London Borough Barking & Dagenham

Safeguarding Adults Board

Safeguarding Adult Review

Mary

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1 INTRODUCTION

1.1 This safeguarding adults review was commissioned following the death of an 83 year old woman Mary who lived alone. Mary had been known to LB Barking and Dagenham adult social care and had been in receipt of a care package which included daily (weekday) visits from a care agency. On 9th June 2016 she had been taken to the emergency department of a local hospital and was discharged home in the early hours of the next morning. Her body was found on 14th June after a neighbour told the police that he had not seen Mary for a few days.

1.2 Cause of death has been recorded by the coroner as heart failure, pulmonary hypertension, emphysema/acute bronchitis.

1.3 A Safeguarding Adult Board (SAB) must carry out a safeguarding adult review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. In this case, a referral was made for a safeguarding adult review because of concerns that:

- information sharing between agencies at the point of hospital discharge was not effective and there was an overreliance on informal information from a neighbour
- the aspect of the care plan that addressed Mary's poor living conditions had not been fully implemented.

1.4 The decision to conduct the review was made by the chair of the Adult Safeguarding Board on 11th August 2016.

2 REVIEW PROCESS

2.1 The review report has been written by Jane Wonnacott an experienced independent reviewer who has had no previous involvement with LB Barking Safeguarding Adult Board. Jane is a qualified and experienced social worker with over twenty years' experience of carrying out independent reviews of practice.

2.2 A panel of senior managers was appointed to work with the lead reviewer. The panel consisted of:

- Acute Hospital named nurse for safeguarding adults BHRUT
- Assistant Integrated Care Director North East London NHS Foundation Trust
- Group Manager LB Barking and Dagenham Adult Social Care
- Manager Barking and Dagenham Safeguarding Adult Board
- Review Team Metropolitan Police

2.3 All organisations involved with Mary were asked to submit a chronology of their involvement for review by the panel. From this review the following questions were identified as needing to be addressed through the review process:

- How does the system manage access to a person's home where they require care and how effectively are key safes used as part of that process?
- How effectively do systems ensure that staff in care agencies have accurate information as to whether a person is in hospital or not?
- How might environmental conditions have exacerbated the subject's medical condition and need for hospital care.

2.4 Practitioners who had direct contact with Mary were invited to a meeting to reflect on their involvement. The purpose of this meeting was to help the lead reviewer and panel gain an understanding of why events unfolded as they did and factors that might have been influencing practice decisions at the time.

2.5 An important aspect of reviews is the contribution of family members and significant members of the local community. In this case we are grateful for the contribution of Mary's nephew and a close neighbour who were willing to meet with members of the panel.

2.6 An opportunity was provided for practitioners who contributed to the review to see a draft report in order to check accuracy and discuss findings and recommendations. The report was then agreed by the safeguarding adults review sub group prior to final approval by London Borough Barking and Dagenham Safeguarding Adults Board.

3 CASE SUMMARY

3.1 Mary and her sister had lived in the local area for many years, sharing the house until Mary sister's death in 2013. Mary remained in the house alone and there were no reported concerns until early 2016 although her nephew did notice some deterioration in the home conditions from the summer of 2015 onwards.

3.2 Mary was under the care of the GP for a leg condition and in February 2016 the records show that her GP carried out dementia screening which found that she did have a slight cognitive impairment but was fully competent to make decisions.

3.3 In February 2016 it seems that there may have been a deterioration in Mary's emotional stability as there were a series of phone calls to the Metropolitan Police (at one point 26 calls in nine days), mostly in relation to concerns about males trying to access her property. One of these calls resulted in a vulnerable adult referral to adult social care due to the police officer's concerns about the state of the home. Concerns cited were cartons and old food containers on the work surfaces and general lack of cleanliness.

3.4 Not all calls to the police resulted in a visit to the home, as on some occasions operators noted the repeat nature of the calls and that Mary appeared to be

suffering from “harmless delusions”. This is a commonly used term within the Metropolitan Police and describes a situation where it is reasonable to believe that there is no substance to the complaint. In this case when officers had visited the home there was no evidence of any untoward activity but there is no evidence that the sheer number of calls was known by adult social care as their assessment progressed in early March 2016.

3.5 The assessment was completed within one month, using the expected framework. This framework[1] is designed to ensure that the service user is fully involved in the assessment process. Although Mary was at first reluctant to engage with the assessment, the social work records show that the social worker was diligent in attempting to build a relationship to support the development and implementation of a care plan.

3.6 From the start, the social worker was concerned about the condition of the home including evidence of hoarding and rotting food. The care plan, which was eventually agreed by Mary, included a deep clean by environmental health and a 45 minute visit each weekday from a carer. The purpose of the carer’s visit was documented in the plan as:

- Assist with personal care/grooming – washing and dressing
- Prompt medication
- Assist with meal/drink preparation of choice- breakfast
- Assist to maintain good standard of hygiene and minimise the risk of falls/injury
- Assist to live in a clean and safe environment – make, change bed
- Support to promote social inclusion and minimise the risk of social isolation – assist to get ready for social club
- Leave area clean and tidy
- Help to improve confidence.

3.7 It would have been a challenge to deliver this level of care in five x 45 minute visits each week. The review has been told that the time allowed was not budget driven but instead was driven by Mary’s reluctance to accept care in the home; in fact a further one hour per week had been proposed by the social worker in the care plan but rejected by Mary; as was the offer of day care.

3.8 The care agency started visits in April after some reluctance on Mary’s part to let the carer into the home. Mary did agree to a key safe being installed and the usual method of entry for the carer was via the key stored in the safe.

3.9 The deep clean by environmental health had not happened by the time of Mary’s death. There seems to have been delay caused by the process of getting quotes from contractors (at one stage this was affected by staff sickness) as well as an issue about whether payment was the responsibility of housing or adult social care.

[1] The FACE assessment is accredited by the Department of Health and used to support a person centred assessment in line with the requirements of the Care Act 2014.

Before housing would agree to pay they required a care plan which clearly set out how a one-off clean would be of benefit in the long term and improvements would be sustained. This was not specified in this way in the care plan and the housing department did not commission the clean.

3.10 During this period Mary had minimal contact with the GP. She only wished to see one particular GP in the practice and generally used the pharmacy to access repeat medication.

3.11 Mary's first attendance at hospital was on 2nd June 2016, when her carer called the ambulance as Mary was having difficulty breathing. Mary was seen in the emergency department at Queens Hospital and discharged home. Due to the conditions in Mary's home the London Ambulance Service made a safeguarding referral to LB Barking & Dagenham. The social worker was therefore aware that Mary had been taken to hospital and the next day informed the carer that Mary was back at home and asked the carer to resume visits.

3.12 On 5th June at 22.09, Mary's nephew called the ambulance as he had spoken to Mary on the telephone and she was complaining of shortness of breath. An ambulance crew attended but Mary did not wish to be taken to hospital.

3.13 On 9th June at 17.04, Mary's neighbour called an ambulance as Mary was again complaining of shortness of breath. The ambulance took her to King Georges Hospital where she was seen in the emergency department, treated and identified as fit for discharge at 21.30. Due to a shortage of available hospital transport she was not taken home until 5.07 on 10th June. Next of Kin were not informed that Mary had been seen in the emergency department and discharged home.

3.14 At this point there is a discrepancy in the accounts of the care agency and Mary's neighbour as to whether the carer had visited after Mary had been taken to hospital on 2nd June. According to the neighbour there were no visits but the timesheets from the care agency show that the carer visited everyday w/c 30th May and w/c 6th June. Each visit is logged as 45mins. The timesheets are not countersigned by the service user as required by the form; instead the carers name has been inserted.

3.15 It is agreed that at some point the carer left the front door key in Mary's door. The carer had told this review that they arrived as usual on 10th June but the key was no longer in the key safe and they were confronted by the neighbour who accused them of leaving the key in the door at the previous visit and said they had removed it for security purposes. The neighbour also informed the carer that Mary had been taken to hospital the previous evening and was not at home. The carer therefore abandoned their visit and discussed the situation with their manager. The carer also contacted the social worker, upset about their conversation with the neighbour; the information regarding Mary being taken to hospital was not discussed and the social worker remained unaware of her visit to the emergency department.

3.16 Coincidentally, Mary had been discussed at the regular multidisciplinary integrated care meeting at 13.10 on 10th June. This meeting was attended by the social work

manager. It is not clear from the chronology that those attending were aware that she had been discharged home but the outcome of this meeting was that social care were acknowledged to be involved and would report back to the next meeting.

3.17 Mary's neighbour recalls visiting Mary at home later that day and going out to do some shopping; this was the last time he saw her. This concurs with the ambulance report on 14th June which notes that Mary had last been seen at around midday on 10th June.

3.18 On 14th June the neighbour called the police as he had not seen Mary for some days. The police called for an ambulance and the ambulance crew found Mary who was deceased.

4 FINDINGS AND RECOMMENDATIONS

4.1 Specific findings and recommendations set out in this section are based on the main themes identified from the case summary. In summary these are:

- As expected by legislation[2] and established good practice, Mary's wishes and feelings were fully taken into account in the package of care that was provided for her and sadly this was not sufficient to meet all her needs. There was a lost opportunity to recognise that there may have been a relatively recent deterioration in her psychological and emotional wellbeing as not all the information known to the police was also known to social care. This could have prompted a more formal risk assessment by social care which involved all relevant professionals and consideration of Mary's capacity to make decisions.

- This review highlights the need for effective communication between hospital emergency departments, family members and service providers at the point patients that may be considered vulnerable are sent home. The system did not work well leaving the care agency unaware that Mary was at home and assuming that the care package had been stopped.

- It has not been possible to determine whether Mary's home conditions contributed to her death but it is clear that coordination between social care and environmental health was insufficiently robust and resulted in an unacceptable delay in providing services.

- The key safe system did not work well. Leaving the key accidentally in the front door was poor practice on behalf of the care agency and it seems that no one had informed the neighbour of the importance of returning the key to the safe. Although acting with the best of intentions, keeping the key prevented the carer from entering the property as soon as she arrived on 10th.

[2] Care Act 2014

Finding One

There is the risk that the continuity of a care package may be disrupted when a patient is sent home from a hospital's emergency department rather than being admitted to a ward.

4.2 There was a misunderstanding on the part of the care agency regarding the difference between a patient being admitted to a ward and being discharged home from the emergency department. At the root of this seems to be a lack of understanding as to whether a care package automatically stops when a person is in the emergency department. The hospital (rightly) assumes that the package has not been cancelled and is continuing as before and they will therefore have no reason to inform social care of the discharge home. The organisation providing hospital transport have systems in place to ensure the person is taken into the property and all is well and on this occasion there were no concerns identified and no reason to contact social care.

4.3 When service providers know a person has been taken to hospital they may (wrongly) wait to be told to resume visits. Providers need to be clear that they should continue to provide care unless informed by the commissioning agency to stop. The agency has now said that in future they will always assume that visits to the home should continue until they receive formal notification that they are no longer required.

4.4 Another aspect of the discharge home relates to whether or not a next of kin was informed. Mary was a vulnerable adult who on the second occasion was taken home at 5am with no family member being informed of her discharge. Best practice at the hospital would have been to (with Mary's consent) inform next of kin who could then have ensured that any care package was in place.

4.5 In view of the discrepancy between the accounts of the care worker and the neighbour regarding events surrounding Mary's hospital visits and discharge, best practice in the care agency should be to obtain a signature from the service user on each visit as required by their paperwork. This is not evident on the papers seen for this review although there is no reason to doubt the accuracy of the records.

Recommendation One
Barking and Dagenham Safeguarding Adults Board should ask acute hospitals to review their systems and practice at the point a patient is sent home from the emergency department to ensure that next of kin and/or relevant others are always informed that the patient is leaving hospital where the patient consents to information being shared. This should be linked to existing procedures whereby, if a person lacks capacity, a best interest decision should be taken to inform the next of kin and/or relevant others.

Recommendation Two
Barking and Dagenham Safeguarding Adults Board should ask organisations providing care packages in the home to make clear that a care package does not stop until they are formally informed of its' cessation by the commissioner of their services.

Recommendation Three
The care agency involved with Mary should review their record keeping in order to ensure that the timesheets are signed by the service user or an explanation is noted as to why this is not possible. The Council's Commissioning team should consider the introduction of effective electronic monitoring which could provide improved tracking of care visit timeliness and compliance to both the provider and the commissioner.

Finding Two

Although the social work assessment was in line with legislative requirements and expected practice there was an absence of a coordinated multi agency approach involving police, social care and health services.

4.6 The assessment carried out by the social worker shows clear evidence of the person centred approach expected within the Care Act 2014 as, Mary's views about the level of care she wanted clearly drove decision making. What is less clear is whether a risk assessment[3] was carried out including consideration being given to Mary's emotional state and whether this was contributing to a level of self-neglect that fell within safeguarding procedures. One reason for the care plan not fully considering potential risk associated with Mary's emotional and psychological needs seems to be a lack of effective information sharing between organisations at a number of points.

4.7 At the point that the original Merlin was sent by the police to social care, there had been a significant number of calls by Mary to the police and these continued after the Merlin had been sent. It seems the social worker was unaware of the sheer number of calls (26 calls in nine days) which would seem to indicate deterioration in Mary's psychological health. There are comments in the police notes about Mary having "harmless delusions" and "possible mental health issues" but these could not be taken into account in the social care assessment as they were not aware of all the contacts with the police. The assumption within the police service seems to be that because a Merlin had been sent, social care were involved and there was no need to pass on information about the continuing nature of the calls. Whilst the original Merlin was very comprehensive and clearly set out the concerns, the additional information regarding continuing calls would have been helpful to the social work assessment.

4.8 Since these events the Metropolitan Police are piloting an approach to working with vulnerable people which includes the development of 'Safeguarding Strand' hubs focused on work with vulnerable people. The aim of these hubs is to develop strong links with partner agencies and ensure that where required, strategy discussions take place which bring together all relevant information. In this case a strategy

[3] The London Adult Safeguarding Policy and Procedures note that risk assessment should be integral in all assessment and planning processes.(3.3.3)

discussion after the Merlin had been sent would have brought to the attention of adult social care the rapidly accumulating nature of the calls from Mary to the police.

4.9 Mary's needs might have been better met via a more holistic approach and there is little evidence that the system promoted a shared understanding between those responsible for meeting her health needs (GP and other health professionals), the police and social care. Although Mary was discussed by the integrated care team[4] on 10th June the only action (because social care was involved) was a follow up from social care in October. It is unclear whether the potential significance of three calls to the ambulance service in a short period of time was considered, possibly due to the first and third attendances being at different hospitals and her refusal to be taken on the second occasion. The GP seems to be largely absent from discussions about Mary's care plan and there is no evidence that 's permission was sought to involve the GP in the development of the plan.

4.10 A fully informed holistic assessment that brought together all information from police, health and social care would have been best practice in order to establish whether there was any link between Mary's psychological and emotional state and her physical wellbeing. For example, this review has been informed that a chest condition can cause delusions if the person's oxygen levels drop. There is no evidence that this was the case for Mary but the possibility could have been explored.

Recommendation Four
Barking and Dagenham Safeguarding Adults Board should keep under review the new hubs being piloted by the Metropolitan Police and ask for assurance that the process for strategy discussions in respect of vulnerable adults is bringing together all relevant information held within the Police. The Barking and Dagenham Safeguarding Adults Board should ask Adult Social Care and the Police to reviews the systems in place, to address the sharing of Merlins and timeliness in doing so.

Recommendation Five
Barking and Dagenham Safeguarding Adults Board should ask adult social care to provide evidence as to whether their assessments:

a) promote working with service users to share information with all relevant professionals in the network especially GPs,
b) integrate an assessment of risk and management plan which encompasses the points set out in the London Adult Safeguarding Policy and Procedures paragraphs 3.3.3 and 3.3.4.

Finding Three

[4] The integrated care team in London Borough of Barking and Dagenham is made up of health and social care providers who co-ordinate and offer multi-disciplinary quality care to vulnerable adults.

The system for providing a deep clean of Mary's property was slow and left Mary living in an inappropriate environment

4.11 Although the review has not received any evidence that Mary's health was adversely affected by her home conditions, her physical environment would not have had a positive impact on her wellbeing. Although Mary refused more help from carers, she did agree to the deep clean of her property and there was an unacceptable delay in this being provided.

4.12 The root cause of the delay appears to be a debate about whether social care or housing should pay for the clean, compounded by an apparent lack of agreement about what should be included in a care plan supporting the case for it to be housing to fund the clean. There is now an agreement in place that deep cleaning in situations such as Mary's will be funded by social care. In addition all social workers have been advised to use the London Fire Brigade clutter assessment tool when requesting funding.

Recommendation Six

Barking and Dagenham Safeguarding Adults Board should ask for evidence from adult social care and the housing department that the new agreement is working and that social workers are using the London Fire Brigade clutter assessment tool appropriately.

5 CONCLUSION

5.1 Giving an adult control over the care that they receive is a fundamental aspect of our legislation and in this case Mary's views about her needs did not always tally with those of others who wanted to provide help. There is no evidence that her mental state met the threshold for compulsory intervention but as with all reviews, when practice is carefully scrutinised there are always lessons to learn. This review has identified points where better communication between professionals would have improved an assessment of Mary's psychological state and highlighted the need to carefully consider whether she was receiving the most appropriate help with her mental state. There was also the opportunity to deliver a speedier deep clean of her property which would have improved Mary's living environment.

5.2 In this case, Mary died of natural causes and it cannot be said with any certainty that her death could have been prevented by a different course of action by professionals involved. That notwithstanding, there was an extremely unfortunate series of events which meant that she left the emergency department without anyone being informed that she was being taken home, her carer did not see her on the Friday morning she left hospital and no one called on the Monday as it was

presumed she was still in hospital. These events meant there was a lost opportunity to identify a potential deterioration in her health although this would not have been possible had the deterioration occurred over the weekend when she did not wish to have a carer visit.

5.3 The circumstance of Mary's death has been very distressing for those that knew her and the review team would like to thank all those that contributed their views about why events happened as they did and how practice could have been improved. We are particularly grateful to Mary's family and neighbour for their willingness to take part despite the difficult and upsetting circumstances surrounding this review.

6 APPENDIX 1 – OUTLINE CHRONOLOGY

Outline Chronology	
20th Feb 2016	Mary called the police concerned about intruders. Police attended and were concerned about the unhygienic home conditions. Police notification (Merlin) sent to adult social care prompting an assessment.
21-29th February 2016	Mary made various calls to Police regarding males trying to access property. Operator notes Mary suffering “harmless delusions”. Police attended on two occasions and spoke to neighbours and Mary.
4th April 2016	Internal communication within the housing department regarding whether housing or social care were responsible for payment for a deep clean of the property.
9th April	Phone call from neighbour to Police advising he was concerned for welfare of Mary following her request to him for assistance. Police visited and due to the conditions in the home a Merlin was sent to adult social care.
15th April 2016	Adult social care assessment completed and request for services approved. Care agency introduced to Mary.
18th April 2016	Care service was proposed to commence however Mary did not allow entry and nephew was advised.
9th May 2016	Phone call from adult social care to Police requesting assistance as Mary had not been seen and carer had not been able to gain access. Police attended and was advised by neighbour that they had seen Mary earlier that day. Social worker attended property that afternoon, was let in by neighbour, and advised police Mary was fine.
11th May 2016	Carer gained entry to the home via a key safe which had been installed. Informed social worker that hoe conditions were worse than at time of the assessment visit.
26th May 2016	Joint visit to property by SW and environmental service company to assess property and provide quote.
2nd June 2016	Ambulance called by Mary’s carer and Mary taken to the emergency department at Hospital 1. Sent home at her request. Ambulance Service made a safeguarding referral due to the home conditions. SW advised care agency to resume visits.
3rd June 2016	Follow up email sent to housing officers re need for urgent deep cleaning/fumigation.

5th June 2016	Ambulance called by Mary's nephew as Mary was complaining of shortness of breath. Mary did not wish to be taken to hospital.
9th June 2016	Ambulance called by Mary's neighbour as she was complaining of shortness of breath. Mary taken to and the emergency department at Hospital 2.
10th June	Mary discharged from the emergency department at Hospital 2 and taken home at 5am by hospital transport.
10th June morning	The carer called to see Mary and was informed by the neighbour that Mary had been taken to hospital the previous evening the key is not in the key safe but is being looked after by the neighbour as the carer had allegedly left it in the front door the previous day. Carer abandoned visit and spoke with manager and SW.
10th June midday	The neighbour was aware that Mary is home and delivered some shopping.
10th June 13.10	Mary was discussed at integrated care meeting at the hospital.
14th June 2016	Neighbour call to Police. Mary found deceased by ambulance crew.