City and Hackney
Safeguarding Adults Board

Safeguarding Adults Review of the circumstances concerning Mr GH

Overview Report

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Overview report writer

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CITY & HACKNEY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW OF THE CIRCUMSTANCES CONCERNING MR GH

Safeguarding Adults Review Panel Chair: Nicole Klynman
Lead reviewer/overview report writer: Suzy Braye

FINAL VERSION – December 2016

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1. INTRODUCTION

1.1. Brief overview of the circumstances that led to this review

1.1.1. Mr GH, aged 80, died in St Joseph's Hospice on 28th August 2015, his cause of death given[1] as 'liver malignancy (radiological diagnosis)'. Prior to his admission 10 days previously, he had lived alone in a one-bedroom, first-floor flat in a sheltered housing scheme, having taken up the tenancy in 2006; the flat was adapted for his needs and had a Telecare alarm installed.

1.1.2. Mr GH had a number of long-standing and complex health problems: rheumatoid arthritis, gout, asthma, bronchitis, type 2 diabetes, hypertension and kidney disease; he had right-sided weakness and limited left-side functioning as a result of a stroke 5 years previously. He had venous leg ulcers and a skin condition similar to eczema - varicose eczema, a feature of venous disease – in which the normal pattern is for skin to break, heal and then break again in a chronic cycle[2]. He was prone to pressure sores due to his relative immobility. He experienced shortness of breath, and was unable to stand or transfer without the assistance of carers. He received care and support from a care agency commissioned by London Borough of Hackney Adult Social Care, a total of 31.5 hours per week with 4 visits per day involving 2 carers and a hoist to assist transfers. His personal care included dressing/undressing, strip washing/shower, support with oral care and grooming, change of continence pads, preparation of breakfast and other ready-meals (delivered by a provider), prompting with medication and emptying/cleaning of his commode. He employed a private cleaner who visited twice weekly. His mobility was severely impaired and he used an electric wheelchair/mobility scooter to move around his flat. He also received weekly community nursing services to attend to his leg dressings along with other needs arising from his skin condition, and periodic visits and reviews from his GP, under the surgery's home visiting service for vulnerable patients. He was on occasion admitted to Homerton Hospital (sometimes via A&E) for medical assessment and care when required for his skin condition, pain, or other needs such as urinary or respiratory tract infections, and latterly for assessment of his declining health.

1.1.3. Safeguarding alerts had been raised four times, with concerns about management of his finances and about skin ulcers and pressure sores.

1.1.4. He was in close contact with his sister and brother-in-law, who live in the south of England, with whom he spoke every week. They visited him regularly and at the end of his life were closely involved in discussion and liaison with professional staff about his care[3].

[1] On his death certificate
[2] Homerton IMR: supporting documentation
[3] GP IMR and St Joseph's IMR

1.1.5. Three months prior to his death, Mr GH had been diagnosed with liver cancer. He did not wish further invasive investigations to take place, and expressed the wish to remain at home. Following deterioration in his condition, however, and his GP's referral to palliative care services, he agreed to admission to the hospice, where he died 10 days later.

1.2. City and Hackney Safeguarding Adults Board's decision to conduct a review

1.2.1. Safeguarding Adults Boards have a statutory duty under s.44 of the Care Act 2014 to arrange a Safeguarding Adults Review (SAR):

- Where an adult with care and support needs has died and the Board knows or suspects that the death resulted from abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

1.2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

1.2.3. On 27th October 2015 the Adult Social Care social worker last involved with Mr GH made a referral to the SAR sub-group of the City & Hackney SAB, acting on the recommendation of a safeguarding case conference on 4th September 2015. The sub-group determined at its meeting on 12th November 2015 that the circumstances of Mr GH's death met the criteria for undertaking a SAR. The SAB therefore set up a SAR Panel to conduct a review that would help the Board meet the objectives as set out in its SAR protocol[4]:

- To be provided with a report that analyses and makes recommendations that will contribute to improving safeguarding outcomes for adults at risk of abuse or neglect;
- To review the effectiveness of both single agency and multi-agency procedures in securing safeguarding of adults at risk of abuse or neglect;
- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together;
- To inform and improve single and inter-agency practice for safeguarding adults at risk of abuse or neglect;
- To contribute to the accountability to service users, the general public and relevant government departments and regulatory bodies of the

[4] City & Hackney Safeguarding Adults Board Safeguarding Adults Review Protocol, v.8, 2015.

agencies in City & Hackney responsible for safeguarding adults at risk of abuse or neglect.

1.3. Summary of review findings

1.3.1. This review found a wide range of services was engaged in supporting Mr GH, whose health care needs were complex in themselves and also necessitated extensive personal care and support and a specially adapted domestic environment. This review found evidence of some good practice by the agencies individually in their work with him.

1.3.2. Equally there were shortcomings in how the agencies responded to his needs. Aspects of Mr GH's care became the focus of adult safeguarding concern: alleged neglect of Mr GH's skin care by adult community nursing services, alleged shortcomings in how his personal care was provided, and alleged financial abuse by unknown persons (both his cleaner and a former care worker fell under suspicion). Other concerns to which consideration could have been given under safeguarding processes were not made the subject of referrals. On the allegations of financial abuse, Mr GH himself was able to offer reassurance that he was not being financially abused. The ability of the safeguarding process to draw conclusions about allegations of neglect by the adult community nursing service was hampered by professional disagreements about the nature, timing and cause of his skin breakdown and pressure sores. Evidence that the pattern, consistency and quality of care by the community nursing service were compromised has emerged in this review.

1.3.3. Mr GH's social care and support provision appears not to have kept pace with his changing needs as he approached the end of his life. Lack of on-going contact with him by Adult Social Care between reviews, and an absence of communications from health personnel about his changing needs, meant that his increased vulnerability did not trigger reconsideration of his care and support needs.

1.3.4. While liaison between agencies occurred over day-to-day matters, no one agency took a holistic overview of his situation. There were failures of communication, particularly over matters relating to his end of life care, exacerbated by recording systems that were not shared in common. As his health declined, there was no concerted approach to accommodating his needs speedily and effectively. Structural mechanisms intended to promote joint working were not used; proactive care coordination, multidisciplinary team meetings, One Hackney processes, referral for continuing care assessment and/or timely palliative care might all have made a difference to the quality of his experience in his final weeks, and possibly enabled him to remain at home as he wished.

1.3.5. This review makes recommendations to the City & Hackney Safeguarding Adults Board on assurances it should seek from the agencies

involved, and on matters relating to interagency coordination and leadership in cases involving complex health and social care needs.

2. MEMBERSHIP AND TERMS OF REFERENCE OF THE SAR PANEL

2.1. Role of the SAR Panel

The role of the SAR Panel is set out in the CHSAB SAR Protocol: *"The role of the Panel is to commission evidence from all relevant agencies involved in the case under review, to assess and analyse that evidence and make judgements about the lessons learnt."* The Panel must work in a way that:

- Recognises the complex circumstances in which professionals work together to safeguard adults at risk of abuse or neglect;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

2.2. Membership of the SAR Panel

- Chair of the Panel: Dr Nicole Klynman, Consultant in Public Health,
- Lead reviewer and overview report writer: (1) Rahat Ahmed-Man, Independent Consultant, initial enquiries; (2) Professor Suzy Braye, Independent Consultant, author of this report[5];
- City & Hackney Clinical Commissioning Group: Teresa Gorczynska, Interim Designated Adult Safeguarding Manager / Julie Dalphinis, Designated Adult Safeguarding Manager;
- Homerton University Hospital NHS Foundation Trust: Lesley Rogers, Head of Healthcare Compliance;
- London Borough of Hackney: Adrienne Stathakis, Assistant Director of Adult Social Care / Ilona Sarulakis, Principal Head, Adult Social Care.

The Panel was advised by:

- GP Federation: Dr Stephanie Coughlan;

The Panel was supported by:

- City & Hackney Safeguarding Adults Board Manager: Paul Griffiths;
- City & Hackney Safeguarding Adults Board Business Support Officer: Jayde Maynard.

[5] A change of lead reviewer took place part way through the Panel's enquiries.

2.3. Terms of reference for the review

The SAR sub-group provided terms of reference for the review, which identified specific matters for the SAR panel to enquire into:

a) Good practice that took place in this case;
b) Ownership and coordination of the services to meet Mr GH's health and social care needs;
c) Safeguarding processes, practice and procedures applied to Mr GH's case;
d) Communication and information-sharing that took place between the agencies involved;
e) Coordination of the actions of the health and social care services involved in Mr GH's case (i.e. hospital & adult community nursing/community health services, homecare provision, social services, GP practice/primary care and sheltered housing provider);
f) Strategy and management of Mr GH's finances;
g) Learning and recommendations for commissioning and monitoring of the health and social care services involved (noting that learning could be helpful for 'One Hackney');
h) Management of Mr GH's end of life care;
i) Necessary actions by the City and Hackney Safeguarding Adults Board role to ensure the learning from this review leads to lasting service improvements.

3. THE REVIEW METHODOLOGY

3.1. The review model

The approach chosen by the SAR Sub-Group was a review model that involved:

- Appointment of a SAR panel, with an independent chair and core senior level membership from a range of agencies;
- Individual Management Reports commissioned by the Panel from each agency that had involvement with Mr GH before his death, setting out the nature of their involvement, its progress over time, the reasons for actions taken or not taken, and reflection on their learning;
- Appointment of an independent reviewer and author to work with the Panel, and provide an overview report and summary report containing analysis, lessons learnt and recommendations. The first lead reviewer was replaced by a second lead reviewer part-way through the process;
- Formal reporting to the Safeguarding Adults Board in order to support the development by the Board of an action plan, and monitoring of implementation across partnerships.

3.2. Internal management reviews (IMRs)

3.2.1. The panel requested IMRs from the following agencies:

Agency	Nature of involvement with Mr GH
Anchor Trust	Anchor Trust is a not-for-profit housing association providing housing, care and support to people over 55. Since 26th June 2006 Mr GH had held tenancy of a self-contained flat in a 24-unit scheme classed as sheltered housing promoting independent living; a scheme manager provides housing-related support, with personal care and support provided by a third party agency. There was no contractual arrangement between Anchor and London Borough of Hackney.
First Choice Homecare	First Choice was the homecare agency that, since 29th October 2012, had provided personal care and support to Mr GH, commissioned by Adult Social Care.
Homerton University Hospital NHS Foundation Trust	HUHFT is an integrated trust providing both acute (hospital-based) and community services commissioned by City & Hackney CCG, London Borough of Hackney and NHS England. Mr GH used the trust's adult community nursing provision and was at times an in-patient at Homerton University Hospital.
London Borough of Hackney Adult Social Care	Adult Social Care was the London Borough of Hackney department responsible for assessing and meeting Mr GH's care and support needs. Social workers undertook periodic reviews of his needs, and commissioned services to meet them.
St Joseph's Hospice	The hospice provides services for people with life-limiting conditions, including palliative care, medical and nursing services, emotional support, practical advice, physical and psychological services, spiritual care, and social and creative activities. MR GH was an in-patient for the last 10 days of his life.
The Wick Health Centre	This was Mr GH's GP practice, providing general medical services, as well as enhanced services for particular groups, clinics and additional services such as benefits advice and health checks. Mr GH registered in 2007, and in 2014 was placed on their Vulnerable Home Visiting Service.

3.2.2. The purposes of the IMRs were:

- To enable agencies to reflect on and evaluate their involvement with Mr GH, identifying both good practice and systems, processes or practices that could be improved;

- To contribute the individual agency perspective to the SAR Panel's overview of interagency practice in Mr GH's case;
- To identify recommendations for change, at either individual agency or interagency level.

3.2.3. IMR writers were asked to provide a narrative report explaining and evaluating their agency's involvement with Mr GH, and a detailed chronology of that involvement, supported by relevant documentation. The Panel provided templates containing standard headings, and a briefing/training event for IMR authors. The period chosen for scrutiny was the year preceding Mr GH's death: 28th August 2014 to 28th August 2015. Some IMR writers gave additional information on events prior to or following that period.

3.2.4. Following scrutiny of the submitted documentation, the Panel invited agencies to submit responses to specific questions, following which further clarification was sought in some cases.

3.3. Thematic analysis

3.3.1. From the agencies' chronologies, a consolidated chronology was produced, mapping the actions of each agency by date against the actions of others. From this cross-referencing emerged some significant episodes and key themes in how the agencies, singly and jointly, responded to Mr GH's situation and needs. The narrative reports and further information from the IMR writers allowed further exploration of key episodes and themes.

3.3.2. After a preliminary meeting, the Panel met on 3 occasions with lead reviewer 1 and on 2 occasions with lead reviewer 2. The Panel chair and lead reviewer 1 met on two occasions with the GP advisor to the Panel, who also attended a later Panel meeting with lead reviewer 2. In addition, the CCG Panel member provided written responses to questions from lead reviewer 2 about aspects of medical and nursing care applicable in Mr GH's case.

3.3.3. Based upon this review process, this overview report contains:

- A summary of the circumstances of Mr GH's case;
- A chronology detailing the key actions reported by the relevant agencies;
- A themed analysis of learning that emerges from the actions taken or not taken by individuals and agencies;
- A concluding evaluation of the ways in which Mr GH's circumstances were responded to;
- A set of recommendations for the CHSAB as a whole concerning the areas in which policy, procedure and practice need to be improved.

3.4. Family involvement

Shortly after Mr GH's death, his sister and brother-in-law submitted a list of concerns about the care Mr GH had received prior to his admission to the hospice. The document was intended as a contribution to the safeguarding adult case conference that took place on 4th September 2015, a week after his death (the conference that resulted in the referral to the SAR sub-group). Their concerns were included in the terms of reference subsequently set out for the SAR Panel. The Panel Chair had a telephone conversation with Mr GH's sister and brother-in-law, inviting them to participate in the SAR process and to meet with herself and lead reviewer 1. They declined, and this has made it difficult to clarify certain matters relating to management of Mr GH's finances. They nonetheless expressed interest to know the review outcome; its conclusions and recommendations will be shared with them.

4. MR GH: THE PERSON

4.1. Sources of information

Without direct involvement from family members, the Panel has relied upon written documentation from agency records, and upon the comments of professional staff who knew him, where these were reported by IMR-writers following staff interviews.

4.2. A pen picture

4.2.1. Mr GH was born on 31st May 1935, in London. He described himself as having worked 'on the ships', had worked as a dockside corn porter[6], and that he enjoyed visits to the pub 'with his mates' after work[7]. One social worker, who felt they had had a positive rapport, described him as an 'old-school man's man'. He was 'a very independent individual who could indicate his own preferences'[8], a private man who 'kept his own counsel' and was proud of his independence, who lived a happy life based upon decisions made by his own choice[9].

4.2.2. Those working with him knew that he had a sister with whom he was in close contact; they describe him as speaking fondly of her, as though they were very close. They believed that he had never married, and that he had no children. While he was in the hospice, however, he mentioned a daughter, and his sister confirmed that he did have a daughter who was estranged; she had changed her name and her whereabouts were unknown.

[6] Death certificate
[7] ASC IMR
[8] First Choice IMR
[9] ASC IMR

4.2.3. His health care needs were complex, and arose from a number of conditions, including rheumatoid arthritis, gout, asthma, bronchitis, type 2 diabetes, hypertension and kidney disease. He had right-sided weakness and limited left-side functioning as a result of a stroke 5 years previously. He had venous leg ulcers and a skin condition similar to eczema - varicose eczema, a feature of venous disease – in which the normal pattern is for skin to break, heal and then break again in a chronic cycle; his various co-morbidities further affected the ability of his skin to heal. He had been seen in the past by a consultant dermatologist, and received pressure-relieving care and wound care from adult community nursing services.

4.2.4. Between 2002 and 2009, when he was able to walk with a stick, he had attended leg ulcer clinic to have dressings changed. By 2011 he was dependent on his mobile scooter, visiting the surgery to have his legs dressed, but remained very able to go out to manage his own affairs, including going to the bank and visiting his GP[10].

4.2.5. From 2014 onwards his bilateral leg ulcers became more problematic; they would heal but break down again, were painful and required bandages at all times. His scooter became more uncomfortable, giving him pain in his sacrum area, and he found both privately purchased and prescribed pressure cushions unsuitable. His mobility decreased; he went out less, which it is thought saddened him, and at home used a urinal and/or incontinence pads as his scooter would not fit into the bathroom. Adult community nursing staff visited weekly to care for his skin, changing his leg dressings and monitoring any pressure areas. If concerned, they would refer him to the tissue viability nurse[11]. Two nurses were required to change his dressings, one lifting and holding his leg while the other dressed it; he found the process painful. The OT arranged a ceiling hoist and chair in his shower. Manual handling was difficult, even with a hoist, as the room was small[12].

4.2.6. Adult social care had assessed his care and support needs as eligible for services, and he received personal care and support commissioned by them from an independent agency. Hours were increased to meet changing needs; for example from April 2014 his care required 2 carers who provided care (30 minute visits) 4 times a day. He was also in close contact with the housing scheme manager, who provided support and liaison with others such as the care agency, the GP and adult community nursing.

4.2.7. Those who worked with him describe him as 'a large but very gentle man', 'a gentle person and a nice man'; he was 'very chatty'. During earlier years he went out in his electric wheelchair to the pub and to the betting shop, but other than that little is known about his friendship networks[13]. With declining health, he remained very sociable, however, and used the

[10] Homerton IMR: supporting documentation
[11] Homerton IMR: supporting documentation
[12] Homerton IMR: supporting documentation
[13] ASC IMR

communal areas in the housing scheme, attending meetings organised by the scheme manager. He read magazines and listened to music; nursing staff talked of singing songs with him, and of talking about TV programmes he had watched. He was described as 'fun to visit'. If he was having lunch when nurses arrived, he would ask them to wait while he ate: 'he had a good appetite' and enjoyed the opportunity to chat.

4.2.8. He was always proud of his appearance and immaculate in presentation: 'always very clean, always well-shaven and smartly dressed'[14]. He was exacting about visits, and would readily complain to managers if visits were missed. He did sometimes complain that his bandages were tight, although he understood the nurses' explanations for the reasons. His flat too was clean and tidy, and his cleaner was understood to be close to him. The fridge was well stocked and 'he didn't appear to be lacking anything'[15]

4.2.9. Where mental capacity or ability to make decisions is mentioned in documentation, it is always to emphasise that Mr GH appeared 'cognitively intact at all times'[16], was clear and coherent about what he wanted, able to express himself and his wishes. No mention is made of any concerns that would have given rise to a capacity assessment, and no IMR makes mention of such an assessment.

4.2.10. Some of those providing health/social care and support had known him for many years; both community nurses and care workers held him in great affection and felt they had good rapport with him. Several nursing staff were shocked and distressed at his death, and expressed regret at not having been involved in caring for him prior to his death. They would have liked to offer continuity at the end of his life.

5. CASE CHRONOLOGY

The history of Mr GH's involvement with health and social care agencies is taken from the combined chronologies submitted by the agencies that completed IMRs, along with additional written information provided on request by those agencies. A combined narrative of necessity involves some overlap or repetition.

5.1. On **6th December 2012** the First Choice home care manager asked Adult Social Care to provide an occupational therapy assessment, and to increase Mr GH's visits to 'double-handed' as two carers were required to assist him to stand and mobilise[17].

5.2. On **17th December 2012** a care worker reported to the First Choice office that Mr GH had fallen while receiving assistance with personal care. An ambulance

[14] Homerton IMR: supporting documentation
[15] Homerton IMR: supporting documentation
[16] Homerton IMR: supporting documentation
[17] First Choice IMR

was called, and picked him up; he had no injury and refused hospitalisation[18]. A care worker made a further report of difficulty assisting Mr GH on **4th January 2013**.

5.3. On **22nd January 2013** Adult social care undertook a review and completed an Outcome Focused Support Plan. The review identified risks from Mr GH's refusal to use the recommended pressure cushion, and concerns around the quality of care provision: Mr GH felt the care agency did not follow the support plan. The social worker reported his concerns to Procurement, but the IMR notes that there is no record to indicate whether Procurement followed up with the agency and the person to whom the report was made has left, so any follow-up cannot be clarified[19].

5.4. The First Choice IMR provided details of events **between 29th January 2013 and 21st March 2014**[20]:

- Adult social care advised the care agency that Mr GH had 'some issues' (not specified) but was generally happy with the service; the First Choice care coordinator undertook a spot check (29/1/2013);
- Mr GH made a number of representations about his care workers:
    - advising the agency that he wanted a male care worker because "female carers steal his money" (11/2/2013);
    - refusing care because he didn't like the care worker and requesting a change of worker (11/3/2013);
    - asking to be attended by a particular worker and agreeing to wait 2 days until they returned from leave (29/4/2013);
    - asking for a different care worker (the scheme manager also made representation) as the care worker didn't keep to time, rushed him and didn't tidy up at the end of the visit (26/11/2013); the agency subsequently followed up with Mr GH to check he was happy with his new worker (27/11/2013 & 9/1/2014)
    - pulling his alarm chord because the care worker was late (3/2/2014);
    - requesting his bedtime visit an hour earlier as he felt he remained seated for too long during the day and this made him sore (21/3/2014)
- The agency liaised with various parties:
    - GP surgery and adult community nursing about the need for a chiropody appointment (19 & 20/3/2013);
    - Mr GH's sister when they received no response, and were told he was in hospital following a fall (9/9/2013);
    - Occupational therapy in order to advise visit times so that she could call at the same time (26/11/2013).

[18] First Choice IMR
[19] ASC IMR
[20] First Choice IMR

5.5. On **10th January 2014**[21] the GP surgery undertook an asthma and diabetes review.

5.6. On **15th April 2014** Adult social care completed an Outcome Focused Support Plan, increasing Mr GH's care package to 4 double-handed visits per day, in response to occupational therapist's recommendations on use of a new hoist[22].

5.7. The First Choice IMR reports a number of actions during **May 2014**:

- The care worker reported that Mr GH could not stand. The scheme manager called an ambulance; the crew advised Mr GH consult his GP (6/5/2014);
- The care coordinator called the GP due to Mr GH's on-going inability to bear weight; the GP arranged transport to hospital for an x-ray. The care coordinator also requested an update from Adult Social Care following an OT visit; Mr GH was left in bed as the carer could not get him up on her own (7/5/2014);
- The care coordinator explained to Mr GH why the care worker could not transfer him from bed to chair on his own (13/5/2014).

5.8. On the **9th May 2014** a senior practitioner occupational therapist from the London Borough of Hackney Community OT Service and an Adult Social Care social worker made a joint visit to Mr GH[23]. The social worker completed an assessment and undertook to request a change to the care and support provision to meet Mr GH's needs. Mr GH reported he had remained in bed for several days, and would like to be transferred to a powered wheelchair during the day, but also that he needed to be transferred back to bed as his bottom became painful when sitting for long periods. Care workers were required to attend to all personal activities of daily living, and for transfers to and from his bed. The OT considered that Mr GH's weight and height constituted a manual handling risk, but the bedroom was too narrow for the preferred ceiling-fitted hoist option, therefore a mobile hoist was to be provided, along with a manual handling assessment. The OT noted that this short-term solution would not meet Mr GH's long-term needs and recommended that he consider moving to a wheelchair-accessible property. Mr GH reported that a previous occupational therapy assessment, carried out by an independent agency, had recommended converting showering facilities into a wet room, but that this had not happened.

5.9. On **16th May 2014** the hoist was delivered[24]. The occupational therapist undertook a follow up visit on **19th May 2015**[25], with two carers present, and demonstrated hoist transfers. The scheme manager agreed to ensure necessary space was cleared for safe operation of the hoist. Mr GH indicated he would like to pursue wheelchair-accessible housing options. The occupational therapist undertook to look into the wet room recommendation (and later found no

[21] Wick IMR
[22] ASC IMR
[23] OT notes provided by ASC at Panel's request
[24] OT notes provided by ASC at Panel's request
[25] OT notes provided by ASC at Panel's request

evidence from records that referral for a disabled facilities grant had ever taken place following the assessment in 2012).

5.10. From **21st May 2014** two carers were sent to assist Mr GH with all transfers[26].

5.11. On **25th May 2014**, the adult community nursing service requested the care workers to leave Mr GH in bed to facilitate inspection of his skin[27].

5.12. On **16th June 2014** the occupational therapist reviewed Mr GH's case[28]. He indicated he did not after all want to move to another property but would prefer adaptations to his existing home. The occupational therapist advised that the space available for the wet room was insufficient to allow access in a large shower chair, and that other turning spaces were also very narrow. She continued to recommend rehousing (possibly to another property in the same building if one could be made available). She identified that the powered wheelchair provided was too small and was causing pressure areas on his thighs. The following day the occupational therapist phoned Mr GH to arrange a further visit to discuss options. He became very upset that a level-access shower was not to be fitted and that as a result he had to move from his home. When the occupational therapist reiterated that such facilities could not be recommended as the property was not wheelchair-accessible he told her to 'forget it' and ended the call. The occupational therapist resolved to contact him again at a later date, and also to liaise with the housing scheme manager.

5.13. The GP surgery undertook a blood pressure check on **27th June 2014**, and a medication review on **17th July 2014**[29].

5.14. On **28th July 2014**, the care worker alerted the care coordinator that the adult community nursing service had not changed Mr GH's leg dressings; the care coordinator left a message for the nursing service, to which they responded, saying they would visit the following day[30].

5.15. On **1st August 2014**, the housing scheme manager alerted Adult Social Care that only one care worker was operating the hoist that required two carers[31].

5.16. The adult community nursing service received a call from First Choice on **5th August 2014** to say that a nurse had not arrived to change Mr GH's leg dressings. Mr GH himself also phoned. The administrator ascertained that the visit was not due until the following day, when it took place as scheduled[32].

[26] First Choice IMR
[27] First Choice IMR
[28] OT notes provided by ASC at Panel's request
[29] Wick additional information
[30] First Choice IMR
[31] Anchor IMR
[32] HUHFT IMR

5.17. On **7th August 2014** a care worker informed the scheme manager that Mr GH had a red bottom, querying whether this was the start of an ulcer. The scheme manager contacted the adult community nursing service to inform them, and to discuss whether a safeguarding alert was required[33]. (None was made.)

5.18. On **8th August 2014** the First Choice care coordinator called the GP surgery to request a visit as Mr GH was in severe pain[34]. He had refused permission to call an ambulance[35]. Also alerted by the care coordinator, the adult community nursing service rang Mr GH, who advised he was already in his wheelchair (making a skin review difficult) and a visit was agreed (and took place) the following day. However, the GP visited to attend to lower abdominal pain; antibiotics were prescribed for a suspected urinary tract infection[36].

5.19. On the **22nd August 2014** the GP raised concerns with the adult community nursing service that Mr GH had not been seen for 2 weeks. The HUHFT IMR states: "*This is correct and a failing on the nursing team, the patient was not allocated another visit following the 09.08.14. The standard is that all patients should be allocated their next appointment the day of their outcomed[37] visit*".

5.20. An adult community nursing visit took placed the following day, **23rd August 2014**, to renew his leg dressings, and again on **26th August 2014** (when it was reported his leg dressings remained intact and cream was applied to his slightly reddened sacrum) and **2nd September 2014** (when leg dressings were renewed). On both these occasions the nurses requested that the care workers leave Mr GH in bed to facilitate the review and treatment[38].

5.21. On the **8th September 2014** the occupational therapist contacted the housing scheme manager (following unsuccessful attempts in July and August), who reported that work was about to begin for installation of a wet room floor in Mr GH's property, funded by a disabled facilities grant. Despite her concerns about the property not suiting Mr GH's long term needs, the occupational therapist undertook to review manual handling needs and to explore other adaptations such as widening doors to facilitate access in a wheelchair and shower chair[39].

5.22. On the **10th September 2014**, contractors installed a wet room in Mr GH's flat[40]. On **13th September 2014** a home visit assessment by the

[33] Anchor IMR
[34] First Choice
[35] First Choice IMR
[36] Wick IMR
[37] An 'outcomed visit' is one in which the nurse visited and saw the patient (HUHFT IMR).
[38] HUHFT IMR
[39] OT notes provided by ASC at Panel's request.
[40] Anchor IMR

occupational therapist[41][42], with the housing scheme manager present, resulted in recommendations for a ceiling track hoist, widened doorways, and concertina doors to enable better access around the flat. The OT was to contact Anchor's alterations and improvements team to explore landlord permissions for the ceiling hoist to be fitted, and also to explore an extension to the disabled facilities grant for the works to be completed. The manual handling risk had been reduced, and Mr GH gave permission for some bedroom furniture to be removed to facilitate better access by the carers when operating the mobile hoist. A shower chair was also to be ordered.

5.23. The scheme manager noted she would find out whether the local barber did house calls. She also reported that Mr GH had attended the wheelchair clinic but had declined a suitable wheelchair, as it didn't fit his property. The occupational therapist reiterated the need for a suitable wheelchair with pressure cushion support, indicating that a review would be needed as Mr GH had lost weight since the last review. The housing scheme manager agreed to request assessment from the wheelchair service.

5.24. On **16th September 2014** adult community nursing staff visited and renewed Mr GH's leg dressings; Mr GH was noted as stating that his bottom was now healed[43].

5.25. On **22nd September 2014** the housing scheme manager emailed the care agency with concerns: the care workers were not placing Mr GH's hoist on charge in the evening, resulting in it being unavailable for the morning visit so he was left in bed; a care worker arriving late, and the washing left for the cleaner being more than she could cope with so requesting care worker support with this task[44].

5.26. An adult community nursing service visit was recorded for **23rd September 2014**, but there is no documentation on what took place[45].

5.27. On **25th September 2014** the housing scheme manager reviewed the wet room; Mr GH required a wet room wheelchair to assist with accessing the shower[46].

5.28. On **30th September 2014** a routine home visit as part of the Vulnerable Adult Service was undertaken by the GP surgery[47]. Mr GH's main concern is recorded as being unable to wash properly as he couldn't fit his wheelchair into the shower. His care plan is recorded as including carers 4 times/day to help him wash and dress and transfer in/out of bed, Oathouse meals delivered, with carers preparing cereal and make him sandwiches for other meals; a private

[41] OT notes provided by ASC at Panel's request
[42] Anchor IMR
[43] HUHFT IMR
[44] Anchor IMR
[45] HUHFT IMR
[46] Anchor IMR
[47] Wick IMR

cleaner twice a week; use of incontinence pads until carers come to change him or a urine bottle. Pain in his legs was reported as better with cocodamol but he required laxatives. Pressure sores were noted on the left side of his bottom but the adult community nursing service reviewed him regularly. The community matron was to look into pressure cushions.

5.29. On **10th October 2014** the occupational therapist received notification that disabled facilities grant funding was available for a ceiling track hoist and on the 15th October she arranged a feasibility assessment. She also provided an attendant-propelled shower chair commode, urinal bottle, slide sheets and slings for the existing hoist.[48] Adult Social Care have confirmed that all the work arising from this assessment was completed and checked in 2015.

5.30. The adult community nursing service visited on **14th October 2014** and noted a Waterlow score of 16, indicating high risk of damage to skin. Mr GH's leg dressings were renewed. Further visits took place on **21st and 28th October 2014**, but there is no documentation on what took place. On **4th November 2014** leg dressings were renewed, and it was noted that the skin was slightly red and dry[49].

5.31. On the **5th November 2014** the housing scheme manager alerted ASC that the new hoist had not arrived[50].

5.32. An adult community nursing service visit took place on **11th November 2014**, when leg dressings were renewed; it was noted there were no signs of infection and skin changes appeared superficial.[51]

5.33. On **17th November 2014**, Adult Social Care undertook a review, as part of the regular review cycle, and completed a FACE Brief Review Record[52]. The social worker was aware of Mr GH's declining health, leg ulcers and risk of pressure sores and of concerns expressed by the housing scheme manager in September about the care provision. Mr GH expressed satisfaction with his carers.

5.34. An adult community nursing service visit took place on **18th November 2014**, when leg dressings were renewed.

5.35. On **24th November 2014**, Mr GH advised the housing scheme manager he had received a letter for £140 reduction in electricity costs. The manager registered him so that his account could be credited.

5.36. The same day, Mr GH's cleaner alerted the housing scheme manager that Mr GH had asked her to place a towel on his chair as he was uncomfortable. The housing scheme manager asked the care agency for care workers to check

[48] OT notes provided by ASC at Panel request
[49] HUHFT IMR
[50] Anchor IMR
[51] HUHFT IMR
[52] ASC IMR

whether he had broken skin, soreness or ulcers[53]. The care worker reported that he had a sore around the back of his bottom and around his scrotum area[54], and the care coordinator alerted the adult community nursing service[55].

5.37. The following day, **25th November 2014**, an adult community nursing service visit took place[56]; Mr GH's leg dressings were renewed but he was already in his wheelchair so no review of pressure areas could take place. It was noted that a visit was needed early in the day, while carers were present.

5.38. On **2nd December 2014**, care workers advised the care coordinator that Mr GH's sore had not been dressed, despite requests to the adult community nursing service. The care coordinator called the service and was told that nurses' visits were weekly. The care coordinator advised them that the sore had broken and that an urgent visit was needed[57]. The HUHFT IMR notes the call, indicating the carer had reported Mr GH's sacrum had broken down. He was already listed for a visit that day, which subsequently took place. His leg dressings were changed, with skin noted to be slightly red and cream applied. Pressure areas were checked - sacrum, heels, elbows, shoulders blades, spine and ears – and all skin found to be intact[58].

5.39. On **3rd December 2014** the housing scheme manager contacted the adult community nursing service to request a new referral for pads to be delivered, as the supplier had indicated no referral had been received[59]. An adult community nurse visited to undertake a continence reassessment[60].

5.40. On **9th December 2014** the adult community nursing service advised Mr GH that his appointment was to be rescheduled[61].

5.41. On **16th December 2014** care workers reported to the care agency that they had found Mr GH fallen, with a cut on his forehead. The care agency called an ambulance, which attended, but Mr GH refused to be taken to hospital. The agency advised Adult Social Care[62]. The same day an adult community nursing service visit was logged, but there is no documentation on what took place[63]. The GP surgery noted the administration of influenza vaccine[64].

5.42. The adult community nursing service received calls on **17th December 2014** from the housing scheme manager saying Mr GH had reported he had not seen a nurse for 2 weeks, and on **18th December 2014** from the care agency

[53] Anchor IMR
[54] First Choice IMR
[55] First Choice supporting documentation and HUHFT IMR
[56] HUHFT IMR
[57] First Choice IMR
[58] HUHFT IMR
[59] Anchor IMR
[60] HUHFT IMR
[61] HUHFT IMR
[62] First Choice IMR
[63] HUHFT IMR
[64] Wick IMR

saying he had not been attended to for over a week. The alarm monitoring service also reported he had pulled the alarm call, saying he hadn't been seen for 2 weeks[65]. The care agency records that the adult community nursing service apologised, saying that the nurse scheduled to visit was off sick[66], and notes a call back from them to say a nurse had now visited. The next visit recorded in the adult community nursing service records, however, is **23rd December 2014**, when leg dressings were changed, and no broken skin or swelling recorded.

5.43. On **29th December 2014**, the housing scheme manager alerted the care agency that care workers were incorrectly disposing of incontinence pads, and advised the agency the correct method[67].

5.44. An adult community nursing visit took place on **30th December 2014** and leg dressings were renewed.

5.45. On **5th January 2015** the housing scheme manager rang the continence nursing service, as no pads had been received[68]. The service visited the following day, **6th January 2014[69]**, to reassess, and recommended no changes. The adult community nursing service also visited and renewed Mr GH's leg dressings.

5.46. On **12th January 2015** the cleaner reported to the scheme manager that Mr GH was experiencing headaches[70]. The scheme manager arranged a GP visit, which took place the same day. Mr GH reported headaches since a fall 3 weeks ago (which resolve when lying down or at night) and a chesty cough for a week. The doctor carried out an examination including chest, blood pressure, pulse, temperature, oxygen saturation and neurological examination and agreed Mr GH would monitor headaches for 2 weeks. A course of antibiotic was prescribed[71].

5.47. On **13th January 2015** the adult community nursing service visited and renewed Mr GH's leg dressings.

5.48. On **15th January 2015**[72] the housing scheme manager arranged transport for Mr GH to attend an eye screening appointment on **20th January 2015**, of which the GP received notification once it had taken place[73].

[65] HUHFT IMR
[66] First Choice IMR
[67] Anchor IMR
[68] Anchor IMR
[69] HUHFT IMR
[70] Anchor IMR
[71] Wick IMR
[72] Anchor IMR
[73] Wick IMR

5.49. An adult community nursing visit took place on the **21st January 2015**, and Mr GH's leg dressings were renewed[74]. The following day the GP received a request from the adult community nursing service to carry out a home visit (the reason is not clear), which took place but there was no answer[75].

5.50. On **26th January 2015** the housing scheme manager contacted the chemist to arrange delivery of medication that had not been delivered. The same day, continence pads were delivered, and the manager contacted the supplier to ensure future deliveries[76].

5.51. On **27th January 2015** an adult community nursing visit took place and Mr GH's leg dressings were renewed[77].

5.52. On **29th January 2015** the housing scheme manager advised Mr GH that his bank had declined the direct debit request for his rent. He arranged to pay by card, and undertook to speak to his bank[78].

5.53. On **30th January 2015** the GP made a home visit[79], recording that Mr GH had a recurring cough, shortness of breath, and an ulcer on his skin since a fall once month previously (no evidence of swelling or fracture). The GP conducted an examination (BP, pulse, oxygen) and requested further investigation (chest x-ray and transport), prescribing fucidic acid for the ulcer.

5.54. On **3rd February 2015** an adult community nursing visit took place and Mr GH's leg dressings were renewed. The following week, **10th February 2015**, he was having his lunch and requested the dressing be renewed on a subsequent visit; the nurse reviewed the dressings and found them intact with no strike through. They were renewed the following week, **17th February 2015**[80].

5.55. On **19th February 2015** the GP practice nurse visited for an annual asthma and diabetes review[81]. It was noted that Mr GH needed assistance when dressing and that having to lie flat during this procedure caused mild shortage of breath. He agreed to try an aerochamber. Diabetes was noted as well controlled, with all checks up to date.

5.56. The adult community nursing service visit scheduled for **24th February 2015** could not be completed as there was no answer and it appears the key code was not used[82].

[74] HUHFT IMR
[75] Wick IMR
[76] Anchor IMR
[77] HUHFT IMR
[78] Anchor IMR
[79] Wick IMR
[80] HUHFT IMR
[81] Wick IMR
[82] HUHFT IMR

5.57. On **2nd March 2015** the housing scheme manager assisted Mr GH to update his freedom pass.

5.58. On the **3rd March 2015** the care worker advised the care agency that nurses had not visited for the last 2 weeks. The care coordinator called the adult community nursing service[83]. The HUHFT IMR acknowledges that a visit had been missed because Mr GH's care required two nurses and the second nurse was busy; it should have been rescheduled for the following day, not for a week later[84].

5.59. On the **9th March 2015** the housing scheme manager noted that Mr GH smelt strongly of urine, also that his washing had a strong smell. She emailed the care agency to ask that continence pad be changed 4 times per day as prescribed, and also raised the question of whether laundry was part of the package[85]. The care agency IMR notes receipt of this concern; the care coordinator noted she knew Mr GH was not allocated time in his care plan for laundry, but she had asked the care workers to do it when the private carer could not.[86]

5.60. The adult community nursing service visited on **10th March 2015**. Mr GH's leg dressings were renewed and cream applied to his skin. It was noted that his ulcers had reopened but that pressure areas remained intact[87].

5.61. On the **17th March 2015** the adult community nursing service phoned Mr GH but did not receive an answer. A visit took place the following day, **18th March 2015**, and again on the **24th March 2015**; there is no documentation on what took place on either visit.

5.62. On the **3rd April 2015** Mr GH's brother in law raised a safeguarding alert saying that money was being withdrawn from Mr GH's account by one of the carers. A principal social worker spoke to Mr GH. He informed her that he was not being financially abused, that he went out in his electric wheelchair and engaged in spending that he did not wish to be known by his family. His explanation was credible and his brother in law was informed that the abuse allegation was not substantiated, respecting Mr GH's wish for respect of his privacy[88].

5.63. Also on the **3rd April 2015** Mr GH was taken to Homerton Hospital by ambulance, in severe pain. The Emergency Department made a safeguarding referral reporting Mr GH's statement to the ambulance crew that his leg ulcer dressings had not been renewed for 3 weeks. He was noted to be vague; AMT was 6/10. Urosepsis was suspected[89]. His hospital record states he had 'fever,

[83] First Choice IMR
[84] HUHFT IMR
[85] Anchor IMR
[86] First Choice IMR
[87] HUHFT IMR
[88] ASC IMR
[89] HUHFT IMR

delirium, pain in his legs and pneumonia'. The Ambulance Service made an independent referral the same day, stating their concern at what Mr GH had told them about his leg dressings[90].

5.64. The ASC IMR notes receipt of the safeguarding alert on **4th April 2015**, noting that in addition to the concerns expressed by the ambulance crew the Emergency Department had identified grade 2 pressure sores[91]. The GP practice records receipt of a notification of hospital admission after the ambulance was called by the carer

5.65. The HUHFT IMR notes that the incident form was reviewed at the weekly divisional Complaints, Litigation, Incident Procedure meeting. It was noted that a visit was overdue by 3 days (the visit schedule was weekly, every 7 days, but because he had been visited in the last 10 days the incident was closed[92].

5.66. The care agency IMR notes that the care worker reported on the **7th April 2015** that Mr GH had been admitted to hospital; the agency advised ASC of his admission.

5.67. The community team reviewed Mr GH on the ward on **7th April 2015**[93] and discussed his care and discharge plans the ward team. Ward staff made a referral to the tissue viability nurse: "*suspected deep tissue injury to right heel*". A diabetic foot check was completed and Mr GH was referred to podiatry. (The IMR writer notes podiatry visited him at home on 13th April 2015.) The following day Mr GH was assessed as able to maintain a sitting position in an armchair. It was noted he would be discussed in the multi-disciplinary meeting held weekly on the ward[94].

5.68. On the **9th April 2015**, the hospital made plans for Mr GH's discharge the following day, referring him to the adult community nursing service for changes to his dressings twice a week, and advising his family[95]. The GP surgery received a request for his medication list[96]. On the **10th April 2015** the hospital made a request via the brokerage service and Adult Social Care for his care package to re-start that evening; in the absence of confirmation that this was possible, the discharge was delayed. The adult community nursing service visited on **11th April 2015**, not having been advised of the delay.

5.69. On **13th April 2015** Mr GH was discharged; his hospital record notes that he had anaemia, multiple ulcers, urosepsis and chronic renal impairment. He was to have twice weekly visits to manage his leg ulcers and catheter care. His discharge summary was shared with his GP and the adult community nursing team. He had advised the ward staff that he removed the pressure mattress at

[90] LAS referral, submitted as supporting documentation to the ASC IMR
[91] ASC IMR
[92] HUHFT IMR
[93] HUHFT IMR
[94] HUHFT IMR
[95] HUHFT IMR
[96] Wick IMR

home due to the noise it made, and it was noted that he would require reassessment for another mattress. The duty social worker completed a community assessment; he declined meals on wheels but agreed to delivery of frozen meals [97] . The care agency confirmed receipt of the discharge notification [98] and the GP surgery received the discharge notification the following day[99].

5.70. An adult community nursing service visit on **14th April 2015** noted that all vital signs were normal and Mr GH remained alert and oriented, and was eating/drinking well. His leg dressings were renewed [100] . The GP surgery received the final discharge summary the following day, and carried out required actions: change and review medication, repeat bloods in 4-6 weeks time[101].

5.71. On the **15th April 2015** the adult community nursing service's clinical operations manager visited Mr GH at home to apologise for missed the visit prior to admission to hospital, and gave contact details to use if he was concerned about a visit not taking place again (also given to the scheme manager)[102].

5.72. On the **21st April 2015** the adult community nursing service visited and renewed Mr GH's leg dressings. The following day his Waterlow score was recorded as 15 (indicating a borderline medium/high risk of skin damage). A further visit took place on **28th April 2015**, but there is no documentation on what took place.

5.73. On the **29th April 2015**, the care worker advised the care coordinator that Mr GH had a new sore on his bottom; the care coordinator alerted the adult community nursing service, who undertook to visit[103]. She later also contacted the GP as the care worker reported Mr GH had pain in his leg; the GP undertook to review his medication[104]. The adult community nursing service notes the call as reporting a pressure sore on Mr GH's buttock, and records that a visit took place but there is no documentation[105]. The GP attempted to call Mr GH but his phone was continuously engaged.

5.74. On the **30th April 2015** the care worker advised the care coordinator that no nurse visit had been carried out the previous day; the adult community nursing service told the care coordinator that a nurse had visited but been unable to gain access[106]. An adult community nursing visit then took place: Mr

[97] HUHFT IMR
[98] First Choice IMR
[99] Wick IMR
[100] HUHFT IMR
[101] Wick IMR
[102] HUHFT IMR
[103] First Choice IMR
[104] First Choice IMR
[105] HUHFT IMR
[106] First Choice IMR

GH's leg dressings were renewed and pressure areas inspected; sacrum, elbows, spine, shoulder blades, ears and left heel were all reported as intact[107]. There is no mention of the reported sore on his buttock being viewed.

5.75. A further adult community nursing visit took place on **5th May 2015**, renewing Mr GH's leg dressings and noting that a wound to the right heel was granulating.

5.76. The care agency emailed Adult Social Care on the **7th May 2015** to notify that Mr GH's pads had run out[108]. The following day the continence service confirmed to the adult community nursing service that deliveries had failed; an additional delivery authorised for 13th May, with a request to inform Mr GH[109].

5.77. On the **8th May 2015** Adult Social Care advised the care agency of the safeguarding alert raised on 3rd April 2015, requesting details of missed adult community nursing visits that the care agency had reported. The agency was invited to attend a case conference planned for 29th May 2015[110].

5.78. On **11th May 2015** the GP made a home visit. The updated care plan notes the scheme manager was concerned about Mr GH's weight loss and gradual decline and decrease in his level of functioning; he was not as sociable as before, not coming out of his room, not shaving. The GP IMR notes that while an inpatient Mr GH had discovered he had a liver lesion; the probability that it was cancerous was discussed - primary or metastasis - and that he did not want any referrals or imaging as it was too difficult to attend appointments[111].

5.79. On **12th May 2015** the adult community nursing service visited and renewed Mr GH's leg dressings, applying cream to dry skin. It was noted that his right heel was granulating; no swelling was noted on his legs and his left leg shin was intact; the profiling bed and mattress were in good condition. They confirmed to the GP surgery that they had taken the required blood samples[112].

5.80. On the **14th May 2015**, during a conversation between the social worker and the care coordinator, checking that the continence pads had been delivered, the care coordinator advised that Mr GH did not look himself; he was pale and withdrawn and at times looked confused[113].

5.81. The following day, **15th May 2015**, the GP made an urgent home visit to Mr GH, having reviewed blood and urine test results; due to his confusion, recent onset of chest infection and abnormal results an ambulance was called to take him to A&E[114]. The HUHFT IMR notes the referral from the GP: Mr GH was said

[107] HUHFT IMR
[108] First Choice IMR
[109] HUHFT IMR
[110] First Choice IMR
[111] Wick IMR
[112] HUHFT IMR
[113] First Choice IMR
[114] Wick IMR

to be increasingly confused over the past week, with reduced baseline function and weight loss. The GP's opinion was chest infection based on blood results but the confusion was concerning. Mr GH was admitted to hospital: his cognitive state was intact and his acute mental test score 7/10. The working diagnosis was lower respiratory tract infection. It was noted that the GP was to investigate weight loss in community. A discussion with the scheme manager took place; she raised concerns about a cough, headaches and weight loss, and stated that his wheelchair required repair before his discharge[115].

5.82. On the **16th May 2015** a skin assessment noted that the sacrum was red but remained intact. The following day, **17th May 2015**, Mr GH was transferred from acute to elderly care, and his leg dressings were changed. A grade 3 sore to the right heel and a grade 2 to the big toe were noted.

5.83. On the **18th May 2015** the adult community nursing service reviewed Mr GH on the ward and discussed his care and discharge plans with the ward team. The consultant review noted: weight 78.9kg - 10kg weight loss in 1 month, lower respiratory tract infection, acute kidney injury secondary to chronic kidney disease and dehydration, delirium. Mr GH said he had been off food for 1 month and feeling down since his illness. The need for a dietician referral was noted, but the IMR writer found no evidence this was followed up[116].

5.84. The following day, **19th May 2015,** the tissue viability nurse reviewed Mr GH's skin, noting a grade 2 pressure ulcer on right heel (2cm x 1.5cm), a grade 3 pressure ulcer on the 1st metarsal phalangeal joint (2.2cm x 1.5cm); venous changes to both legs. Swallow assessment was performed, with no obvious signs of aspiration and he was able to drink from normal open cup. A physiotherapy assessment also took place, querying whether he had developed contractures since the last admission[117].

5.85. The tissue viability ward round on the **20th May 2015** noted that the venous eczema on his legs had improved; bandaging was to take place twice a week. (Contact was made with the adult community nursing service, which confirmed he had been being seen once a week, with the last visits on 30th April, 5th May and 12th May.) The following day a therapy assessment took place (the nature of the therapy is not specified)[118].

5.86. On the **22nd May 2015** the hospital occupational therapist contacted the scheme manager for an update on the wheelchair; it was believed Adult Social Care were dealing with this. On the **26th May 2015** the scheme manager advised the occupational therapist that the social worker had contacted a number of repairers without success. A reassessment had been requested from Hackney Wheelchair Services, and a home visit was booked for 16th June 2015[119].

[115] HUHFT IMR
[116] HUHFT IMR
[117] HUHFT IMR
[118] HUHFT IMR
[119] HUHFT IMR

5.87. Also on the **26th May 2015**, Mr GH was diagnosed with a lesion on his liver (from a CT scan) and small gallstones (from ultrasound). He was initially listed for outpatient colonoscopy and gastroscopy, but on the 28th May 2015 the consultant concluded that no invasive investigations (colonoscopy and gastroscopy) would take place due to Mr GH's frailty and multiple co-morbidities. An MRI scan would be done, and the consultant explained to Mr GH that if a tumour was found it would not be appropriate to give him further aggressive treatment. Discharge was planned for 1st June; the GP was advised[120], and the occupational therapist contacted the wheelchair service for the appointment to be brought forward[121].

5.88. On the **29th May 2015** the wheelchair service advised that Mr GH had an attendance wheelchair also. The occupational therapist considered this better than nothing, although the scheme manager said he didn't use it, and the social worker believed it would restrict his social activities. The GP expressed the view that Mr GH could tolerate gastroscopy and undertook to discuss this with him. An adult community nursing service referral was completed for wound care, drawing attention to pressure ulcers on the ankle and toe and outlining the dressings required; a visit was requested for 2nd June 2015[122].

5.89. Discharge was arranged for **1st June 2015**[123], with liaison taking place between Adult Social Care, the care agency and Mr GH's sister[124]. It was however cancelled as ambulance crew raised concerns about their ability to carry Mr GH up the stairs to his home[125]. An adult community nursing visit took place on **2nd June 2015** but Mr GH had not been discharged; it took place instead on the **3rd June 2015**, but there is no documentation on what took place[126]. The same day the care worker reported to the care coordinator that Mr GH was home, with new medication and a new sore on his foot[127]. The GP surgery received the discharge report, noting that kidney failure had worsened while an inpatient and it was advised to stop a particular medication (bendroflumethiazide) for a week before reviewing blood pressure.

5.90. On the **4th June 2015**, the housing scheme manager emailed the care agency to notify them that residents had complained about care workers using communal facilities, and sleeping on the settee in the foyer: "*Sorry to have to complain about the care workers who attend GH, as I know they work very well with him*". She stated they should not be in the building between visits, but recognised their difficulty in gaps between jobs during bad weather; she did not mind their occasional use of the communal lounge, but not the foyer or corridors, or use of electrics to recharge phones, and directed them to a nearby café. The coordinator gave assurance that she would advise care workers accordingly.

[120] Wick IMR
[121] HUHFT IMR
[122] HUHFT IMR
[123] HUHFT IMR
[124] First Choice IMR
[125] HUHFT IMR
[126] HUHFT IMR
[127] First Choice IMR

5.91. On the **5th June 2015** the housing scheme manager noted Mr GH's return from hospital having purchased an electric wheelchair; she made a referral to the wheelchair service for assessment[128]. The same day, the GP visited Mr GH, who stated he did not want any further tests/investigations; he was aware he was getting weaker, losing weight, and may have cancer. The GP record notes a possible safeguarding issue, querying whether money was being taken by an ex-carer who still comes in although no longer with care agency[129].

Mr GH later informed the scheme manager that his GP had informed him he had lung cancer[130] for which there was no treatment; she phoned the GP to ask how she could support Mr GH following his disclosure to her[131].

5.92. On the **9th June 2015** there was a telephone discussion between the GP and Mr GH's sister about his diagnosis and end of life care. The GP made a referral to the community matron, requesting a visit be made to discuss end of life care. The community matron contacted Mr GH's sister to arrange a visit[132].

5.93. On the **10th June 2015** the GP surgery received the discharge summary from the hospital, including medication and actions for the GP[133]. The adult community nursing service confirmed receipt of a request from the GP for blood pressure checks, and visited Mr GH, but there is no documentation on what took place[134]. A further adult community nursing visit took place on the **16th June 2015**, again with no documentation on what took place[135].

5.94. On the **17th June 2015** the care worker advised the care agency that an occupational therapist had visited to show them how to reposition Mr GH on his chair. However, Mr GH had asked them to revert to the previous positioning, as it was easier for him to reach things[136].

5.95. The same day the community matron visited Mr GH to discuss end of life care: Mr GH wanted to stay in his own home, didn't want to move closer to his sister, and would like to go on holiday to the seaside[137].

5.96. On **18th June 2015**, the adult community nursing service noted a request from an occupational therapist (who had asked the service to provide ulcer care to Mr GH) to advise her of their next visit. The following day, **19th June 2015,** the adult community nursing service noted receipt of a skin assessment

[128] Anchor IMR
[129] Wick IMR
[130] It is not clear whether this is a mistake or a misunderstanding, and on whose part. It is clear that Mr GH received his diagnosis of a liver lesion from the consultant while in hospital, not from the GP.
[131] Anchor IMR
[132] Wick IMR
[133] Wick IMR
[134] HUHFT IMR
[135] HUHFT IMR
[136] First Choice IMR
[137] Wick IMR

appointment. An adult community nursing visit was made to Mr GH but there is no documentation on what took place[138].

5.97. On **22nd June 2015**, the report of the safeguarding investigation carried out by Adult Social Care (into the concerns raised by the Ambulance Service and the Emergency Department at the time of Mr GH's admission to Homerton Hospital on 3rd April 2015) concluded that the allegation of neglect by the adult community nursing service was partially substantiated: the failure to dress Mr GH's legs was partly substantiated and the allegation that he had septic legs on admission to hospital was substantiated[139]. The care agency care coordinator received an invitation to attend a case conference the following day[140].

5.98. The safeguarding case conference took place at Mr GH's home on **23rd June 2015**[141]. The allegation that Mr GH's legs were not dressed for 3 weeks was not substantiated; the allegation that he did not receive care as required was substantiated (a visit was missed and Mr GH was not notified); the allegation of neglect was partially substantiated on the ground that the adult community nursing service did not provide support at the required time.

5.99. On **24th June 2015** an adult community nursing visit took place but the nurse was unable to assess Mr GH's skin; the service left a message for care workers to contact the nurse so that a joint visit could be facilitated for the following day; Mr GH was informed[142]. On the **25th June 2015** the skin assessment was performed in conjunction with care workers: sacrum, heels, elbows, ears, shoulder blades were all noted to be intact.[143]

5.100. On **30th June 2015** during an adult community nursing visit Mr GH's leg dressings were renewed. A wound to the right heel appeared superficial and was healing[144].

5.101. On the **7th July 2015** Mr GH asked the scheme manager to order a gel cushion for his wheelchair, for which he would pay by phone[145].

5.102. Also on the **7th July 2015** Mr GH's leg dressings were renewed during an adult community nursing visit. His right leg had a superficial ulcer and one on the right big toe.

5.103. On the **13th July 2015** the care agency received an email from the housing scheme manager asking for carers to bring all rubbish to the ground floor, as rubbish left in the first floor bins caused strong odours on the landing; cleaners

[138] HUHFT IMR
[139] ASC IMR and safeguarding investigation report
[140] First Choice IMR
[141] ASC IMR and case conference minutes
[142] HUHFT IMR
[143] HUHFT IMR
[144] HUHFT IMR
[145] Anchor IMR

had also requested that gloves were placed in bins, not thrown on the bin room floor[146].

5.104. On **14th July 2015** an adult community nursing visit took place but there is no documentation on what took place. A further visit took place on **21st July 2015**, when Mr GH's leg dressings were renewed; a wound to the right heel appeared superficial. Leg dressings were renewed again on the **28th July 2015**, with the wound to the right heel again noted to be superficial, and not oozing[147].

5.105. On the **30th July 2015** the GP IMR notes a call from a care worker (content not given); Mr GH was referred to the community matron for a continence assessment. The community matron made a home visit the same day, and requested the adult community nursing service to re-dress Mr GH's legs as they were stained. A referral was made to the incontinence service[148]. The reassessment and product requirement form were received the following day; the requirements were authorised and the changes to his prescription noted[149].

5.106. On the **3rd August 2015** an adult community nursing visit took place with the care worker present. Mr GH's leg dressings were renewed and it was noted that he looked well and safe. He refused to have a protective dressing applied to his right heel, stating it kept falling off. His Waterlow score was 21, indicating a very high risk of skin damage; this was interpreted as evidence of the decline in his general health. He stated his bed was not working properly and the adult community nurse referred this for an emergency out-of-hours repair[150].

5.107. An adult community nurse visited again on **6th August 2015**. Mr GH declined review of his leg dressings, stating they only needed to be renewed weekly[151].

5.108. On **7th August 2015**, the housing scheme manager emailed the care agency as she had met a carer in the laundry the previous evening who had stated she worked for the agency, but this was subsequently discovered to be untrue. The housing association chronology states: "*Agency asked to report to safeguarding team*", but does not clarify who asked whom to make the alert; in either event, there is no record in any IMR or supporting documentation of a safeguarding alert being made. The scheme manager advised Mr GH not to let this woman into his flat and not to give her money[152].

5.109. Also on the **7th August 2015** the scheme manager discussed with family members (unspecified) her concerns on being told that the cleaner on several occasions had been unable to draw weekly money due to insufficient funds. The

[146] First Choice IMR
[147] HUHFT IMR
[148] Wick IMR
[149] HUHFT IMR
[150] HUHFT IMR
[151] HUHFT IMR
[152] Anchor IMR

family alerted the local authority safeguarding team; it was also agreed that cleaner would keep a record of withdrawals[153].

5.110. Also on **7th August 2015** Mr GH was reported to have painful legs and the GP made a home visit. Mr GH's sister was present and the GP discussed with them both Mr GH's prognosis and future care; it was agreed to involve the palliative care team. A safeguarding issue around theft of money was discussed (no further details given)[154].

5.111. The adult community nursing home notes record a multidisciplinary meeting with the social worker on **8th August 2015**[155]. No further details are given.

5.112. The adult community nursing visit scheduled for **10th August 2015** was rescheduled to the following day[156]. It took place on the **11th August 2015**, when leg dressings were renewed; the wound to the right heel was noted as superficial and a protective dressing applied[157].

5.113. On the **12th August 2015** the GP made a request to the adult community nursing service for a fasting blood test to be carried out.

5.114. On **13th August 2015** the Ambulance Service notified the adult community nursing service that Mr GH had fallen and sustained a laceration to his left arm, and requested a nurse visit to assess his arm, as he did not wish to go to hospital. A nurse visited but there is no documentation on what took place[158]. The Ambulance Service advised the GP also and the same day Mr GH was discussed in the multidisciplinary team meeting, where it was noted: "mass in the liver, does not want any investigation, wants to be left alone, had a recent fall, ambulance called out, good care package in place"[159].

5.115. On **14th August 2015** an adult community nursing visit took place; Mr GH was in bed. His blood pressure, heart rate, respirations and oxygen saturations were monitored and all found to be within normal limits. The housing scheme manager was informed[160].

5.116. The same day the GP received a call from Mr GH's sister, who had been due to call for an update following the palliative care decision the previous week. The GP increased Mr GH's analgesia and on **17th August 2015** made a Macmillan referral[161].

[153] Anchor IMR
[154] Wick IMR
[155] HUHFT IMR
[156] HUHFT IMR
[157] HUHFT IMR
[158] HUHFT IMR
[159] Wick IMR
[160] HUHFT IMR
[161] Wick IMR

5.117. The St Joseph's IMR records the referral from the GP, and notes that Mr GH gave permission to speak with his sister. The hospice contacted the adult community nursing service requesting an increase in visits starting that night to help with medication, specifically analgesia & anti-fungal medication[162].

5.118. Also on the **17th August 2015**, the adult community nursing service visited and renewed the dressings to Mr GH's legs, applying a protective dressing to his right heel. It is noted that he made no complaint of pain[163].

5.119. On the **18th August 2015** the adult community nursing service visited to take blood tests.

5.120. Also on **18th August 2015** a clinical nurse specialist and senior social worker from the hospice made a joint visit to Mr GH. They noted his main distress was caused by pain in both legs, for which cocodamol and oramorph had been prescribed. The cleaner had been dispensing oramorph as the care workers were not able to do this. Pressure sores to Mr GH's buttocks needed attention. The social worker decided for safety reasons and faster symptom control that he should be admitted to the hospice, and after discussion with his sister Mr GH agreed[164].

5.121. The hospice nurse advised the adult community nursing service that Mr GH was to be admitted to the hospice, and informed them that he had pressure sores[165]. The home notes recorded by the hospice nurse describe this as pressure sore grade 1 to buttocks[166]. The hospice also requested medical details from the GP[167].

5.122. On admission it was noted by the charge nurse that Mr GH had 4 small grade 2 pressure sores on his sacral area. A medical assessment was conducted; he had abdominal pain over the epigastrium/right hypochondrium, present all the time. He said he was aware he had stronger painkillers at home but wasn't able to take them; he had oramorph once but felt sick with it. His legs were painful from leg ulcers and contracted as a result of gout and arthritis; he reported he was unable to straighten them as he found them stiff. He had fallen at home the previous week, and was frustrated that since then his care workers had not allowed him out of bed[168].

5.123. Later that day the palliative care nurse let Mr GH's sister know that he had agreed to be admitted to manage his pain and discomfort. Contact details of the in-patient unit provided[169].

[162] St Joseph's IMR
[163] HUHFT IMR
[164] St Joseph's IMR
[165] HUHFT IMR
[166] HUHFT IMR
[167] Wick IMR
[168] St Joseph's IMR
[169] HUHFT IMR

5.124. On the **19th August 2015** medical assessment and discussion around preferences of care took place[170]. The IMR notes: "Questions about capacity but felt hospice was an appropriate place for him to be" (capacity is not mentioned further). He expressed a wish to stay at the hospice rather than be transferred to hospital, but wished to get out of bed and back in chair. Concerns about his care were noted[171].

5.125. His legs were redressed and a right foot wound (lateral aspect) grade 4 was observed, reported, discussed and seen by/with Doctors. The charge nurse informed the social worker of the grade 4 pressure sore on lateral side of right foot (and also that Mr GH's papers were in the safe). The social worker met with Mr GH and discussed money concerns (no detail is given). The social worker agreed to meet with his sister the following day. Nursing staff were to raise a safeguarding referral about the pressure sores. Mr GH was discussed at the multidisciplinary team meeting and a 'proforma for recording and reporting safeguarding concerns for adults/child at risk' was completed, to be forwarded to safeguarding leads[172].

5.126. The doctor spoke to Mr GH's sister who raised concerns about his discharge from hospital in May 2015. The doctor explained he was very frail and could be approaching the end of his life[173].

5.127. The hospice senior social worker advised the Adult Social Care social worker of Mr GH's admission, seeking to ascertain what care package he had & when it was last reviewed. She was concerned that it had not been meeting his needs[174]:

- He was left for 13 hours, between the last evening visit at 18.00 and the first morning visit at 7.00 without turning, fluids or medication;
- The carers had advised that they could not give mouth care as he was bed-bound and may choke (despite the fact that they were feeding him and he had a hospital bed that could be elevated);
- He was unable to have medications that were not in a dosset box, as care workers were not able to administer them, with the result that the salbutamol inhaler, nystatin for mouth and morphine for pain were not given.

5.128. The Adult Social Care social worker was concerned about the pressure sore as adult community nurses were visiting weekly, and asked that a safeguarding referral be sent straight to her to investigate. She was aware that a financial safeguarding referral had been raised by Mr GH's brother in law and investigated, finding there was no case to answer (referring to the enquiry in

[170] St Joseph's IMR
[171] St Joseph's IMR
[172] St Joseph's IMR
[173] St Joseph's IMR
[174] St Joseph's IMR

April 2015). But she stated she would look further into the recent financial abuse allegation and raise a further alert if she felt there was a need[175].

5.129. The hospice contacted the dental practice used by Mr GH, but they did not have records relating to him[176].

5.130. On the **20th August 2015**, hospice ward staff requested review by the tissue viability nurse. A doctor saw Mr GH and noted his pain was better controlled and he was feeling more comfortable[177]. The same day the hospice senior social worker met with Mr GH's sister and brother in law, who raised concerns[178]:

- The lack of mouth care and absence of medication;
- The cleaner, who lived round the corner and had worked with Mr GH for 4 years. He reported paying her £40pw; she withdrew his money, paid his bills, shopped and cleaned. They advised the senior social worker of their financial abuse safeguarding alert;
- A former carer, no longer employed by the agency, had been seen visiting until about two weeks ago. The housing scheme manager had seen her on the premises and asked her to leave but she had returned. They described Mr GH as having been non-committal, but he acknowledged that he had her number on his mobile.

While in the hospice Mr GH had mentioned a daughter, and his sister confirmed he did have a daughter but she was estranged, had changed her name, and her whereabouts were unknown. The senior social worker agreed to give Mr GH emotional support, to raise further safeguarding referral about the pressure sores and to find out the outcome of his brother in law's safeguarding alert[179].

5.131. The senior social worker emailed the safeguarding referral to the Adult Social Care social worker, as had been agreed between them[180].

5.132. On **21st August 2015**, the tissue viability service noted a referral from the hospice, stating that Mr GH required review due to a grade 4 pressure ulcer (site not stated)[181].

5.133. The same day the hospice dietician asked nursing staff to continue to support Mr GH by feeding him at meal times and to keep a food record chart for 3 days to aid further nutritional assessment. The physiotherapist undertook a limited assessment due to his pain, and there were internal consultations between doctors on the care plan and medication[182].

[175] St Joseph's IMR
[176] St Joseph's IMR
[177] St Joseph' IMR
[178] St Joseph's IMR
[179] St Joseph's IMR
[180] St Joseph's IMR
[181] HUHFT IMR
[182] St Joseph's IMR

5.134. On **23rd August 2015** the hospice nursing staff requested a pain reassessment, which a doctor undertook, increasing Mr GH's medication with agreement to monitor closely for opiate toxicity. Unprompted Mr GH reported to the doctor that he felt his carers at home were 'rough' and hurt him during their care. He said they spoke over him in another language and did not listen to him. These concerns were passed on to the charge nurse to be given to the social worker so they could be to safeguarding alert. The IMR writer found no evidence that this was done[183].

5.135. The physiotherapist attempted a further assessment on **24th August 2015** but Mr GH was too tired[184].

5.136. Also on the **24th August 2015**, the hospice senior social worker spoke about the financial issues with the housing scheme manager, who shared her concerns about Mr GH's susceptibility to cold callers. She mentioned the former carer who had been found on the premises and had lied about being with an agency; she had been told not to return. The senior social worker undertook to keep the scheme manager updated about Mr GH[185].

5.137. The same day the hospice senior social worker visited Mr GH to say his sister was coming the following day. She passed back to his sister his request that she bring toiletries and clothes[186].

5.138. On the **25th August 2015** the hospice senior social worker met Mr GH's sister & brother in law at the bedside; he slept through most of the discussion. They had brought a picture of his daughter in the hope it would open a conversation, and a nephew was coming from abroad to see him. The doctor explained that he was approaching the end of his life. They again expressed their concerns about his home care and were reassured that the hospice was taking some of these issues forward[187].

5.139. Discussion took place between hospice doctors about changes to medication and a letter was faxed to the GP[188]. The hospice chaplain visited Mr GH and sat with him gently chatting for a while; he appeared relaxed and peaceful but didn't respond[189].

5.140. The Adult Social Care social worker rang the hospice senior social worker to arrange a safeguarding strategy meeting. The senior social worker advised her that the tissue viability nurse would be assessing Mr GH the following day, and that he was deteriorating and was expected to die in the near future. She also raised concern that his sister and brother in law had not received an

[183] HUHFT IMR
[184] St Joseph's IMR
[185] St Joseph's IMR
[186] St Joseph's IMR
[187] St Joseph's IMR
[188] St Joseph's IMR
[189] St Joseph's IMR

outcome to the alert they raised about finance and that concerns were ongoing. She was concerned too that the prescribed medication that nobody was able to administer except the cleaner[190].

5.141. Also on **25th August 2015** the 'next of kin' (likely to be referring to Mr GH's sister) notified the housing scheme manager that several unexplained withdrawals had been taken from Mr GH's bank account. The scheme manager advised reporting this to safeguarding. She also spoke to the social worker and was informed a meeting would be arranged[191].

5.142. The same day, **25th August 2015**, the safeguarding referral from the hospice was logged as received[192]: that on admission Mr GH had mouth ulcers, grade 4 pressure sores, septic leg ulcers and signs of general neglect. The IMR notes that Mr GH died before these concerns could be investigated. The social worker took advice from the safeguarding team and the alert resulted in the SAR process.

5.143. On **26th August 2015** it was noted by the hospice doctor that Mr GH continued to deteriorate but seemed comfortable. He gave slight recognition to voice; the senior social worker visited but he did not respond[193].

5.144. The same day the person described as the 'next of kin' advised the housing scheme manager of Mr GH's failing health. The scheme manager took advice from the Housing Association's Governance and Safeguarding Officer; a safeguarding alert was raised on the housing association's internal system[194]; it is not stated what specific concern was being raised.

5.145. On the **27th August 2015** Mr GH was given fan therapy for raised temperature. The tissue viability nurse visited and photographed Mr GH's wounds[195]. The same day the hospice senior social worker visited him and read him a card that had been sent describing a collage of photos contained within it[196].

5.146. The same day the Adult Social Care social worker invited the hospice senior social worker to the safeguarding strategy meeting 4th September, but she was not available so arranged cover attendance from a hospice social work colleague, advising Mr GH's sister of this[197].

5.147. Also on the **27th August 2015** the tissue viability nurse and the adult community nursing service's clinical operations manager visited. They noted worsening eczema around the gaiter of both legs. They considered the ulcers on

[190] St Joseph's IMR
[191] Anchor IMR
[192] ASC IMR
[193] St Joseph's IMR
[194] Anchor IMR
[195] St Joseph's IMR
[196] St Joseph's IMR
[197] St Joseph's IMR

the left bunion and lateral right foot were not pressure ulcers but had occurred due to generalised deterioration and low blood flow to the feet. Malodour from wound was observed. A dressings plan was made with the aim of keeping Mr GH comfortable[198].

5.148. Mr GH died at the hospice on **28th August 2015**[199][200].

5.149. On **1st September 2015** the hospice senior social worker advised the Adult Social Care social worker of Mr GH's death[201]. The 'next of kin' notified the housing scheme manager, and requested the wake to be held at the housing scheme[202].

5.150. **On 3rd September 2015** Mr GH's sister and brother-in-law emailed a list of concerns to the housing scheme manager and the hospice senior social worker, as they were unable to attend the strategy meeting the following day[203]. The Adult Social Care IMR notes (but does not give the date) that a list of 23 concerns about inadequacies in the care plan had been received from Mr GH's sister[204].

5.151. The safeguarding strategy meeting (relating to the concerns raised by the hospice on 20th August/25th August 2015) took place on **4th September 2015**[205].

5.152. On **8th September 2015** the housing scheme manager requested removal of Mr GH's equipment[206].

5.153. On **23rd September 2015** the hospice senior social worker asked the Adult Social Care social worker for the minutes of the strategy meeting[207]. The following day the Adult Social Care social worker said the minutes had not yet been produced, but she had left a message to update Mr GH's sister and brother-in-law about the Safeguarding Adults Review. She requested information about the cause of Mr GH's death but the hospice senior social worker declined, saying it was appropriate to ask Mr GH's relatives what was on the death certificate.

[198] HUHFT IMR
[199] HUHFT IMR
[200] The cause of death stated on his death certificate is liver malignancy.
[201] St Joseph's IMR
[202] Anchor IMR
[203] St Joseph's IMR
[204] ASC IMR
[205] Anchor IMR
[206] HUHFT IMR
[207] St Joseph's IMR

6. THEMED ANALYSIS

6.1. Introduction to the themed analysis

The following section reports on findings that emerge from the chronology, providing pointers to the learning that emerges from this review of Mr GH's care prior to his death. A key focus is on how the various agencies involved worked together to help and protect him. The account incorporates the key areas of enquiry set out in the terms of reference, grouped within 3 key themes:

- Ownership and coordination:
  - ToR(b) Ownership and coordination of the services to meet Mr GH's health and social care needs;
  - ToR(d) Communication and information-sharing that took place between the agencies involved;
  - ToR(e) Coordination of the actions of the health and social care services involved in Mr GH's case (i.e. hospital & adult community nursing/community health services, homecare provision, social services, GP practice/primary care and sheltered housing provider);
  - ToR(g) Commissioning and monitoring of health and social care services;
- Safeguarding
  - ToR(c) Safeguarding processes, practice and procedures applied to Mr GH's case;
  - ToR(f) Strategy and management of Mr GH's finances;
- Management of end of life care
  - ToR(h) Management of Mr GH's end of life care

Within each theme, both the strengths identified (ToR(a)) and the aspects needing improvement are explored. Recommendations relating to the actions of the City & Hackney Safeguarding Adults Board (ToR(i)) are given in a subsequent section.

6.2. Ownership of services to meet Mr GH's needs

6.2.1. General practice

6.2.1.1. Mr GH was placed on the GP's Vulnerable Home Visit Scheme, an enhanced service designed to proactively manage people who are frail or have complex needs, with a view to minimising the need for hospital admission.

6.2.1.2. Annual asthma and diabetes reviews were carried out (10/1/2015; 19/2/2015) along with routine home visits (30/9/2014), blood pressure checks (27/6/2014) and medication reviews (17/7/2014).

6.2.1.3. The GP also responded proactively to particular concerns expressed by those in contact with Mr GH, undertaking appropriate investigations and acting upon their outcome. As Mr GH's health declined, such episodes became more frequent; visits responding to specific health needs were logged on 7th May and 8th August 2014; 12th, 22nd and 30th January, 29th April, 11th and 15th May, 5th and 17th June and 7th August 2015.

6.2.1.4. The GP paid particular attention to ascertaining and respecting Mr GH's wishes about his liver lesion diagnosis. With Mr GH's permission, the GP liaised with his sister about his prognosis and end of life care, with discussions logged on 9th June, 7th August and 14th August 2015. The GP also made a referral (9th June) to the community matron, requesting a visit to discuss end of life care, which subsequently took place (17th June)

6.2.1.5. Three concerns arise, however. First, given Mr GH's complex health needs potential vulnerability, the surgery's regular multidisciplinary team meetings would have been an appropriate forum for coordinating multidisciplinary teamwork on an on-going basis particularly as his health deteriorated in the final 5 months of his life. Only one discussion is noted: on 13th August, five days before his hospice admission, following an ambulance service alert that he had fallen but declined hospital admission. The GP record states "*mass in the liver, does not want any investigation, wants to be left alone, had a recent fall, ambulance called out, good care package in place*", with no indication of any action considered necessary by the GP or anyone else. Any one of a number of healthcare professionals could have identified Mr GH much earlier as someone who needed to be discussed in this forum, which could have played an important, proactive role in ensuring that all services were aware of his changing needs, could review their involvement, and respond as necessary to ensure a greater level of comfort, safety and monitoring.

6.2.1.6. Second, the GP did not make arrangements for the administration of oramorph, originally prescribed and dispensed by Homerton Hospital to assist with pain control following Mr GH's discharge from hospital. (It is noted that oramorph is not a controlled drug at the 10mg/5ml dosage that was prescribed.) The care workers were not allowed to administer medication, their involvement being limited to prompting Mr GH if medication was due, and the adult community nursing service was not advised that oramorph had been prescribed. On one occasion Mr GH's private cleaner rang the surgery and sought permission to give the oramorph herself. The GP surgery has stated[208] that the prescribed dose of oramorph was not controlled, and that the GP knew, from prior knowledge of the cleaner's circumstances, that she was competent at drawing the dose into a syringe; he therefore

[208] Further information supplied to the Panel by the GP Surgery.

felt on balance, because he did not wish Mr GH to be in pain, that it would be in Mr GH's interest for her to give the analgesia. It is recognised (in the surgery's IMR) that the practicalities of administering the drug had not been explored by the GP, and that "*a referral should have been made to the district nurses to administer the medicine rather than relying on the patient's cleaner*"[209].

6.2.1.7. Third, there was delay in progressing a referral to palliative care. In June the GP had referred Mr GH to the community matron for discussion of end of life care. Mr GH's stated wish at that point was to remain at home, and it seems that no need for palliative services was identified; certainly there was no change to how his health and care needs were met. The decision that the GP would make a palliative care referral was made in a home visit discussion between the GP, Mr GH and his sister on the evening of 7th August. The surgery's IMR indicates that the GP did not make the referral until 10 days later, on the 17th August, following a follow-up enquiry by Mr GH's sister – a delay of 5 working days. The IMR recognises this shortfall, attributing it to "*human error*" arising from "*workload and an oversight*"[210]. The delay in Mr GH gaining access to appropriate care and support at a time of potential pain and discomfort may or may not have impacted upon the need for his eventual end of life care to be provided through hospice admission rather than in his own home.

[209] The Wick GP Surgery IMR
[210] The Wick Surgery IMR

6.2.2. Adult community nursing

6.2.2.1. Adult community nurses visited Mr GH once a week to attend to the dressings on his legs, which were required as a result of his venous leg ulcers and associated varicose eczema. His skin had long been prone to chronic breakdown and ulceration, with the healing process affected by the co-morbidities associated with his other complex health needs such as diabetes. His relative immobility also meant that he was prone to pressure sores at points of contact, particularly his feet and sacral area, as he spent long periods in bed or sitting on his wheelchair or mobility scooter. On both his April and May admissions to hospital, the service did carry out a ward visit to discuss discharge planning. After his discharge from hospital admission on 13th April 2015, the hospital requested two visits a week from the adult community nursing team to attend to his leg dressings and monitor his skin (he was subsequently re-assessed by the community nursing team as requiring weekly visits[211]). Again after his discharge on 3rd June, twice-weekly visits were requested.

6.2.2.2. Two nurses were needed to change his dressings, including one senior, due to the extreme stiffness in his legs and the pain he experienced; one nurse would lift his leg so that the other could attend to the dressings. In order to inspect Mr GH's skin for signs of pressure sores, particularly on his sacrum, the nurses required him to be in bed rather than in his wheelchair. This necessitated liaison with his care workers so that with notice of a nurse visit they could leave him in bed until the visit had taken place. Access to Mr GH's flat could be gained through the use of a key code, which the adult community nursing service had access to for use by all the nurses.

6.2.2.3. The pattern of adult community nursing visits became a concern that triggered adult safeguarding, particularly when it coincided with the identification by others (such as during hospital admission) of leg ulcers and pressure sores. Other concerns did not trigger safeguarding referral. The concerns are summarised below. The HUHFT IMR lists all visits conducted by the adult community nursing service (these are shown in Appendix 1).

6.2.2.4. The weekly visiting pattern was not consistently maintained. On five occasions, visits were significantly overdue (with either 14 or 21 days since the previous visit).

- On 22nd August 2014 the GP raised concerns with the service that Mr GH had not been seen for 2 weeks. The HUHT IMR acknowledges: "*This is correct and a failing on the nursing team".*
- On 3rd April 2015, safeguarding referrals was made (by the London Ambulance Service and by Homerton Hospital A&E,

[211] Clarification provided by the HUHFT.

alleging that Mr GH's dressings had not been changed for 3 weeks and that his pressure sores were infected. The detail of these concerns is given in the later section on safeguarding; here the focus remains on the visiting pattern. While the allegation of a 3-week gap was not substantiated in the safeguarding enquiry, there is evidence in the chronology for the present review to suggest that there had been such a gap.

6.2.2.5. A twice-weekly pattern of adult community nursing visits was requested by the hospital when Mr GH was discharged from both periods in hospital (3rd to 13th April 2015 and 15th May to 3rd June 2015). Twice weekly visiting was not routinely established, however, until the beginning of August 2015. It was therefore not in place prior to his second admission (15th May 2015), when a grade 3 pressure sore to the right heel and a grade 2 pressure sore to the big toe were noted. A review on the 19th May confirmed a grade 2 pressure ulcer on right heel (2cm x 1.5cm), a grade 3 pressure ulcer on the 1st metarsal phalangeal joint (2.2cm x 1.5cm) and venous changes to both legs. And in the period between his second discharge on 3rd June and his admission to the hospice on 18th August 2015 the pattern had remained predominantly weekly until the fortnight immediately prior to his admission (when it is evident that his dressings were changed on three occasions).

6.2.2.6. On admission to the hospice on 18th August 2015 it was noted that Mr GH had four small grade 2 pressure sores on his sacral area, and the following day when his leg dressings were changed a grade 4 wound to the lateral aspect of his right foot was noted. The hospice social worker raised safeguarding concerns with the Adult Social Care social worker by phone that day, following up with a written safeguarding referral. The nature and cause of this skin break down remains disputed; further details are given in the safeguarding section. There was no clear finding of neglect; the episode led to the commissioning of the present review.

6.2.2.7. There are some gaps in the account that the IMR writer could give: the number of nurses present is not routinely noted on adult community nursing service records and while for many of the visits the care provided is recorded in brief clinical notes, for a proportion (approximately 20% of those carried out during the review period) there is no documentation on what took place, making it difficult to identify what care was given. The IMR writer notes that the quality of entry into the patient record was deficient on 14 occasions.

6.2.2.8. Further complications arose in relation to the visiting pattern:

- It emerged during the safeguarding enquiries into missed visits (details given in a later section) that the service worked on a weekly cycle of visits, not a 7-day one. Thus a patient could be seen

early during one week and later in the following week, leaving a gap of more than 7 days between visits.

- On some occasions nurses did not gain access because they did not have the key code with them (e.g. 24th February 2015, 29th April 2015) despite it being available to the service. The HUHFT IMR comments that it was given to all staff who visit, although a nurse interviewed by the IMR writer mentioned difficulties gaining access, and that on occasion the housing scheme manager would let them in; it is not clear why this would be necessary if they had the code. On 29th April 2015, the adult community nursing service undertook to visit after a care worker identified that Mr GH had a new sore on his bottom. The service records indicate that a nursing visit took place, but there is no documentation of what took place. However, on the 30th April 2015 the care agency reported that no visit had taken place, and the adult community nursing service explained that a nurse had visited but been unable to gain access. This is concerning, because it indicates that when nurse visits were recorded as having taken place, but there is no documentation recording what was done, this could mean that no access was gained and therefore Mr GH was not seen.
- A further occasion casts doubt on whether Mr GH was always seen on 'outcomed visits' for which no documentation exists. On 16th December 2014, when a visit was recorded as having taken place but no documentation was made to record what was done, the following day the housing scheme manager reported to the adult community nursing service that Mr GH had not seen a nurse for 2 weeks, and on the 18th December the care agency too reported that he had not been seen. This casts some doubt on whether Mr GH was seen on the visit of 16th December, and taken alongside the discrepancy relating to the 29th April 2015 visit (above) calls into question other visits that are recorded as having taken place but without documentation of what was done clinically.
- On some occasions dressings could not be changed because two nurses were not present on the visit, despite it being acknowledged that two nurses were required.
- On some occasions when dressings were not changed (because only one nurse was present, or access could not be gained, or on one occasion because Mr GH declined as he was having his lunch) there appeared to be no provision for an earlier rescheduled visit to be made.
- Communication between the service and Mr GH appears not to have been clear; Mr GH often queried, either directly or through care workers or the scheme manager, when a visit was due. The HUHFT IMR observes that the date of future visits should always have been noted in the home records.
- On some occasions pressure areas could not be inspected because notification of the visit had not been given to the care workers, and Mr GH was therefore already seated in his wheelchair. Examples include 25th November 2014, when an inspection of his skin had

been explicitly requested after the care worker reported that he had sores around his bottom and scrotum.

- There is no indication that the high Waterlow scores recorded on some visits to Mr GH (16th December 2015, 21st April 2015 and 3rd August 2015) triggered any changes in how Mr GH was cared for, and they do not appear to have been shared with others involved in his care.
- After Mr GH's discharge on 13th April 2015, although the referral from the hospital to the adult community nursing service was for twice-weekly visits, and although the service had visited him while in hospital for discharge planning, only weekly visits resumed (14th, 21st, 28th April, 5th May). Again after his discharge on 3rd June 2015, with a request for twice-weekly visits, the visiting pattern was irregular (visits on 10th, 16th and 19th June (all without documentation) 25th and 30th June, the pattern thereafter reverted to weekly (7th, 14th, 21st, 28th July).

6.2.3. Hospital health care

6.2.3.1. Mr GH was admitted to Homerton Hospital a number of times during the period under review, and on other occasions refused admission:

- Admission on or around 9th September 2013, following a fall;
- 17th December 2013: He fell while receiving assistance with personal care; an ambulance was called and picked him up; he had no injury and declined hospitalisation;
- 16th December 2014: He fell and sustained a cut; an ambulance attended but he refused admission;
- Between 3rd and 13th April 2015 he was an inpatient, following admission from A&E, where he had been taken by ambulance as he had severe pain in his legs. He was diagnosed with urosepsis and was also referred to the tissue viability nursing service with a "*suspected deep tissue injury to right heel*".
- Between 15th May 2015 and 3rd June 2015) he was an inpatient following admission arranged by the GP who was concerned about confusion, recent onset of chest infection and abnormal urine and blood test results. The diagnosis was lower respiratory tract infection, acute kidney disease (secondary to chronic kidney condition), dehydration and delirium. A skin assessment noted that his sacrum was red but remained intact. When his leg dressings were changed a grade 3 pressure sore to the right heel and a grade 2 pressure sore to the big toe were noted. The tissue viability nurse reviewed his condition on the 19th May, noting a grade 2 pressure ulcer on right heel (2cm x 1.5cm), a grade 3 pressure ulcer on the 1st metarsal phalangeal joint (2.2cm x 1.5cm) and venous changes to both legs.
- On 13th August 2015 the Ambulance Service notified the adult community nursing service that Mr GH had fallen and sustained a

laceration to his left arm; they requested a nurse visit to assess his arm as he did not wish to go to hospital.

6.2.3.2. Admissions appear to have been appropriately arranged and managed, and liaison took place with the GP surgery regarding discharge summaries and notifications of on-going follow-up required. There were lapses of communication with the adult community nursing service, who, having been asked to visit following discharge, were not advised that discharge was delayed and thus attempted visits that could not be effected. The HUHFT IMR makes the point also that the referral to the adult community nurses relating to Mr GH's discharge on 3rd June did not mention that he was to receive palliative care, and that the nursing staff were not aware of the new development relating to his diagnosis of liver lesion.

6.2.3.3. The extent of multidisciplinary teamwork within the hospital is not clear; there is only one mention (by the hospital occupational therapist, 5th Aril 2015) of feedback being given to the weekly multidisciplinary team. Equally is it not clear why, when Mr GH was in receipt of a substantial package of care and support, whether discharge planning included liaison with community based adult social care services about his possible changing needs.

6.2.4. Adult social care

6.2.4.1. It is not known when Adult Social Care first assessed Mr GH as needing care and support. His care package was well established well before the period under review. His case was managed by the Review Team, which meant that it was only actively allocated to a practitioner at the time the annual review was due, and once all matters identified in that review had been dealt with it would be de-allocated again until the next time. Between reviews, the duty desk would deal with any matters presented.

6.2.4.2. Several annual reviews are noted in the Adult Social Care IMR:

- An annual review by a social worker of his needs and care plan took place on 22nd January 2013. At this review Mr GH expressed concern that the care agency did not follow the support plan. The social worker alerted Procurement but there is no indication that any further action was taken to investigate or monitor the provision, and there was no follow up with Procurement to ascertain whether they had progressed the matter.
- A revised care plan was set in place on 15th April 2014, increasing visits to 4 daily, double-handed, following OT assessment on use of a newly installed hoist. This service was implemented on 21st May 2014.
- On 17th November 2014 an annual review took place. Two months before, the housing scheme manager had raised concerns directly

with the care agency about the service they provided, but at the review Mr GH expressed satisfaction with his care.

- On 13th April 2015 a hospital social worker undertook a community assessment prior to Mr GH's discharge from hospital; no details are provided. It is not clear whether, or how, this assessment linked with the care planning process undertaken by the locality team.

6.2.4.3. Adult Social Care social workers were directly involved in responding to safeguarding referrals during 2015. Their role here is set out in the later separate section on safeguarding.

6.2.4.4. Mr GH also received assessment and intervention from the London Borough of Hackney Community Occupational Therapy Service, with a high level of well-documented activity during 2014. Following identification of manual handling risks when care workers lifted Mr GH, a mobile hoist was provided to assist with transfers to and from bed, and subsequently a ceiling track hoist was installed. Equipment was also provided to facilitate the use of a wet room funded through a disabled facilities grant, and to enhance wheelchair accessibility of the property through adaptations to doorways. The occupational therapist gave care workers clear instructions on the use of Mr GH's equipment, liaised effectively with the social worker and housing scheme manager, and was assiduous in following up and reviewing the effectiveness of the provision. She identified risks of pressure sores from an ill-fitting wheelchair and initiated a wheelchair reassessment when she noticed in mid-2014 that Mr GH had lost weight between reviews (though the cause of this was not questioned at the time).

6.2.4.5. Despite the intensity of the care package it commissioned for Mr GH, Adult Social Care was noticeable by its absence as concerns unfolded about Mr GH's declining health. Despite the complexity of his needs, they did not play a coordinating role, or maintain an overview of his situation between episodic involvements for the purposes of reviewing their own input or investigating a safeguarding concern. They were not routinely advised of developments other than those relating to safeguarding matters. Even the annual reviews appear not to have taken a holistic overview of his situation, the focus remaining on social care support needs and Mr GH's satisfaction with the service, rather than proactive engagement with other source of information. On the one occasion, when explicit concerns were raised during the review by Mr GH (and were referred by the social worker to Procurement), there was no follow up to ascertain the outcome of any quality monitoring of the provider.

6.2.4.6. Thus it appears Adult Social Care were not aware of Mr GH's decline in health. The last review had taken place some 9 months prior to his death, with the care and support package unchanged

during that period despite his increasing frailty. As part of the final safeguarding alert, made as Mr GH was admitted to St Joseph's hospice, serious concerns were expressed about the adequacy of the care plan and the extent to which it could by then meet his needs.

6.2.5. Care agency care and support

6.2.5.1. Mr GH had been receiving care and support from First Choice since October 2012. In December 2012 the agency first raised the need for two carers per visit to assist him to stand and mobilise. This did not become part of his care plan until April 2014, when his care was increased to 4 double-handed visits per day in response to an occupational therapy recommendation about use of a hoist that had by then been installed.

6.2.5.2. During the period under review, the housing scheme manager acknowledged the care workers' relationship with Mr GH ("*I know they work very well with him*"), but she expressed a range of concerns about the care agency's delivery of the care and support.

- She alerted Adult Social Care that only one care worker was operating the hoist that required two carers (1/8/2014).
- She emailed the care agency with concerns: the care workers were not placing Mr GH's hoist on charge in the evening, resulting in it being unavailable for the morning visit so he was left in bed; a care worker arriving late; the washing left for the cleaner being more than she could cope with so requesting care worker support with this task (22/9/2014).
- She alerted the care agency that care workers were incorrectly disposing of incontinence pads, and advised the correct method (29/12/2014).
- Having noted that Mr GH smelt strongly of urine, and that his washing had a strong smell, she emailed the care agency to ask that his continence pad be changed 4 times per day as prescribed, and also raised the question of whether laundry was part of the package. In response the care agency's care coordinator noted that although laundry time was not allocated in his care plan she had asked the care workers to do it when the private carer could not (9/3/2015).
- She emailed the care agency to report that residents had complained about care workers using communal facilities, and sleeping on the settee in the foyer. They should not be in the building between visits, but she did not mind their occasional use of the communal lounge, but not the foyer or corridors, or use of electrics to recharge phones, and directed them to a nearby café. The coordinator gave assurance that she would advise care workers accordingly (4/6/2015)
- She asked that carers bring all rubbish to the ground floor, as rubbish left in the first floor bins caused strong odours on the

landing; cleaners had also requested that gloves were placed in bins, not thrown on the bin room floor (13/7/2015).

6.2.5.3. While Mr GH sometimes stated satisfaction with his care arrangements (and this is noted by the care agency), there was a pattern of dissatisfaction also. Between January 2013 and March 2014 he made a number of representations about his care workers:

- At the adult social care review of his plan on 22nd January 2013 he told the social worker that the care agency did not follow the support plan. The social worker alerted Procurement but there is no indication that any further action was taken to investigate or monitor the provision.
- He advised the agency that he wanted a male care worker because "female carers steal his money". This does not appear to have been interpreted as a safeguarding issue, and was not reported by the agency (11/2/2013).
- He refused care because he didn't like the care worker and requesting a change of worker (11/3/2013).
- He asked to be attended by a particular worker and agreeing to wait 2 days until they returned from leave (29/4/2013).
- He asked for a different care worker (the scheme manager also made representation) as the care worker didn't keep to time, rushed him and didn't tidy up at the end of the visit (26/11/2013). The agency subsequently followed up with Mr GH to check he was happy with his new worker (27/11/2013 & 9/1/2014).
- He pulled his alarm chord because the care worker was late (3/2/2014).
- He requested his bedtime visit an hour earlier as he felt he remained seated for too long during the day and this made him sore (21/3/2014)

6.2.5.4. With the exception of the allegation that care workers stole his money, both the scheme manager's and Mr GH's representations appear to have been responded to by the care agency. The overall picture, however, was not brought to the attention of Adult Social Care, either by the care agency itself or those raising concerns. On the early occasion when concerns were reported to Procurement, these did not appear to trigger any on-going monitoring of the care and support provision by adult social care, or indeed any follow up of how the concerns had been addressed. This is perhaps explained by the case management model operated by adult social care; Mr GH's case was managed by the review team, which carried out a yearly review with no contact in between unless triggered by a specific referral of concern. Where concerns were later raised with adult social care, they related to safeguarding issues about his skin care and finances rather than concerns about delivery of the care package. The Adult Social Care IMR comments that the main monitoring of provider services is done by Hackney's Quality Assurance and

Compliance Team, but that there is no clear feedback system from this team (which is part of Commissioning) to adult social workers. It also observes that the case management system, with its sporadic involvement for reviews, can prevent social workers developing a relationship with the individual that can encourage deeper exploration of their needs and concerns.

6.2.5.5. One final concern about the care and support provided by the care agency went unnoticed. On 23rd August 2015, while the hospice doctor was undertaking a pain reassessment, unprompted Mr GH reported to the doctor that he felt his carers at home were 'rough' and hurt him during their care. He said they spoke over him in another language and did not listen to him. These concerns were passed on to the charge nurse to be given to the social worker so they could inform a safeguarding alert, but they receive no further mention and do not appear in any of the safeguarding concerns explored as a result of the referral raised at the time of his admission to the hospice.

6.2.6. Housing related support

6.2.6.1. The housing scheme manager was proactive in attending to Mr GH's housing-related support needs and to many other practical matters. These included, for example, assisting him to claim a reduction in electricity costs (24/11/2014), alerting him to a declined direct debit payment (29/1/2015), assisting him to renew his freedom pass (2/3/2015) and ordering a gel cushion for his wheelchair (7/7/2015).

6.2.6.2. As identified above, she also played a key role in liaising with other agencies about his needs, and with his family, at times playing a key coordinating role in ensuring he received the care and support he needed.

6.2.6.3. She was also able to advocate on his behalf, or on behalf of other residents, when care did not meet expectations, or where adjustments were needed to how care workers or adult community nurses provided services. There were a number of such occasions (as indicated in an earlier section), and it might be expected that a repeat pattern of concerns of this nature would be escalated beyond the front line practitioners with whom she was in regular contact. Such escalation might have been effective in drawing the attention of managers in those agencies, or of their commissioners, to the need for closer monitoring of services provided.

6.3. Coordination of services to meet Mr GH's needs

6.3.1. Under the Care Act 2014, there is a statutory duty of cooperation between the local authority and other agencies, relating to the local authority's statutory care and support functions under the Act[212]. The NHS Act 2006 provides a statutory duty for NHS bodies to cooperate with each other in the exercise of their functions, and for NHS bodies and local authorities to cooperate with each other to secure and advance health and welfare[213]. Contractual arrangements may also define more detailed mutual expectations.

6.3.2. Many of the staff involved with Mr GH's care routinely undertook routine liaison with others from other agencies. The care agency was active in this regard, liaising for example with:

- the GP surgery and adult community nurses about the need for chiropody assessment (19 & 20/3/2013);
- Mr GH's sister when they found him not at home (he had been admitted to hospital, 9/9/2013);
- occupational therapy so that a visit could be made with care workers present 26/11/2013);
- ambulance crew and later with the GP, when Mr GH could not stand (6/5/2014);
- the scheme manager about the condition of Mr GH's skin (7/8/2014);
- the GP when Mr GH was in severe pain (8/8/2014);
- the adult community nursing service on several occasions about the condition of Mr GH's skin when it gave cause for concern, and about overdue adult community nursing visits (e.g. 28/7/2014, 3/3/2015);
- Adult Social Care when Mr GH's continence pads had run out (7/5/2015).

6.3.3. The housing scheme manager was similarly proactive in routine communications:

- She contacted the adult community nursing service to request a new referral for continence pads to be delivered when none had been received by the supplier (3/12/2014) and again followed up when no delivery was received (5/1/2015).
- She arranged transport for Mr GH to attend eye screening (15/1/2015).
- She contacted the chemist to arrange delivery of medication that had not arrived (26/1/2015).

[212] Section 6 provides a general duty of cooperation between the local authority and relevant partners in the exercise of its care and support functions. Section 7 provides a duty of cooperation in specific cases. Any agency so requested must comply unless to do so would be incompatible with its own duties or adversely affect its work.

[213] Section 72 and section 82.

6.3.4. The private cleaner was also well linked into communication with the housing scheme manager:

- She alerted the housing scheme manager that Mr GH had asked her to place a towel on his chair as he was uncomfortable, triggering the scheme manager to ask the care workers to check for broken skin, soreness or ulcers (24/11/2014).
- She reported to the scheme manager that Mr GH was experiencing headaches, alerting her to the need for a GP visit (12/1/2015).

6.3.5. The occupational therapist was proactive in liaising with the social worker, the housing scheme manager, the housing association and the care workers over Mr GH's needs for aids, adaptations, equipment, safe transfers and wheelchair accessibility around his property.

6.3.6. The adult community nurses would on occasion notify the care workers of their intended visit, asking them to leave Mr GH in bed in order to facilitate inspection of his skin.

6.3.7. Despite this pattern of routine communication, there was an absence of overall coordination and coherence, and a holistic view of Mr GH's needs seems to have been missing. There were many visitors to his home, and operational staff sometimes advised each other of events and practical needs. Each service had its plan for how relevant care was to be provided. But this took place in a vacuum left by the absence of a coordinating/ monitoring lead role that could have proactively ensured that a holistic plan was in place, and the whole professional system and support network was calibrated to his changing needs as his health deteriorated. Instead the different services remained in response mode. Mr GH would have benefited from a structured multidisciplinary approach to considering all aspects of his care, and the appointment of a lead agency to maintain an overview of his needs at strategic level.

6.3.8. It is striking that possible structures and mechanisms intended to facilitate multiagency coordination were not routinely used in Mr GH's case.

- The constraints on Adult Social Care's involvement (resulting from the review-only model of involvement) and the fact that others did not proactively alert them to his declining health meant that they did not keep abreast of the changing situation and were not in a position to play a coordinating role. When safeguarding concerns were shared, the investigations of those concerns appears disconnected from the broader picture of his overall care and support needs.
- There is only one mention of Mr GH having been discussed at the GP surgery's regular multidisciplinary team meetings (13th August 2015 on the day that he fell and declined hospitalisation). This represents a missed opportunity, which could have been initiated by any of the

healthcare professionals involved, to discuss a coordinated overall approach as his health declined.

- The GP's referral to the community matron in June 2015 for consideration of end of life care did not result in any collaborative efforts to support him more proactively at home in the light of his expressed wish to remain there. Further, it appears the community matron did not communicate the gravity of Mr GH' health decline to adult community nursing staff colleagues, some of whom were shocked to hear of his subsequent death, as they had not known he needed end of life care. It appears that the community nurse does not access the RiO adult community nursing records system, and therefore mutual exchanges of information cannot take place through this method.
- There was no apparent use of the One Hackney liaison model, which was set up in January 2015[214] explicitly to "cross the boundaries between primary, community, voluntary, acute and social care services" and to support GP practices in delivering practice-based integrated care.
- The was no contact between the hospital and adult social care about Mr GH's discharges from hospital, despite the fact that he was in receipt of a substantial care and support package.
- High Waterlow scores noted by the adult community nursing service do not appear to have been shared with others involved in his care, or triggered consideration of the need for any additional supports.
- There was limited communication from the hospital to the adult community nursing service, particularly around the practicalities of discharge.
- There was no apparent consideration of whether Mr GH met the criteria for continuing care[215] prior to his admission to St Joseph's Hospice. Continuing healthcare provided proactively once the nature of his health deterioration became known, with the diagnosis of a liver lesion, may have facilitated provision of specialist services that could have fulfilled his wish to remain and die in his own home.

6.3.9. Several factors may have played into this absence of a coordinated approach. There is no doubt that Mr GH's wishes and feelings were taken seriously by all involved in his care, and a strong emphasis was placed on respect for Mr GH's autonomy. He was someone who knew his own mind, and at times declined to follow advice (for example on the correct use of pressure cushions 22/1/2014). He was able to advocate for himself, and make his views known if not happy with the care he received. He was known to be proud of his independent lifestyle, which continued despite his complex health challenges. As noted earlier, his mental capacity to

[214] One Hackney became operational on 5th January 2015 for social work involvement, but would still have been recruiting other disciplines.

[215] Continuing healthcare is on-going care that is arranged and funded solely by the NHS where the individual has a *primary health need*; it thus meets needs arising from disability, accident or illness (DH, 2014). The National Framework (DH, 2012) sets out how continuing healthcare needs are assessed, determined as eligible and provided.

make decisions relating to his health and social care was never in question, at least not until his final days in the hospice, and until then he had remained clear and coherent about what he wanted, able to express himself and his wishes. In this context, he could have been seen as the coordinator of his own care.

6.3.10. A further factor hindering coordination relates to records – first whether they convey an accurate picture and second whether they are shared with others. That some of the recording in adult community nursing records relating to Mr GH's case was incomplete has been acknowledged in the HUHFT IMR, making it impossible to track the clinical input that took place. And the chronology compiled for this review casts doubt on whether all visits logged as 'outcomed visits' did in fact result in the nurse seeing Mr GH – there are at least two occasions where it is clear that he was not seen despite the visit being 'outcomed'.

6.3.11. Adult Social Care records too are not comprehensive, with key episodes such as safeguarding referrals and investigations not documented for this review. Whether this is because the records did not exist or because they were not available to the reviewer is not clear. In relation to health care records, the HUHFT IMR points out that acute care and community based settings use different electronic record systems, and both are separate from the system used in GP surgeries: *"during 2014/2015 it would not have been possible for staff working in the hospital to view or enter information in the community based records system and vice versa."* This may have been a significant contributory factor to the deficiencies in communication that took place.

6.3.12. A final observation on how agencies worked together in providing for Mr GH's health and social care needs relates to how differences of professional opinion were dealt with. As is evident from the safeguarding account that follows, there were very different interpretations of the observable condition of Mr GH's skin on the occasions he was admitted to hospital. Following the April 2015 admission, it was disputed whether he had an ulcer on admission or merely reddened skin, with community staff alleging he had acquired a grade 2 pressure sore while in hospital. Following the August 2015 admission to the hospice, St Joseph's staff diagnosed a grade 4 pressure sore, whereas community nursing staff who visited him reported he did not have a grade 4 pressure ulcer but generalised deterioration of his skin as he was reaching the end of his life. Without a key means of securing discussion of these matters there is a risk that the process slips into one of mutual blaming that can inhibit learning.

6.4. Safeguarding

6.4.1. It is important to note that prior to 1st April 2015 (the date on which the Care Act 2014 was implemented), the relevant guidance on interagency adult safeguarding systems was the "No Secrets" guidance issued in 2000 by the Department of Health. Safeguarding Adults Boards were not a statutory requirement, and there was no statutory duty on any party to make enquiries into potential abuse and neglect. The Care Act 2014 introduced new statutory requirements:

- Local authority duty (section 43) to set up a safeguarding adults board, with statutory membership from the clinical commissioning group and the police, and a statutory function to help and protect adults with care and support needs who are experiencing or at risk of abuse or neglect and as a result of their needs are unable to protect themselves;
- Local authority duty (section 42), where they have reasonable cause to suspect that an adult meets the above criteria, to make such enquiries as are necessary to enable it to decide what action needs to be taken and by whom.

The Care Act duties, implemented on 1st April 2015, thus applied only for the latter part of the period under review here.

6.4.2. Two aspects of Mr GH's health and social care became the focus of adult safeguarding concern: alleged neglect of Mr GH's skin care by adult community nursing services and alleged financial abuse by unknown persons (both his cleaner and a former care worker fell under suspicion). The account that follows contains two types of events: those that became the subject of safeguarding referrals, and those that were not but where the information indicates they could have been considered as potential abuse or neglect.

6.4.3. **11th February 2013:**

6.4.3.1. Mr GH advised the care agency that "he doesn't want a female carer, they always steal his money"[216].

6.4.3.2. This comment does not appear to have been interpreted by the care agency as a potential safeguarding issue. It appears no notification was made or further action taken.

6.4.4. **3rd April 2015**

6.4.4.1. The Adult Social Care duty desk received a telephone call from Mr GH's brother in law stating that money had been withdrawn from Mr GH's account and he believed that it was one of the carers. A principal social worker spoke to Mr GH. He informed her that he was

[216] First Choice IMR supporting documentation: care records

not being financially abused and gave a credible explanation for the expenditure, which he did not wish to be known to his family. His brother in law was informed that the abuse allegation was not substantiated[217].

6.4.4.2. There is no safeguarding documentation for this alert. It appears it was dealt with through contacting Mr GH, accepting his reassurance that he was spending the money himself. His privacy was respected in the nature of the feedback given to the referrer.

6.4.5. **3rd April 2015**

6.4.5.1. London Ambulance Service faxed an alert to Adult Social Care raising concern about neglect/acts of omission. Called by his carers to attend because Mr GH had "terrible pain" (his description) in his legs, they took him to the Homerton A&E Department; their safeguarding alert states:

- *"Leg ulcers and a pressure sore at the bottom of the spine. He is supposed to have district nurses every Tuesday to ensure his condition doesn't get worse. The nurse last came on 24/3/2015 (10 days previously) and as a result the sores have become septic"*.
- *"Patient disclosed to hospital staff that he fell out of his wheelchair and sustained a lump on his wrist. This was not reported by his carers since last week. He has not received any treatment for it and it has not been checked out.*"

6.4.5.2. Adult Social Care also received a safeguarding referral from the staff nurse at A&E, stating:

- *Mr GH "bought into Homerton A&E by LAS, stated that dressings to leg ulcers had not been redressed in over 3 weeks. LAS handed over that documentation stated district nurses were present on 24th March 2015. They should be completing dressings every 7 days according to care plan."*
- *"Patient was septic, therefore priority was to sort out the pathway and emergency medicine."*

6.4.5.3. The hospital also followed its internal procedure, reviewing the incident at the weekly divisional Complaints, Litigation, Incident Procedure meeting. It was confirmed Mr GH had been visited in the last 10 days, with the visit just 3 days overdue, and the incident was closed.

6.4.5.4. Within the safeguarding system, the referral was graded level 2 (medium/high risk) and allocated for investigation by a social worker. A strategy meeting was held on 8th May 2014 (noted as

[217] ASC IMR

falling outside the target timescale of 5 days from the alert, due to delay in allocating the case), attended by representatives from adult social care, adult community nursing and Mr GH.

6.4.5.5. An interim protection plan was implemented, with weekly adult community nursing service visits and liaison by Mr GH if he experienced any problems with the schedule.

6.4.5.6. The social worker prepared an investigation report, and a case conference was held on 23rd June 2015. Mr GH reported that visits were more regular, though one nurse had not changed his dressings on her visit. His skin remained weak and easily broke down. The pressure-relieving cushion he was offered was too high.

6.4.5.7. At the strategy meeting it had been acknowledged that a visit due on 31st March 2015 had not taken place because Mr GH's care required two nurses and one was not available, although at the case conference the reason given for the missed visit was that the two nurses who visited did not have the key code to gain entry (new nurses did not have it and not all would check before visiting). The adult community nursing service could not confirm that the leg dressings had been renewed on the previous visit on 24th March 2015.

6.4.5.8. From the combined chronology, it is possible to identify the following pattern:

- 17th February: dressings renewed;
- 24th February: visit missed, key code not used to gain entry;
- 3rd March: care agency alerted adult community nursing service that dressings had not been changed for 2 weeks;
- 3rd March: home visit but the second nurse required was busy so the visit was rescheduled. The HUHFT IMR comments that it should have been rescheduled to the following day, not the following week;
- 10th March: dressings renewed;
- 18th March: visit but there is no documentation on what took place;
- 24th March: visit but there is no documentation on what took place;
- 31st March: visit missed, key code not used to gain access.

6.4.5.9. Therefore it does seem that the dressings were not changed between 17th February and 10th March, a period of 3 weeks. And following the visit to change them on 10th March it is not possible to confirm that they were changed again before the hospital admission on 3rd April, as no record was kept of what took place on visits in between.

6.4.5.10. The outcome of the conference was:

- The allegation that legs not dressed for 3 weeks was not substantiated;
- The allegation that he did not receive care as required was substantiated (missed visit and no notification to Mr GH)
- The allegation of neglect was partially substantiated, as the adult community nursing service did not provide support at the required time.

6.4.5.11. The investigation focused specifically on the period immediately prior to Mr GH's admission on 3rd April. It may have been assumed that because the visit on the 24th March was logged as 'outcomed' (i.e. client seen) the leg dressings had been changed at that point, although no clinical notes were made to document what was done. In the light of such an assumption (whether justified or not) the finding that the dressing changes were only 10 days overdue was logical, given the acknowledged missed visit on the 31st March. What did not emerge during the investigation was the earlier period of 3 weeks in late February/early March during which it is clear that dressings were not changed, and may be the period to which Mr GH himself was referring when he made the complaint.

6.4.5.12. It remains disputed what ulcers/sores Mr GH had when and where. It appears his leg ulcers were infected; the Ambulance Service referred to them as 'septic' and this description is substantiated by the hospital's record. The pressure sore at the base of his spine, mentioned by the Ambulance Service, receives no further mention. There is disagreement about whether he had a grade 2 pressure sore on his heel: this was not mentioned either by the Ambulance Service or on the safeguarding referral from the hospital. When later questioned, the referrer could not recall whether it was noticed on admission. At the strategy meeting it was alleged by the adult community nursing service that prior to his admission Mr GH had only redness on his leg, not an ulcer and a grade 2 pressure sore on his heel had been acquired in hospital (although from the visit dates above, it is clear that he hadn't been seen by an adult community nurse for 10 days prior to the admission, so the observation cannot be evidenced). In any event, an adult community nursing visit on 14th April 2015, the day after his discharge, observes all skin areas were intact.

6.4.5.13. The progress of this referral is fully documented, with the Ambulance referral, the Homerton referral, the safeguarding referral record, the strategy meeting minutes, the investigator's report and the case conference minutes all available. However, there was no on-going plan for coordinating and monitoring further patterns of care, or to address the reasons for missed visits.

6.4.6. 5th June 2015

The GP record of a visit to discuss Mr GH's liver lesion diagnosis, notes a possible safeguarding issue, querying whether money was being taken by an ex-carer who still came in, although no longer with care agency. The GP learnt of this from the housing scheme manager, following his visit to Mr GH; the manager indicated that she and the family were gathering evidence from bank statements before the family took things further. As a result, the GP practice considered they needed to take no action[218].

6.4.7. 7th August 2015

6.4.7.1. The Anchor IMR states that the scheme manager emailed the care agency to report she had met a carer in the laundry room the previous evening; the carer had claimed she worked for the agency but this was subsequently discovered to be untrue. The IMR states, "*Agency asked to report to safeguarding team*", which does not clarify who asked whom to make the alert; in either event, there is no record in any IMR or supporting documentation of a safeguarding alert being made. The scheme manager advised Mr GH not to let this woman into his flat and not to give her money.

6.4.7.2. The Anchor IMR also states that the same day the scheme manager discussed with family members (unspecified) her concerns on being told that the cleaner on several occasions had been unable to draw weekly money due to insufficient funds. The family alerted the local authority safeguarding team; it was also agreed that the cleaner would keep a record of withdrawals.

6.4.7.3. The GP IMR reports that the GP visited Mr GH and his sister the same day to discuss his prognosis and care, and that "*a safeguarding issue around theft of money was discussed*". The family had already made a referral and mentioned to the GP that they had yet to receive a response[219].

6.4.7.4. There is no safeguarding documentation for this episode. However, the referral to the SAR sub-group by the social worker following Mr GH's death gives relevant information that is not presented anywhere else. It states that Mr GH's brother in law contacted the safeguarding adults team expressing concern that Mr GH was being approached for money by one of his former care workers from First Choice. The scheme manager had told her not to come onto the premises but she continued to do so. The duty senior visited Mr GH on 11th August 2015, and he stated that his former care worker had visited him 3 weeks previously. *"The care worker had called him out of the blue to ask after his welfare and asked if it was ok for her to visit him, which he agreed to. He said the care worker chatted with him and helped him to shave. Duty Senior asked if he gave*

[218] Further information provided by The Wick Surgery
[219] Further information provided by The Wick Surgery

her any money and he said 'no'. She asked if he would have given the care worker any money had she asked for it, he said 'no'. He said the only person he gave money to was the private care worker who did his housework. (He) reported that the care worker would not be coming back as the warden had told her that she would be calling the police if she was to come back. He said that even if the care worker was to return he would not open the door to her. He stated that his brother in law would be taking over the management of his finance … He said if he had any concerns, he would contact our department, the warden or his family."

6.4.7.5. It seems that although risk to Mr GH as an individual was addressed through the social worker's visit, none of the agencies took any further steps in relation to the potentially criminal nature of the former care worker's visit, or of potential risks to other residents.

6.4.8. 23rd August 2015

6.4.8.1. The St Joseph's IMR reports that while the hospice doctor was undertaking a pain reassessment, unprompted Mr GH reported to the doctor that he felt his carers at home were 'rough' and hurt him during their care. He said they spoke over him in another language and did not listen to him. These concerns were passed on to the charge nurse to be given to the social worker so they could be added to the safeguarding alert, but this does not appear to have happened as there is no further mention of them.

6.4.9. 19th August 2015 / 25th August 2015

6.4.9.1. The day after Mr GH's admission to St Joseph's Hospice, the hospice senior social worker spoke to the adult social care social worker, raising concerns about neglect and financial abuse, following this up with a referral form stating: "*Seen at home and found to be in pain; when legs dressed found to have grade 4 pressure ulcer; GH was unshaven, looked unkempt, poor mouth hygiene (thrush) – unable to access medication*". He was said to have difficulty communicating, to be dehydrated and very weak, and was not thought to be safe at home.

6.4.9.2. On admission it was noted by the charge nurse that Mr GH had 4 small grade 2 pressure sores on his sacral area. On the 19th August, his legs were redressed and a right foot wound (lateral aspect) grade 4 was observed, reported, discussed and seen by/with doctors.

6.4.9.3. The hospice referral form also mentioned financial abuse, but no details were given. However the possible financial abuse seems to have been the subject of various discussions at different times between the hospice senior social worker, the adult social care social worker, the scheme manager and/or Mr GH's sister. The SAR referral

form completed by the social worker after Mr GH's death states: *"There were three withdrawals from Mr GH's bank account in one week amounting to £300. One hundred pounds on 08/07/2015, £100 on 10/07/2015 and £100 on 15/07/2015. Mr GH told referrer that his cleaner withdrew money to pay bills. However, bank statement indicated that bills were paid by direct debit including BT, British Gas and Care Charges. There was a letter from bailiffs for an unpaid phone bill. Mr GH said he owed other monies but would not give further details. Referrer was going to discuss further with GH's sister the next day*". The Anchor IMR notes that on the 25th August 2015 Mr GH's next of kin (assumed to be his sister) had notified the housing scheme manager that several unexplained withdrawals had been made from Mr GH's account. The scheme manager advised reporting this to safeguarding and she spoke herself to the social worker, who indicated a meeting would be arranged.

6.4.9.4. The Adult Social Care safeguarding referral record was completed on 25th August 2015, recording that Mr GH had mouth ulcers, grade 4 pressure sores, septic leg ulcers and signs of general neglect. The risk level was graded 3 (institutional).

6.4.9.5. An email on 30th August 2015 from the practice manager from the Adult Social Care South Area team to the Safeguarding Adult Manager and the social worker requests: "*Can you kindly complete this open episode; I understand that there is a new allegation regarding likely misuse of pain control; neglect; financial abuse. The referral is coming from a social worker with the hospice team. Please follow through as the SAM on these allegations*".

6.4.9.6. A strategy meeting was held on 4th September 2015 (Mr GH having died on the 28th August) attended by representatives from adult social care, adult community nursing, the hospice, the housing scheme manager, the care agency, and the HUHFT Head of Healthcare Compliance and Safeguarding.

6.4.9.7. Again there was disagreement about the condition of Mr GH's skin. The hospice manager stated Mr GH had a grade 1 pressure sore on his right heel and a grade 4 pressure sore on his right foot (no mention was made of the grade 2 pressure sores in his sacral area). The HUHFT representative reported the view of the tissue viability nurse and the adult community nursing service's clinical operations manager, who had visited Mr GH on 27th August (9 days after the initial assessment by hospice nursing and medical staff). They had noted worsening eczema around the gaiter of both legs. They considered the ulcers on the left bunion and lateral right foot were not pressure ulcers but had occurred due to generalised deterioration and low blood flow to the feet. They observed malodour from the wound.

6.4.9.8. In relation to oral hygiene, the care agency stated that care workers had assisted Mr GH with a mouthwash twice a day. The adult community nursing service representative stated that nurses had administered oral thrush medication regularly.

6.4.9.9. In relation to medication, the adult community nursing service had been unaware that Mr GH had been prescribed oramorph for pain relief, and had not been asked to administer it. The care workers could not administer medication. It appeared that the private cleaner employed by Mr GH had on one occasion requested permission from the GP to administer the oramorph and that this permission had been given.

6.4.9.10. Mr GH had also told hospice staff that he had been unable to access his asthma inhaler and glasses because the care workers had not allowed him out of bed.

6.4.9.11. In relation to finance, Mr GH's bank statements had shown multiple withdrawals. It was known he liked to buy things online. The cleaner had his PIN and would make a regular weekly withdrawal of £130 for him. When Mr GH's brother in law raised a safeguarding alert about a former care worker approaching him for money, Adult Social Care had visited him. He had denied any form of financial abuse and they had no concerns about his capacity to manage his own finances.

6.4.9.12. The strategy meeting did not draw conclusions about the concerns; the outcome was to refer Mr GH's case to the SAR panel for consideration of the need for a SAR to be conducted. In addition, some general recommendations were made for application to other cases:

- Care agency to follow their protocol for dealing with service users' finances;
- Carers to contact GP and adult community nurses if there are concerns about medication;
- Carers to follow tasks to be completed on care plan;
- Carers to ensure service users have access to their medication e.g. leaving close to them'
- The adult community nursing service to look at patients on their list and follow process for dealing with pressure sores;
- GP to review people who are appropriate to administer medication.

6.4.9.13. However the status of this action plan is not clear, nor how it was to be communicated to relevant agencies and implemented. The question of possible criminal acts of financial abuse and of risk of financial abuse to others does not appear to be addressed in the action planned. It is perhaps surprising that the police were not

involved, either in the investigation or a strategy for onward action on these concerns.

6.5. Management of end of life care

6.5.1. End of life care can perhaps be deemed to start from the point at which Mr GH and his GP discussed his liver lesion, which he had learnt about during his admission to Homerton Hospital 3rd – 13th April 2015. The scheme manager had noted weight loss and gradual decline and decrease in his level of functioning; he was not as sociable as before, not coming out of room, not shaving. Mr GH expressed a wish to his GP not to have further referrals or investigations.

6.5.2. During his subsequent admission (15th May - 3rd June 2015) a CT scan diagnosed a liver lesion; ultrasound tests also diagnosed him as having small gallstones. The consultant advised him that no invasive investigations would take place due to his frailty, and if an MRI scan found a tumour it would not be aggressively treated. The GP believed that Mr GH could tolerate further investigations and discussed this with him following his discharge, but Mr GH confirmed that he did not want any further tests or investigations; he was aware he was getting weaker, losing weight, and may have cancer.

6.5.3. As well as discussing end of life care with Mr GH, the GP with his permission liaised with Mr GH's sister and made a referral to the community matron, who visited on 17th June 2015. Mr GH stated he wanted to stay in his own home, didn't want to move closer to his sister, and would like to go on holiday to the seaside.

6.5.4. The GP was attentive to Mr GH's wishes, respecting his decision not to undergo further investigations for his liver lesion. But other than that, there appear to have been no special measures taken until later in the process. There was no communication with Adult Social Care to engage a more holistic overview of how his overall care and support needs could be met. The adult community nursing home notes record a multidisciplinary discussion with the social worker on 8th August, but no details are given and the event does not appear in the adult social care IMR. Following the community matron's visit on 17th June, and Mr GH's expressed wish to remain at home, it is unclear whether any further consideration was given to a palliative care referral at that point, or whether any changes were made to the arrangements to support him at home.

6.5.5. Significantly, there was a missed opportunity to proactively put in place continuing care provision that would have enabled Mr GH to continue living at home with enhanced quality of life during his further decline. The only mention of continuing care was made 2 days after his death, when an adult social care locality-based manager, unaware of Mr GH's death, requested the social worker to make a continuing care referral.

6.5.6. During the early part of August 2015 Mr GH's condition deteriorated quickly. This was noticed by his sister and brother in law; in the list of concerns they submitted to the safeguarding case conference they describe him as having sores in his mouth, a sore throat, difficulty speaking on the telephone and extreme pain his legs. An adult community nurse assessed his Waterlow score on 3rd August as 21, indicating a very high risk of skin damage. This was interpreted as evidence of the decline in his general health. However, there is no evidence of discussion between the adult community nurses and the GP about shared management of his healthcare, and no discussion of how and by whom prescribed medication was to be administered. (It emerged from the list of concerns supplied by Mr GH's sister that the family believed care workers administered all his medication.) By the 7th August, when the GP undertook a home visit and discussed prognosis and care with both Mr GH and his sister, agreement was reached that palliative care services should be involved and the GP undertook to make a referral. Here, however, there was then delay, with the referral being made only on the 17th August, 10 days after the decision. This represents a missed opportunity to provide Mr GH with a more supported home environment and to ensure his comfort during a crucial period of his end of life care.

6.5.7. From the date of the home visit on the 18th August 2015, St Joseph's Hospice took responsibility for Mr GH's end of life care. They responded within 24 hours to the referral and made a multidisciplinary home assessment visit. They concluded that Mr GH's condition made remaining at home an unsafe option and with his agreement made an immediate admission. Their assessment resulted in the raising of a number of concerns about care and support needs that had not been addressed:

- His oral hygiene had not been attended to and he had oral thrush that made his communication difficult;
- The care plan entailed him being left for 13 hours, between the last evening visit at 18.00 and the first morning visit at 7.00 without turning, fluids or medication;
- The care workers had advised that they could not give mouth care as he was bed-bound and may choke (despite the fact that they were feeding him and he had a hospital bed that could be elevated);
- He was unable to have medications that were not in a dosset box, as care workers were not able to administer them, with the result that the salbutamol inhaler, nystatin for mouth and morphine for pain were not given. Medication was not left within his reach when the care workers were not present;
- He had not been allowed out of bed since falling the previous week.

Broader concerns included:

- The private cleaner, apparently with the GP's permission, had administered oramorph.
- Mr GH had grade 4 pressure sore on the lateral side of his right foot and 4 small grade 2 pressure sores on his sacral area.

6.5.8. The hospice coordinated a wide range of services from this point:

- Safeguarding concerns were raised immediately.
- There was proactive liaison with the family, with adult community nurses and with adult social care.
- Mr GH was discussed at multidisciplinary team meetings, and multidisciplinary inpatient services were mobilised – medical, nursing, pain control, physiotherapy, dietician, tissue viability, psychological support and chaplain.
- His papers and personal documents were secured

7. CONCLUSIONS

7.1. Introduction to the conclusions

The conclusions are drawn from the themes emerging, as described above, from scrutiny of evidence provided to the SAR panel. They reflect the terms of reference set for the Panel's review.

7.2. Ownership of services provided to Mr GH

7.2.1. A wide range of services was engaged in supporting Mr GH, whose health care needs were complex in themselves and also necessitated extensive personal care and support and a specially adapted domestic environment. There is evidence of some good practice by all the agencies.

- His GP surgery met, monitored and appropriately responded to his primary health care needs. In order to facilitate decisions on end of life care, the GP saw Mr GH out of hours at his home in the company of his family.
- Hospital admissions were appropriately arranged and managed.
- The adult community nursing service provided continuity of care by nurses who were well known to Mr GH.
- Adult Social Care provided a substantial care and support package, which was reviewed within required timescales and increased to double-handed care when this became necessary.
- The Community Occupational Therapy Service was proactive in engaging with his need for aids, adaptations, and necessary equipment.
- The care agency responded proactively to any expressions of concern received from the housing scheme manager or Mr GH himself.
- The housing scheme manager was proactive in attending to Mr GH's support needs and in liaising with other agencies.

- There was often effective day-to-day communication between various agencies about practical matters of care, for example when care workers observed a need for community nursing attention to Mr GH's leg ulcers and pressure sores.
- The hospice, once involved, played a key coordinating role and ensured what comfort was possible during the last 10 days of Mr GH's life.
- All services acknowledged and respected Mr GH's expressed wishes, paying heed to the pride he took in his independence and capacity for making relevant decisions and managing his own affairs.

7.2.2. Equally there were shortcomings in how some agencies responded to his needs.

7.2.2.1. GP surgery:

- Earlier and more proactive discussion in the surgery's multidisciplinary team meetings, which could have been initiated by any one of the healthcare professionals involved, could have played an important role in coordinating the efforts of all services to meet his needs, and to ensure greater levels of comfort and safety during the final weeks of his life.
- No arrangements were made for the administration of a medication prescribed to assist with pain control.
- It is not clear what end of life care plan arose following the GP's referral to the community matron on 9th June and the community matron's visit on the 17th June, at a time when Mr GH's health and comfort were rapidly declining. When a later decision to refer was made on 7th August, there was a 10-day delay before the referral was made. While the impact of this cannot of course be determined, it is evident that by the time a palliative care assessment was carried out Mr GH was unable to end his life at home as he had earlier expressed the wish to do.

7.2.2.2. Adult community nursing:

- While it is possible that more adult community nursing visits were made than are logged on the record system, on the face of the information available it appears the service did not maintain the required pattern of visiting. On five occasions during the period under review the required weekly visits were seriously overdue (with 14 or 21 days since the previous visit). Twice-weekly visits required following his hospital discharge in April and again in June 2015 were not implemented, visits becoming more frequent only 2 weeks before his admission to the hospice in August 2015.
- Both Mr GH and others (GP, ambulance, housing scheme warden, care agency) raised concerns about missed visits, and about the condition of Mr GH's leg ulcers and pressure sores. These concerns were expressed as safeguarding referrals on two occasions. The outcome of the first was a finding of partial neglect. The second did not reach a conclusion; the condition and cause of Mr GH's skin breakdown remained disputed between the hospice and the

community nursing service. The present review cannot reach firm conclusions on whether lack of attention by the service resulted in the grade 2 and grade 4 wounds reported to safeguarding on the day after his hospice admission, but it seems likely that as a result of the condition of his skin he experienced pain, distress and discomfort during the final weeks of his life.

- The pattern of care was compromised: by the requirement for weekly visits (every 7 days) interpreted as meaning a visit every week (potentially leaving a longer gap than 7 days); by nurses not having the key code needed to gain access to Mr GH's property; by single nurse visits when two were necessary; by failures to alert the care workers of the intended visit so they could leave Mr GH in bed to facilitate skin checks; by error in rescheduling missed visits.
- Visits were not always appropriately recorded. The absence of documented clinical notes in approximately 20% of visits has not only hampered the present review; it also will have impacted upon the continuity of care Mr GH received, and made quality monitoring difficult. Appointments appear to have not always been recorded in the home notes, resulting in Mr GH on occasion being uncertain when a visit was due. Visits appear on the electronic database (RiO) as 'outcomed' when a nurse has visited and seen the patient; however, on at least two occasions in the present review evidence emerged that Mr GH was not seen despite a visit being logged as 'outcomed', calling others into question. It is not evident that supervision or audit picked up these shortcomings.

7.2.2.3. Hospital health care:

- While the hospital liaised with the GP about discharge following Mr GH's two hospital admissions, and made referrals for more frequent adult community nursing visits, they did not advise the adult community nursing service that discharge had been delayed, and did not advise them on the second discharge of his liver lesion diagnosis, or that he was to receive palliative care. Nor, despite his extensive personal care and support needs, was liaison with the community-based Adult Social Care team evident.

7.2.2.4. Adult social care:

- Despite the complexity of his needs, his annual care review needed to reflect a more holistic overview of his situation. Additionally, Adult Social Care needed to pick up ongoing involvement between reviews.
- In terms of contract monitoring, improved liaison between Adult Social Care and other agencies was required, as Mr GH's rapid decline during 2015 does not appear to have been reflected in the support that he received.
- There appears to have been little connection between activities undertaken to pursue safeguarding enquiries and the on-going care and support. For example, Mr GH's increased vulnerability did not seem to result in a reconsideration of his care and support needs.

7.2.2.5. Care agency care and support:

- The housing scheme manager raised concerns about disposal of soiled materials, late arrival, lack of attention to the hoist requirements, use of communal facilities, and odour of urine.
- Mr GH expressed dissatisfaction with aspects of his service – care workers he did not like, late arrival, the care plan not followed. He complained (when admitted to the hospice) that his care workers had roughly handled him and talked to each other in a language he did not understand[220].
- Concerns about the quality of personal care Mr GH received in the period immediately before his hospice admission (e.g. mouth hygiene, access to medication, hydration) were raised in the safeguarding referral made the following day.
- There appears to have been a lack of attention to safeguarding concerns. The care agency did not interpret a complaint (February 2013) by Mr GH that carers stole his money as a safeguarding issue and no action appears to have been taken. Equally, upon receipt of an allegation (from the housing scheme manager) that a former care worker was visiting Mr GH, with attendant risk of financial abuse, they appear not to have made a safeguarding referral about this matter, when it might have been reasonable for them to do so.
- The agency does not appear to have kept Adult Social Care informed of representations they received from Mr GH and the housing scheme manager about the care services provided.

7.2.2.6. Housing association:

- The housing scheme manager, who was very proactively involved in supporting Mr GH, noted repeated instances of concern about the quality of care, from both the adult community nursing service and the care workers, and took appropriate action to raise this directly with those services. On one occasion, a specific matter was raised directly with Adult Social Care. It may have been helpful, in the light of the repeat patterns, to escalate those concerns more routinely to the managers of the services in question in order to trigger closer scrutiny.

7.3. Coordination of services provided to Mr GH

7.3.1. While liaison between agencies routinely occurred over day-to-day matters, overall coherence and coordination of the agencies' various care plans was missing. No one agency took a holistic overview of his situation, leaving a vacuum that became increasingly apparent as Mr GH's health deteriorated. There was no concerted approach to accommodating his changing needs speedily and effectively. He would have benefitted from

[220] While the agency responded to Mr GH's concerns where they knew about them, they were not aware of his allegation of rough handling and talking over him, as this was not passed on by the hospice.

an explicitly multidisciplinary approach and a lead agency to manage the strategic direction of his care. Such an approach could also have assisted in resolving difference of professional opinion about the nature and cause of Mr GH's skin deterioration at key points between April and August 2015. Without such a forum for discussion and resolution, mutual blaming can inhibit learning going forward.

7.3.2. There were noticeable failures of communication between agencies, particularly following his diagnosis of liver lesion and the consequent end of life care needs that it raised. Poor or missing records and recording systems that were not shared in common contributed to the deficiencies in communication. Absence of attention to the administration of oramorph and delay in progressing the palliative care referral potentially impacted upon his comfort. Structural mechanisms intended to promote effective joint working were not used: proactive care coordination, multidisciplinary team meetings, One Hackney processes and/or referral for continuing care assessment might all have made a difference to the quality of his experience in his final weeks, and possibly enabled him to remain at home as he wished.

7.4. Safeguarding

7.4.1. A list summarising safeguarding actions is provided at Appendix 2. Of the 7 possible occasions on which safeguarding risks were apparent, only 4 were referred to safeguarding processes. There were therefore some failures to take appropriate action when there was evidence of possible risk: Mr GH's complaint that he didn't want female carers because they stole his money; lack of referral when the housing scheme manager and the care agency knew that an ex-carer was visiting, and Mr GH's account contained insufficient funds (although the family did raise a safeguarding referral about this matter); Mr GH's complaint to a hospice doctor about how his care workers behaved towards him.

7.4.2. For two safeguarding referrals from Mr GH's brother in law about possible financial abuse, there is no documentation available. While both episodes were discussed with Mr GH, resulting in no further action deemed necessary, a clear audit trail of actions is missing.

7.4.3. The question of possible criminal acts of financial abuse and of risk of financial abuse to others does not appear to be addressed, nor were the Police involved.

7.4.4. The finding of the safeguarding process following the referral of 3rd April 2015, concluding that a gap of 3 weeks in changing Mr GH's leg dressings was not substantiated appears not to have taken account of a pattern of adult community nursing visits that in the present review has established there was a 3 week break in care.

7.4.5. The ability of the safeguarding process to draw conclusions about allegations of neglect by the adult community nursing service was hampered by professional disagreements about the nature, timing and cause of his skin breakdown and pressure sores (referrals of 3rd April and 19th August 2015). While professional judgement must always be used, it seems important to find a means of ensuring reliable, commonly shared diagnosis of skin condition.

7.4.6. There is an absence of follow through on the outcomes of safeguarding enquiries. Despite a finding that neglect by the adult community nursing service was partially substantiated (referral of 3rd April), there was no plan for coordinating or monitoring further care patterns, or to address the reasons. No conclusions were drawn about the allegations of 19th August 2015, and it is unclear how the action plan from the strategy meeting was to be communicated to agencies and monitored.

7.5. Management of end of life care

7.5.1. Mr GH's diagnosis of a liver lesion, and his subsequent rapid decline in health, represent a series of missed opportunities to put in place an effective and coordinated end of life care plan. Earlier referral to palliative care, and/or better coordination of multidisciplinary teamwork, could have made a difference to his experience, and enabled him to remain at home. This would also have enabled continuity in the care relationships that had been built in some cases over many years.

7.5.2. Any of the agencies involved could have identified the need for continuing care assessment as the nature and scale of Mr GH's healthcare needs became increasingly apparent. Assessment for continuing care provision could have resulted in an effective, coordinated approach being put in place.

7.5.3. Without such frameworks, the absence of special measures or adjustments to provision to match Mr GH's changing needs meant that by the time he was admitted to the hospice his needs were acute and his comfort severely compromised, and there was no longer a prospect of him fulfilling his wish to remain at home.

8. RECOMMENDATIONS

The remit of a SAR is to focus upon conclusions that can be drawn about how agencies work together, and the focus of the Panel's recommendations is therefore upon actions that the City & Hackney Safeguarding Adult Board may see fit to take. However, a number of IMR writers have made recommendations in their IMRs for changes identified as needed within their own agency. The board will wish to request that agencies include these in any action plans they produce at the board's request in response to the recommendations in this SAR report.

8.1. The board should seek clarification and assurance from the Wick GP practice on the following matters:

8.1.1. What standard processes can be expected in relation to a person placed on the home visiting service for vulnerable patients, and in particular what notifications to other relevant agencies can be expected;
8.1.2. That mechanisms are in place to identify patients for discussion in multidisciplinary team meetings and to ensure that relevant personnel (including GP practice-based staff) are identified for attendance, and that the effectiveness of such mechanisms has been audited;
8.1.3. How key outcomes from multidisciplinary team meeting decisions are monitored;
8.1.4. What standards can be expected for the planning and implementation of an end of life care pathway once a diagnosis has been made and how adherence to such standards is monitored;
8.1.5. What systems are in place for ensuring that necessary referrals to specialist services such as palliative care are made in a timely way, and how adherence to this is monitored;
8.1.6. What procedures are in place to ensure that timely referral to community nursing services is made where assistance may be required for the administration of medication;

8.2. The board should seek clarification and assurance from the HUHFT Adult Community Nursing Service on the following matters:

8.2.1. That it has ensured and audited that all adult community nursing staff are familiar with necessary key codes for access to property where required;
8.2.2. That appropriate oversight and audit arrangements are in place and are used to ensure home visit notes contain information that will be of assistance to patients, such as the date of the next visit;
8.2.3. That appropriate oversight and audit arrangements are in place and are used to ensure that clinical notes for visits made are clearly documented for each visit;
8.2.4. That the electronic data system RiO can differentiate between a visit on which the patient was seen and a visit that was made but without access to the patient being gained (the present review found that 'outcomed visit' could be used for both eventualities) and that appropriate oversight and audit arrangements are in place;
8.2.5. That the recording system or other mechanisms have the capacity to alert the service to gaps between visits that are longer than expected;
8.2.6. That an appropriate level of staffing is provided for all visits where more than one nurse is required;
8.2.7. What measures can be used to ensure that in complex cases records are jointly visible to hospital and community health care providers, in the light of the lack of synergy between current systems;
8.2.8. What measures can be expected following a Waterlow assessment that places a patient's score in the high risk category;

8.2.9. That all staff have received appropriate briefing on safeguarding requirements, and that a protocol is in place for the implementation and monitoring of actions plans following any safeguarding enquiry involving the service;

8.2.10. That measures used for the internal quality monitoring of the adult community nursing service have been reviewed and accountability mechanisms strengthened where necessary.

8.3. The board should seek clarification and assurance from Homerton University Hospital that it has appropriate mechanisms in place to ensure discharge checklists identify all necessary notifications to other agencies.

8.4. The board should seek clarification and assurance from Adult Social Care on the following matters:

8.4.1. That mechanisms for including quality assurance data in annual review of care and support packages are in place and that arrangements for audit are in place and have been used;

8.4.2. That where long-term care and support is provided to people with complex health and social care needs, the authority has in place measures that enable it to keep abreast of changing circumstances, and to monitor potential changes in social care and support needs that result from rapidly declining health;

8.4.3. That Adult Social Care Commissioning have appropriate contractual arrangements in place to ensure that care agencies are required to alert Adult Social Care to representations made to the care agency (by service users or other agencies) about the quality of the service provided. Equally, that there are appropriate channels of communication between Adult Social Care teams and Commissioning about such representations;

8.4.4. That safeguarding documentation is consistently raised for all referrals, including those passed to locality teams for investigation, with clear feedback between the two systems (safeguarding and adult social care teams), and that arrangements for audit are in place and have been used;

8.4.5. That the police are consulted during strategy-setting on concerns that relate to financial abuse;

8.4.6. That all cases proceeding to strategy meeting and/or case conference give rise to clear action plans and a means of monitoring them, and that audit arrangements are in place and have been used.

8.5. The board should seek clarification and assurance from the care agency on the following matters:

8.5.1. That all staff have received briefing on safeguarding procedures, and that care coordinators understand their responsibilities in relation to reporting;

8.5.2. That all staff have received briefing on recognition and care of pressure sores and leg ulcers and how skin breakdown needs should be taken account of in personal care routines;

8.5.3. That all staff have received training on person-centred care approaches, with particular reference to how manual and hoist-assisted handling is carried out, and how language other than the individual's first language is used in their presence.

8.6. The board should seek clarification and assurance from Anchor Housing Trust on the following matters:

8.6.1. That a system is in place to track multiple concerns about third party services provided to residents (such as care providers or adult community nursing), with a threshold in place that would trigger escalation to the managers or commissioners of those services;
8.6.2. That internal safeguarding procedures specify how matters such as potential risk from uninvited visitors to the building should be dealt with.

8.7. The board should seek assurance from St Joseph's Hospice that it has mechanisms in place to ensure that patient disclosures raising adult safeguarding concerns are recorded and become the subject of a safeguarding referral;

8.8. The board should seek clarification and assurance from the commissioners of adult community nursing services on how they ensure that contracted services reach contracted quality standards.

8.9. The board should seek assurance from partner agencies on how coordination and leadership are ensured where partner agencies share responsibility in cases involving complex health and social care needs. These include:

8.9.1. How CCG expectations on agency participation in MDT meetings, and identification of patients for inclusion in MDT discussions, are implemented;
8.9.2. How multidisciplinary team working is managed through allocation of a lead coordinating and monitoring role held by the discipline closest to the client's primary need;
8.9.3. How One Hackney processes contribute to case coordination and the monitoring of changing needs;
8.9.4. How patients who may be eligible for continuing care provision are identified and referred;
8.9.5. Whether common systems and standard assessment tools for diagnosis and grading of pressure sores and ulcers can be adopted, what mechanisms are available for recording observed skin breakdown (e.g. photography) and what mechanisms can be developed for resolving differences of professional opinion;
8.9.6. That a shared protocol is in place about the circumstances in which pressure ulcers become a safeguarding concern (a matter that NHS England leaves to 'local guidance').

8.9.7. How the community matron, not having access to the RiO nursing record system, is able to ensure effective communications with other community based services.

8.10. The board should ensure there is guidance within its procedures on the safeguarding process to be followed if a referral is made and the person dies before enquiries are complete.

8.11. The board should put in place a clear strategy for taking forward the matters arising from this review, including attention to the following:

8.11.1. A clear communications strategy for the review findings, including (a) how learning is to be disseminated to staff across the range of agencies involved and (b) whether the report or an executive summary of the report is to be published;
8.11.2. An action plan to take forward the board's response to the recommendations arising from this review, to include specific actions, indicators of achievement, location of responsibility, timescales and mechanisms to monitor and review progress;
8.11.3. Action plans requested from all agencies involved in the case, identifying how they will (a) implement learning arising from their own IMR process and (b) implement any actions required of them by the board's own interagency action plan; monitoring information to track progress on implementation;
8.11.4. A review event one year from implementation of its action plan in order to share learning from developments that have taken place across the interagency network.

8.12. The Panel will, in addition to these recommendations arising from review of Mr GH's case, make general recommendations to the Board on the conduct of SARs, building on the process of conducting this review.

9. REFERENCES

DH (2012) *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. November 2012 revised.* London: Department of Health.

DH (2014) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

APPENDIX 1: Adult community nursing visit dates
(+ number of days since previous visit)

6/8/14
9/8/14 (3 days)
23/8/14 (14 days)
26/8/14 (3 days)
2/9/14 (7 days)
16/9/14 (14 days)
23/9/14 (7 days) (no documentation)
14/10/14 (21 days)
21/10/14 (7 days) (no documentation)
28/10/14 (7 days) (no documentation)
4/11/14 (7 days)
11/11/14 (7 days)
18/11/14 (7 days)
25/11/14 (7 days)
2/12/14 (7 days)
16/12/14 (14 days)
23/12/14 (7 days)
30/12/14 (7 days)
6/1/15 (7 days)
13/1/15 (7 days)
21/1/15 (8 days)
27/1/15 (6 days)
3/2/15 (7 days)
10/2/15 (7 days)
17/2/15 (7 days)
24/2/15 (no access gained)
10/3/15 (21 days)(acknowledging rescheduling error after no access)
18/3/15 (8 days)
24/3/15 (6 days)
Mr GH was in hospital 3/4/15 - 13/4/15 (admitted 10 days after his previous nursing visit)
14/4/15 (1 day after hospital discharge)
21/4/15 (7 days) (should have been 2x weekly onwards)
28/4/15 (7 days) (no documentation)
30/4/2015 (2 days)
5/5/15 (5 days)
12/5/15 (7 days)
Mr GH was in hospital 15/5 – 3/6 (admitted 3 days after his previous nursing visit)
10/6/15 (7 days after discharge)(no documentation)(should have been 2x weekly onwards)
16/6/15 (6 days)(no documentation)
19/6/15 (3 days)(no documentation)
25/6/15 (6 days)
30/6/15 (5 days)
7/7/15 (7 days)
14/7/15 (7 days)(no documentation)

21/7/15 (7 days)
28/7/15 (7 days)
3/8/15 (6 days)
6/8/15 (3 days)(Mr GH declined saying only needed weekly)
8/8/15 (2 days)
11/8/15 (3 days)
13/8/15 (2 days)(no documentation)
14/8/15 (1 day)
17/8/15 (3 days)
18/8/15 (1 day)

APPENDIX 2: Safeguarding activity

11th February 2013: Mr GH told the care agency he didn't want female carers as they stole his money	This was not reported as a safeguarding concern and no other action by the care agency is apparent.
3rd April 2015: Report to Adult Social Care by Mr GH's brother in law that money had been withdrawn from Mr GH's account and he believed it was one of the carers.	A principal social work spoke to Mr GH who told her was not being financially abused and gave a credible explanation of the withdrawals and expenditure. The referrer was informed that the allegation was not substantiated.
3rd April 2015: Ambulance Service and hospital raised safeguarding referrals claiming Mr GH's his leg dressings not changed for 3 weeks; he had leg ulcers and a pressure sore that were infected.	A full safeguarding process was pursued, leading to a case conference at which the allegation of a 3-week gap was not substantiated, but the allegation that care was not provided due to a missed visit was substantiated.
5th June 2015: GP learnt from the housing scheme manager of concerns that an ex-carer was visiting Mr GH and possibly was taking money.	The GP understood that the family were gathering evidence before taking things further, and therefore no action was needed by the practice.
7th August 2015: Housing scheme manager notification to the care agency about an ex carer seen in the building. Safeguarding referral discussed.	Neither agency raised a safeguarding referral. The scheme manager advised Mr GH not to let the woman into his flat and not to give her money. The family made a safeguarding referral. There is no recorded action by the GP or the housing scheme manager. There is no safeguarding documentation for this episode, but the adult social care duty social work senior visited Mr GH (11th August). He denied giving money to the ex-carer, and he would not allow her in in future.
7th August 2015: Housing scheme manager told Mr GH's sister and brother in law that the cleaner had been unable to withdraw weekly money due to insufficient funds. The GP was advised by Mr GH and his sister when visiting the same day.	
19th August 2015: A safeguarding referral was made by phone by the hospice social worker to the adult social care: neglect of personal care by care agency, oramorph given by the cleaner, grade 2 and grade 4 pressure sores; possible financial abuse	Adult Social Care convened a strategy meeting (which took place after Mr GH's death), noting disputed opinions about the nature and cause of the skin breakdown. No conclusions were drawn; general recommendations applicable to others were made. Referral for a SAR was requested.
23rd August 2015: Mr GH reported to a hospice doctor that his care workers had been rough and hurt	The concerns were passed to the charge nurse for inclusion in the above

him. They spoke over him in another language and did not listen to him.	safeguarding referral, but this does not appear to have happened.