Age to Fred and Emma, disability to David. This review has been given no evidence that discrimination occurred that is relevant to these protected characteristics.

5 Covid

5.1 Throughout the timeline of this review the hospitals were, to a greater or lesser degree subject to Covid regulations. All were more pressured by the pandemic than at "normal" times due to an increase in patients and the absence of staff. It is also right to say that staff in all roles would have been tired by the demands of working through the pandemic.

5.2 Whilst there was some national guidance on how hospitals should manage during the pandemic it was also down to some individual judgement and there was not necessarily consistency across hospitals on how each ward was managed. This is not said as a criticism; different wards would have had different resourcing and differing needs over the period.

5.3 During Fred's time in hospital his family were unable to visit him due to the Covid regulations in force at the time. He was not good with technology and didn't use a mobile phone. There was therefore no direct communication between Fred and his family between his admission and his discharge. In fact, the family were later told that the ward had been gifted some iPads by a charity

and they could have used this means to have communicated with him and they might have identified his condition at an earlier point.

5.4 He was due to be discharged to a Care Home for a week whilst his house was being adapted for his return home. That changed when Covid was identified on the ward he had been on. The Serious Incident (SI) notes a shortage of nursing staff. There was an agreement that only essential aspects of nursing care would be recorded during the pandemic. As a result, food and drink intake was not recorded as it would normally have been and Fred's apparent refusal to eat was not recorded. Failing to record food and drink intake may have been unwise and it may be that an abbreviated form of recording could be used if the circumstances arise again. **(Note for future pandemic planning).**

5.5 There was, of course, significant pressure on hospital beds during the pandemic and there may have been some pressure to discharge Fred if he was considered to be medically well enough to do so. However, the evidence seen by this review, from the family and the Serious Incident report is that he was not well enough. The original intention was that he was discharged to a Care Home but this plan was changed due to there being Covid on his ward. This late change of plan, for understandable and sensible reasons, meant that a community plan needed to be agreed. This was agreed, and the day after his discharge, a hospital bed was ordered for him to be delivered to his home. He should not have been discharged without this being in place.

5.6 Emma's daughter was only able to visit on one occasion. She was understandably concerned that contacting the ward with her concerns would add to the pressures on an obviously struggling staff group. However, she contrasted the single, Duty of Candour call that she received during the timeline of this investigation with the good practice of a regular, daily call from the rehabilitation ward once Emma was transferred from Bulphan Ward.

5.7 David's daughter was his nominated visitor during the pandemic. Prior to this other family members had supported him but during the pandemic this fell to her. She spoke of wanting to do more but her significant family commitments meant that she was fully stretched. Prior to Covid other family members had visited and supported David's care.

6 What happened to David, Fred and Emma in hospital?

6.1 Considerable detail of what happened to Fred and Emma in hospital are set out in Serious Incident Reports and will not be addressed in full in this review. The main points relevant to this review are set out in the individual accounts below. David was not subject to a Serious Incident investigation, although information subsequently received suggested that he should have been.

6.2 **David.** David had suffered a cardiac arrest in 2013. He experienced a hypoxic brain injury (part of the brain was starved of oxygen) and was considered to be in a “low state of awareness”. This means that he may have been aware of his surroundings to a degree but would, in practice, be unable to communicate. He was able to sit in a wheelchair and look around him but, it was said, probably had no awareness of his surroundings. He moved to a Care Home in 2017 from hospital. He was fed through a gastronomy tube and was at high risk of having breathing difficulties and chest infections if he was not placed properly in bed. This meant that he had to be at, at least, 45 degrees elevation. This applied throughout all of David’s care, both in the hospital and Care Home.

6.3 In the weeks leading up to his death David was admitted to Mid and South Essex Hospital Trust on 6 July 2021 with shortness of breath, fever and a cough. One of his feeding tubes was “buried”. The hospital records that he was admitted “in a very poor state from the community”. This review has seen no evidence to suggest that David was in fact admitted in a very poor state. The hospital said that they had raised a safeguarding concern against the Care Home regarding this, it later transpired that they hadn’t. If it were the case that David was admitted in a poor condition the hospital should, of course, have raised a concern.

6.4 The “buried” feeding tube was removed under local anaesthetic and David returned to the Care Home on 2 August 2021 being assessed as “medically stable for discharge”. It was documented by the hospital that David had been given a full body wash prior to discharge.

6.5 On 6 August 2021 the Care Home raised a safeguarding concern that David had been returned in a poor condition having flaky skin, a bruise not mentioned in the discharge summary, an incision site prone to infection and other serious concerns. The author of this review was told that these were rebutted by the hospital and the safeguarding enquiry was inconclusive. The hospital responded to the concerns raised within the S.42 enquiry and gave explanations on the points. It was only after the Inquest that this review was given a copy of the Safeguarding Concern from the care home dated the 3 August 2021 and the photographs that accompanied it. The written Concern included photographs which are graphic and troubling and do lead to the conclusion that David was indeed returned to the care home in a poor state. This review was also told that the hospital had raised a counter safeguarding concern with the care home. This proved to be inaccurate.

6.6 The rebuttal by the hospital of the safeguarding enquiry was inadequate and did not consider the photographs provided by the Care Home.

6.7 The Safeguarding Chronology shows that the Safeguarding Concern was sent to the ward and completed by a Matron who admitted to the Inquest that she had done this without the benefit of viewing the photographs supplied by the Care Home. The Coroner concluded, based on the photographs, that David had not received personal care for some days and that he had been neglected. It is difficult to understand why the photographs would not have been viewed as part of the contemporaneous safeguarding review.

6.8 It follows from this that hospital notes saying that personal care, including "a full wash on the day of discharge" were false. The Coroner confirmed that the evidence provided showed that the poor care covered a "number of days".

6.9 David was readmitted to hospital on 12 August 2021 because his PEG (feeding tube) had come out or was loosened. The following day David was said to be nearing the end of his life and "palliative" (the latter proved to be inaccurate at the inquest) and he sadly died on the 15 August 2021.

6.10 David's daughter has submitted a substantial amount of information to this review including medical notes, photographs she had taken and videos. She is clear that her father received poor care by the hospital, including poor bed positioning, that her father was unkempt and unshaven whilst on the ward and that he developed a significant skin condition that was not properly treated. The reason that she kept such copious notes, photographs and videos was because she simply didn't trust the hospital to care for her father. Undoubtedly, she made him more comfortable and she did what she could to ensure that he was looked after. A complaint in respect of David's care was raised by his daughter on 31 August 2021. Two responses were completed with a final response being sent to the family on 8 November 2021. The responses have not been made available to this review.

6.11 Some of the records seen were poorly completed or inaccurate, suggesting for example that her dad could read and write although in reality he was unable to communicate in any way. Whilst this may have been carelessness with the records it failed to accurately portray the man himself. She has also provided an excerpt from the medical notes showing that a PEG tube (Percutaneous Endoscopic Gastronomy) had been inserted incorrectly.

6.12 David's daughter is clear that her father's voice was lost in hospital given that his capabilities were inaccurately portrayed via the notes. Given his brain injury he was unable to communicate in any meaningful way and his daughter was the bridge between him and those who looked after him in hospital. She felt at the time, and still feels strongly, that the hospital could have acted more inclusively by using her voice more effectively in her father's treatment and that, in effect, she could have acted as his advocate. The Continuing Healthcare

Assessment from 2019 stated that David "continues to be in a low state of awareness and relies on those who are familiar with his condition to anticipate his care needs and act in his best interests to protect him from harm or unnecessary health deterioration." This confirms the importance of the role that David's daughter had in supporting him. This could have helped him and would have provided a more direct, and potentially helpful, link between the hospital and the family. It would also have helped to develop a more trusting and mutually beneficial relationship between family and hospital.

6.13 I have read the criteria for a Serious Incident in place at the time (https://www.england.nhs.uk/wp-content/uploads/2020/08/Serious_Incident_framework_NHS_England_.pdf). With the knowledge now available it may well have been appropriate to undertake a Serious Incident investigation at the time on the basis of "**acts of omission which constitute neglect**", exploitation, financial or material abuse, discriminative and organisational abuse, and that:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or
- where abuse occurred during the provision of NHS-funded care".

It is certainly right to reopen the safeguarding concern and to ensure that this is properly undertaken with all the information available.

6.14 The Care Home has not participated in this review in spite of an invitation to do so.

6.15 **Fred** had been a patient on Bayman Ward, Brentwood Community Hospital from 2 to 13 December 2020. Bayman Ward specialises in those people who are frail and elderly. He had been living alone at home and, although frail with a number of comorbidities, he had been caring for himself with support from his family and carers. He had been reported as previously healthy, albeit with kidney disease, a difficulty in swallowing which necessitated a soft diet, and vascular dementia. His family say that he attended a day centre five days a week, he walked unaided and played table tennis one day a week. Following a series of falls he was admitted to hospital on 1 December and was transferred to Bayman Ward on the 2 December. The family confirmed that on the day of admission he was able to walk into the ambulance, speaking to neighbours as he went.

6.16 During his time on the ward his family were reassured by telephone when they rang that Fred was making progress, eating well, mobilising and sitting up in bed. He was discharged on 13 December with the discharge planning supported by the Complex Case Management Team (a specialist adult social care team).

6.17 Fred was readmitted on the 16 December via A and E. He had sepsis, he was dehydrated, not eating, had delirium, a persistent cough and pressure ulcers. He sadly died on the 28 December 2020 having caught Covid.

6.18 At the point of admission to Bayman Ward Fred was assessed on the Waterlow Score (http://www.judy-waterlow.co.uk/waterlow_score.htm) as being at 17 (at risk of Pressure Ulcers). It was recalculated the following day as being 32 (very high risk). The response to this has been recognised as inadequate by the hospital in the Serious Incident Report. Fred was noted to have pressure ulcers by the 9 December. This was not communicated to the family, nor was it recognised in the discharge planning process.

6.19 Because documentation was reduced due to the pandemic and Fred was not subject to a food chart there is no reliable record of Fred's nutritional intake, though the nursing record from the time and relayed to this review indicated that the patient was "eating and drinking well". This contrasts with the family account. Due to the difficulty that Fred had with swallowing he was used to "grazing" all day at home. On some wards a grazing plate was available for people like Fred, due to the ward using a different food supplier this was unfortunately not available to Fred.

6.20 Fred was due to be discharged to a Care Home for a week whilst his home was adapted for his return. But this was cancelled due to there being Covid-positive cases on the ward.

6.21 On the day of discharge the family rang the ward and were told that Fred was fine, doing well, mobilising and sitting up in bed**.** The information given was that Fred had a small pressure ulcer (level 2) at the bottom of his spine. This was the first time the family had been told of this. It was agreed with the family that Fred would return home to a downstairs room which was being specially prepared for him.

6.22 When Fred's family went to the hospital to collect him, they described him as dirty, unshaven, disoriented and vomiting constantly. He had noticeably lost weight. He was in a wheelchair because he couldn't mobilise independently. His heels were dressed due to further pressure sores. The family described being shocked by Fred's rapid and visible deterioration and compared it to how he had been when he walked into the ambulance just prior to admission. The family did not consider that Fred was medically fit for discharge. The Serious Incident Report appears to confirm that he wasn't. He was discharged at 16.10pm

6.23 The family were told by the Social Worker that referrals had been made to a District Nurse, a physiotherapist and an Occupational Therapist as part of the discharge plan. The “package of care” arranged with Social Care was due to start at 18.00 that day and a carer arrived at 21.30. At that point Social Workers were working remotely and relied on information supplied by the ward rather than their own assessment.

6.24 A District Nurse visited on the 14 December, the day after Fred’s discharge and, at the direction of the GP, ordered a hospital bed, Fred was then determined to be “palliative”.

6.25 Over the following 3 days Fred continued to deteriorate before he was readmitted on the 16 December by which time he was only semi-conscious. He was re-admitted via his GP who called an ambulance after seeing him on a home visit.

6.26 In view of Fred’s condition on discharge a safeguarding alert could, and should, have been raised.

6.27 **Emma,** aged 73 at the time of the incident, was in Bulphan Ward, a surgical ward in Mid and South Essex Hospital Trust from 5 January 2021 up to her discharge to a rehabilitation ward on 30 January 2021.

6.28 She had a number of comorbidities including heart and kidney disease. She had been living at home with her daughter and family and had been admitted following a fall and with Covid pneumonia. Over the next few days her condition seems to have improved but on the 10 January she suffered an unwitnessed fall which caused a broken hip.

6.29 For the following few days Emma was too unwell for surgery and it was delayed until 17 January 2020. Following surgery, she remained on the ward until 30 January 2020 when she was transferred to another ward for further rehabilitation.

6.30 The SI has covered this time of Emma’s stay in hospital in detail and has identified failings, notably that a falls assessment was not completed on admission and the wrong hoist was used to raise Emma after her fall on the ward.

6.31 Whilst the SI covers the fall, it does not have a wider remit to consider concerns identified by Emma’s daughter about more generalised treatment on the ward. Throughout her stay on the ward it is said that Emma felt, “*lonely, ignored, vulnerable, humiliated, frightened, very sad and cut off from her family*”. The most difficult time seems to have been after Emma’s fall on 10 January and

before her transfer to the rehabilitation ward on 30 January. During the early part of this period, she was at times "*nil by mouth*" because surgery was possible at almost any point. Her daughter was able to visit on 12 January and she described her mother as, "*bedridden, in pain, covered in oral/nasal cold sores*". Her mouth was dry with no evidence of oral hygiene care or treatment. The author of this review was provided by Emma's daughter with a number of distressing WhatsApp messages that her mother sent at the time, for example, saying that she was "*constantly wet from urine and in so much pain*" (12 January) and "*just spent four hours sitting in poo I'm so sore*" (27 January). "*I am in a tiny room and the door sounds as though it is locked. I have no frame so I cannot move from my chair. If I tried to do so I'd fall over. So yes, I do feel like a prisoner"* (15 January) and "*I need to go to the toilet but I can't find my call button, I've tried calling out but nobody replies*". (15 January).

6.32 Emma's daughter notes that communication from the hospital was poor saying that she received only *Duty of Candour* calls. In fairness, she said that she realised that the staff were particularly pressed during the Covid period but contrasted it with the communication she later received from the rehabilitation ward where there was a daily, reassuring, welfare call, also during the Covid period.

6.33 The SI is specific to the fall suffered by Emma. In respect of matters not covered by the Serious Incident Report, Mid and South Essex Hospital Trust submitted a Safeguarding report in May 2021 to Thurrock Council (Adult Social Care). The hospital substantiated the concerns raised by Emma's daughter with the following learning points noted:

- Evidence of poor documentation and note keeping throughout the admission in relation to personal care and oral care.
- Poor oral hygiene management when the patient was Nil by Mouth.
- Pressure Area Management – SSKIN Pathway (Pressure ulcer documentation which should demonstrate proper management of the ulcer).

Feedback from the complaint was given to Emma's daughter in February 2022 and the concern was closed. SET (Southend, Essex and Thurrock) procedures 2022 say that a concern should be kept open until the SI is complete. The concern was closed at the point the SI was signed off, albeit Emma's family were unaware of the sign-off.

6.34 The Serious Incident report identifies failings. The information from Emma's daughter adds to the concerns about Emma's care on the ward and, in response to a complaint, the Director of Nursing wrote to Emma's daughter, "*it is harrowing to read the description of the poor care that your mother has received whilst on Bulphan Ward".*

7 Serious Incident Reporting

7.1 One of the reasons for the commissioning of this review is that the Safeguarding Adult Board had been concerned about the length of time the two Serious Incident Reports in respect of Fred and Emma had taken and that no initial learning had been shared. This led to a more generalised concern that the Serious Incident reporting system for safeguarding enquiries was not robust. In respect of Fred the CCG (now ICB) notified the Board on 10 August 2021 to say that the SI had been commissioned and was "*going through the 60 day process*". The intention at that stage was to share the contents of the SI in September 2021. An update was given at subsequent meetings but only to say that the SI was still incomplete. The reporting with regard to Emma was similar. With new information received with regard to David, it may well have been appropriate to have undertaken a Serious Incident report. This is referred to above.

7.2 The Board could have been reassured at the time if the explanation had been given that the reporting timescales had been lifted during the Covid-19 period and also that the initial findings from an SI are reported internally within 72 hours of the incident being declared and that changes can be made at that stage.

7.3 Communication has now improved but a recommendation will follow from this review that that Board should monitor the SI process for safeguarding enquiries to ensure that it is robust, that there is appropriate and meaningful family engagement and that learning is shared in a timely manner.

7.4 The NHS has an incident reporting system where there are concerns that the standard of care/treatment provided led to unexpected or avoidable death, harm or injury to patient, carer, staff or visitor. The Serious Incident process will not address safeguarding issues unless they are relevant.

7.5 Mid and South Essex NHS Foundation Trust determined that the treatment of Fred and Emma met the criteria for a Serious Incident (SI). These SIs were undertaken on the framework current at the time (https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf) which had been introduced in 2015.

7.6 The guidance current at the time specified that an initial review should be complete within three days, this is known as a "72 Hour Review". The incident in respect of Emma didn't meet the criteria for a "72 Hour Review" as it was a fall. The incident in respect of Fred did and was completed, albeit this was not shared with the Board at the time.

7.7 NHS England's expectation is that Serious Incidents should be complete within working 60 days of the incident being reported on the StEIS (Transfer of Strategic Executive Information System - the system used to report and monitor the progress of Serious Incident Investigations across the NHS). Where it is not possible to complete the investigation within 60 days an alternative timeframe should be agreed internally and with the individual/family https://www.england.nhs.uk/wp-content/uploads/2020/08/Serious_Incident_framework_NHS_England_.pdf. It is not clear from either report, or discussion with the families, that an alternative timeframe had been agreed.

7.8 During the period of Covid the timescales for SI reporting were relaxed and the reasons for this are understood. This information should have been shared with the Adult Safeguarding Board. There was no relaxation of safeguarding responsibilities.

7.9 However both Serious Incidents referred to in this review were significantly over the timescale required and there was a lack of communication with the families with regard to this. It is concerning that the families were waiting so long for a conclusion. Some reassurance was provided to this review that changes in practice were implemented during the review process and prior to the SI conclusion. There was also a lack of clarity about when the SI process completed. Both families where there was an SI expected to be able to provide comment or have input into the process past the point where the hospital had concluded the SIs. Meaningful engagement with the families would have allowed for their full input.

7.10 The incident date for Fred being recorded as 9 December 2020 and the report was finally approved on 12 September 2022 by the Deputy Chief Nursing Officer. It was submitted to the Commissioners on the same date. At the time of writing in March 2023 Fred's family are unhappy with the report and had hoped to be able to provide comment. The Action Plan in respect of this SI is dated 12 September 2022.

7.11 The Serious Incident in respect of Emma was believed to be incomplete during the drafting of this review. Subsequent information provided has shown that it was signed-off as complete on 7 February 2022. The incident that triggered it occurred on 10 January 2021. The Investigation Report date on the front sheet is 14 April 2021 but it is not clear whether this was the date of completion of the first draft or when the work began. An enquiry about the timeframe confirmed that the author was still in discussion with Emma's daughter in October 2022. The apparent confusion in when/whether the review was signed off and how this is communicated to the family and Board this should be resolved by the full

application of the new framework (see below) and is the subject of a recommendation.

7.12 Since August 2022 the NHS Serious Incident Framework has been replaced by the Patient Safety Incident Response Framework (https://www.england.nhs.uk/patient-safety/incident-response-framework/) with the intention that this replaces the Serious Incident Framework over an implementation year. The timescales for the reporting remain the same as for the previous Serious Incident framework and this is set out in the guidance that accompanies the Framework. (https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/). Also set out in the guidance is how trusts should engage with families. It is good that this Framework is being presented to the Thurrock Adult Safeguarding Board.

8 Care Quality Commission (CQC)

8.1 Brentwood Community Hospital is the overall responsibility of the North East London Foundation Trust (NELFT). Bayman Ward, the ward that Fred was on was managed by NELFT up to 24 November 2020 and then by Mid and South Essex Foundation Trust. Brentwood Community Hospital has not been inspected by CQC. The last time the site was visited by them was in September 2013. An outcome of this review is that the Board will clarify who has responsibility for each ward and that oversight and assurance should be clear.

8.2 Mid and South Essex Hospital Trust was assessed by CQC in early 2023. This was an unannounced focused inspection because information received by CQC gave them cause for concern about the safety and quality of the services of medical care and older people's services. The overall assessment was "*Inadequate*". The areas inspected being "*Safe*", "*Effective*" and "*Well-led*", all were "*inadequate*".

8.3 Bearing in mind the contents of this review the Thurrock Safeguarding Adult Board will wish to monitor the performance of the hospital closely.

9 Common themes

9.1 Analysis and concluding comments on the Terms of Reference:

9.1.1 The whole care pathway from hospital admittance to discharge.

Both Fred and Emma were discharged from hospital in need of more care than prior to their admission. David was also discharged in a very poor condition. Information in the SI reports support the accounts of the family. Fred was only at home for three days post discharge before being readmitted. Emma required a care package for the remainder of her life. The level of care provided to David in hospital has since been found to have been very poor. There are some individual areas of poor practice and, in the case of Emma, expected practice

once she was transferred to a rehabilitation ward. Given that the three cases referred to in this thematic SAR are concerned with the period of Covid-19 at its most challenging there are no conclusions to be drawn in respect of the whole care pathway.

9.1.2 The Serious Incident process to include whether there is transparency in learning.

The incident reporting in respect of Fred and Emma was significantly delayed and the point of completion was unclear, to the families and Board at least. The point of such a review is to gain rapid learning to ensure that what happened is analysed, corrected and the chances of the same thing recurring are reduced. Such reporting is also likely to be cathartic for relatives and loved ones if undertaken sensitively and promptly. For both reasons, recommended timescales should be adhered to. Likewise, the “72 Hour Learning Report” should be shared with the local authority where there is information that is relevant to an open safeguarding enquiry. The Serious Incident Process referred to in this review has since been replaced. Serious Incident Reporting was undertaken with two of the three cases mentioned. Whilst an assurance has since been given that learning was shared internally within the hospital, it was not shared with the Thurrock Safeguarding Adults Board. Despite requests for information following the SAR referral this led to concerns about a lack of transparency. This concern has been addressed by the hospital, and ICB, the Board will monitor the application of the framework.

9.1.3 How well were concerns from family members managed.

The family members interviewed for this review all report very poor communication from the hospital. The inefficient SI reporting system used at the time has compounded this for the families of Fred and Emma. When a loved one has been lost and some degree of fault has been admitted this is, in part, inevitable but the author of this review does not have a sense that the hospital has done all that it could to work with the families to achieve resolution, or to show that learning and change has resulted from what went wrong. At the time of finalising this review the three families remain unhappy. Whilst there is sometimes an inevitability that this will be the case where a loved one has died there were elements of poor communication in all. With regard to Emma and Fred the SI process was delayed and information from the families could have been included and/or clarifications given. In respect of David, he was unable to communicate with the hospital staff. His daughter knew him very well, of course, and was familiar with the care he had received since 2013. She believes that the hospital should have included her more in his care and taken her concerns more seriously. From the information presented latterly to this review, this would have benefited David.

9.1.4 The impact of Covid-19 on the individuals involved.

The three people subject to this thematic SAR were in hospital at the height of the Covid-19 pandemic. Hospital, Social Care and staffing resources were under extreme pressure and staff would, no doubt, have been tired, stressed and concerned. There are some comments in this review about what might have been different and there is some learning in case of further pandemic.

9.1.5 The identification and response to neglect, including learning from this.

The hospital didn't identify neglect themselves in any of the three cases at the time of treatment/discharge. With regard to Fred and Emma the combination of the Serious Incident reports and the complaints process identified failings, albeit some time after the events. It took the Inquest to identify neglect in the case of David some twenty-one months after his death. There were numerous opportunities to have done so before, when the Essex Safeguarding Team asked for a Professionals Meeting in October 2021, when there was a case discussion between Thurrock Safeguarding Team and the Mid and South Essex Hospital Trust safeguarding team in November 2021, a discussion between the Essex Safeguarding Team and the Mid and South Essex Hospital Trust team in December 2021, a discussion with the Continuing Health Care safeguarding lead in December 2021 and a case discussion the same month which involved the author of the original safeguarding response. A further safeguarding forum discussion in February 2022 acknowledged that the areas of David that had been washed weren't documented and yet the finding was still "inconclusive "at that stage. It is now to be reopened but diligence should have been shown before now. A further significant opportunity for the hospital to bring all the information together and to reconsider was the point where this review was commissioned. It is of concern that the totality of the information given to the Coroner was not also given to this review given that it was commissioned for scrutiny and learning. As said in the introduction one of the purposes of an SAR is to make sure that Safeguarding Adults Board get the full picture of what went wrong.

9.1.6 The role family, friends and advocacy play in preventing a culture of poor care.

The period this review covers is a-typical in that the NHS were experiencing the Covid pandemic, hospital staff were stretched and visiting, along with family engagement was significantly reduced. That said, family engagement could, and should, have been better and the body of the report covers this in relation to David, Fred and Emma. A recommendation follows in respect of this.

9.1.7 The openness of agencies to scrutiny and challenge.

This is, in part, covered in the section above on neglect and the response to neglect. This review did not receive full disclosure and aspects of the review findings were challenged at several stages. There was no acceptance at one

stage that a “Thematic Review” has the same standing and authority of a “Safeguarding Adult Review”, this was in spite of the Terms of Reference being agreed by the Board where the NHS is well represented. The experience of the process for completing this review is that there is some way to go before there is an open learning culture; this is a significant concern.

10 Recommendations

1) That Mid and South Essex NHS Foundation Trust ensure that their Serious Incident Reporting is in line with the NHS England guidance for Patient Safety Incident Response Framework (PSIRF). There is a suite of accompanying documents including the Standards https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf which set out a timeframe of no more than six months. Following the transition to the NHS Patient Safety Incident Response Framework in Autumn the Trust will have a process to ensure that incidents are reviewed and the most suitable, proportionate response will be applied to incidents. This will be included within the Trust’s Patient Safety Incident Response Plan. The Trust will need to assure Thurrock SAB that this process is effective with timely learning gained and applied over the following year.

2) That the Mid and South Essex Hospital Trust satisfy themselves and the Thurrock SAB that their record keeping is up to standard.

3) Where there is an open safeguarding enquiry and an ongoing SI/PSIRF, Mid and South Essex Hospital Trust to work with and share relevant information/recommendations with the local authority in order to manage any risks to the adult/others.

4) That the Mid and South Essex Hospital Trust has a patients’ guide to discharge placed prominently on their website. The NHS advise that it is available from the Ward Sister or Patient Advice and Liaison Service (https://www.nhs.uk/nhs-services/hospitals/going-into-hospital/being-discharged-from-hospital/) but there is no reason why it shouldn’t be actively promoted. It will cover the inclusion of family and friends and, where appropriate, how and when an advocate should be appointed.

5) That the Covid section of this review is considered with regard to pandemic planning.

6) That the hospital, Social Care and other agencies consider how they can improve their communication with the family members so that patients and their families are better supported and a more collaborative way of working emerges. A plan for this to be reported to the Thurrock Safeguarding Adults Board.

7) Where a patient is unable to communicate verbally or directly with hospital staff that the family or carer are involved in working out how the voice of the patient is heard and understood in their treatment plans. Examples of how this is done to be presented to the Thurrock Safeguarding Adults Board.

8) That the Board and Mid and South Essex Hospital Trust ensure that the wards under their management at Brentwood Community Hospital receive proper oversight and that safeguarding assurance is provided to the Board.