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**KENT AND MEDWAY  
SAFEGUARDING ADULTS BOARD  
SAFEGUARDING ADULTS REVIEW**

**Violet Hughes**

Executive Summary

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Commissioned by: Kent and Medway Safeguarding Adults Board

September 2017

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**CONTENTS**

1. The Review Process ..... 1

2. Contributing Organisations..... 1

3. Review Panel Members..... 2

4. Independent Chairman and Author..... 2

5. Terms of Reference..... 2

6. Summary Chronology..... 6

7. Conclusions ..... 7

8. Lessons To Be Learned..... 8

9. Recommendations ..... 11

Glossary..... 13

**Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned**

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## EXECUTIVE SUMMARY

### 1. The Review Process

- 1.1 This summary outlines the process undertaken by the Safeguarding Adults Review Panel in reviewing the case of Violet Hughes, who lived in Kent. Violet was a white British woman aged 89 years at the time of her death.
- 1.2 This Safeguarding Adults Review (SAR) was commissioned by Kent and Medway Safeguarding Adults Board (KMSAB), following a referral made by a Safeguarding Adults Coordinator, employed in LA1.
- 1.3 A SAR is not an inquiry into how someone died or suffered injury, or to find out who is responsible. Its purpose is to:
  - look at any lessons we can learn from the case about the way all local professionals and agencies worked together;
  - review the effectiveness of safeguarding adults policy and protocols;
  - inform and improve local safeguarding practice for all agencies involved; and
  - deliver an overview report and recommendations for future action.
- 1.4 The key outcome of a SAR is to improve the safeguarding of adults in future. For this to happen as widely and thoroughly as possible, professionals need to be able to understand fully what happened and what needs to change.

### 2. Contributing Organisations

- 2.1 Each of the following organisations completed an IMR:
  - Trust 1
  - Clinical Commissioning Group 1\*
  - GP Practice 1
  - Community Trust
  - LA 1
  - Trust 2
  - Care Homes Group A

\* CCG1 completed an IMR for GP Practice 2 on behalf of CCG2. The CCG1 IMR author also completed an NHS Overview Report.

### **3. Review Panel Members**

3.1 The members of the SAR Panel were:

- Howard Llewellyn, SAR Independent Chair
- Paul Pearce, SAR Independent Author
- Designated Nurse for Adult Safeguarding, CCG1,
- Detective Superintendent (latterly a different Superintendent and a Detective Chief Inspector), Kent Police
- Head of Safeguarding, (latterly Team Manager then Interim Head of Safeguarding), Local Authority 1
- Interim Principal Social Worker for Adults, Local Authority 2
- Head of Safeguarding, Trust 1

3.2 When a member of the panel changed, this was due to the post holders in an organisation changing.

### **4. Independent Chairman and Author**

4.1 The Independent Chairman of the SAR Panel is a Barrister and Judge. From 2010 to 2016, he was the Chief Officer of a Scottish Criminal Justice Authority. He is currently the Independent Safeguarding Chair of a Church of England Diocese and member of a local authority Adoption Panel. He has enhanced experience of safeguarding and has led Significant Case Reviews for Scottish Child Protection Committees.

4.2 The Independent Author of this report is a retired senior police officer. He did not serve with Kent Police. He has enhanced experience and knowledge of safeguarding issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to safeguarding. He has been the Independent Chairman and author of Safeguarding Adults, Domestic Homicide and Serious Case Reviews. He has a background in conducting reviews and investigations, including those involving serious disciplinary matters.

4.3 Neither the Independent Chairman nor the report author have worked in Kent or have association with any of the agencies represented on the SAR Panel.

### **5. Terms of Reference**

*These Terms of Reference were agreed by the Review Panel in advance of this SAR being conducted.*

## 5.1 Introduction

5.1.1 Following the death of Violet, date of birth 07.01.1929, the Kent and Medway Safeguarding Adults Board (KMSAB) has commissioned a Safeguarding Adults Review (SAR).

## 5.2 Methodology

5.2.1 All agencies are asked to check if they had contact and/or involvement with Violet in the period from 1 September 2013 to 29 July 2015 and if so, to secure their records and notify the Independent Chair of the SAR Panel.

5.2.2 The SAR Panel will decide which agencies will be asked to undertake Independent Management Reports of their involvement with Violet. Where agencies had contact and/or involvement with Violet that was not directly relevant to the criteria for conducting a SAR, they may be asked to provide a report summarising their involvement.

## 5.3 Independent Management Reports (IMRs)

5.3.1 IMRs will be requested from the following agencies:

- GPP2, Town B
- Trust 1
- Trust 2
- Community Trust
- LA1 (to include CH1)
- GPP 1, Town A
- CH2, Town A

5.3.2 IMRs must be submitted using the template current at the time of completion. The SAR Panel will agree and set timescales for the completion of the IMRs (see below).

5.3.3 The SAR will be based on IMRs provided by the agencies that were involved in Violet's care and treatment, in circumstances relevant to the criteria for conducting a SAR. Each IMR will be prepared by an appropriately skilled person who did not have any direct involvement with Violet and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

5.3.4 The Chronology will include each occasion that the agency had contact with Violet between the dates in 5.2.1 above, in circumstances that led to, or should have led to, safeguarding concerns.

5.3.5 Each IMR should analyse:

- The key and priority practice episodes (these will be drawn from the agency chronology);
- The agency's involvement, commenting on the work undertaken and the adherence to intra- and inter-agency policy and procedures, or accepted best clinical/professional practice, in use at the time;
- The agency and inter-agency assessment of Violet's needs, including emotional needs; and any risk identified, including signs or disclosures of neglect or abuse;
- The direct work undertaken with Violet and, if relevant, her family members;
- Inter-agency information sharing and co-operation to meet Violet's identified needs;
- The decisions, actions taken and timescales, noting any gaps, errors and successes and why these occurred;
- The views of the practitioners involved and any management or supervisory oversight of the work, seeking to understand the work undertaken by what was known at the time, not through hindsight, but noting any gaps; and
- The agency context in which the work was undertaken, and any factors intrinsic to the agency or external to the case which may have impacted on the work.

5.3.6 The analysis should highlight both good and poor practice by both individuals and the agency. It should include issues such as the resourcing, workload, supervision, support, and the training and experience of the professionals involved.

5.3.7 A Designated Nurse will take responsibility for compiling an overall Health agencies' overview, if this is required by the relevant CCG or by NHS England. It is requested that a copy of this be sent to the Independent Chair of the SAR.

5.3.8 Any issues relevant to equality, for example disability, cultural and faith matters, should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

5.3.9 The IMR should note the key lessons, including concerns and good practice, which have been learned from the agency review, and any recommendations to be taken as a result within the agency or by other bodies. It should include whether the agency has accepted such internal recommendations as formal actions.



- 5.3.10 When each agency has submitted its IMR, it will be considered at a meeting of the SAR Panel and an Overview Report will then be drafted by the Chair of the Panel. The draft Overview Report will be considered at a further meeting of the SAR Panel and a final, agreed version will be submitted to the Chair of KMSAB.
- 5.3.11 IMRs must be submitted to the Board Coordinator by Thursday 23rd June 2016. Health agencies are to submit their reports to the Board Coordinator by 26th May, to allow for a Designated Nurse to compile an overview report by the submission date of 23rd June.

#### 5.4. Safeguarding Adults Review Panel

- 5.4.1 The Panel will be commissioned by the KMSAB Chair.
- 5.4.2 KMSAB will appoint a panel of senior and experienced practitioners with experience in safeguarding to draw together the learning from the IMRs and Health overview and to comment on the work undertaken. The SAR Panel members should be independent of the line-management for this case.
- 5.4.3 An Independent Lead Reviewer, Howard Llewellyn, has been appointed to support the process and author the final Overview Report. He will also Chair the Panel meetings.
- 5.4.4 The Panel members will be:
- Howard Llewellyn, SAR Independent Chair
  - Head of Adult Safeguarding, Local Authority 1
  - Interim Principal Social Worker for Adults, Local Authority 2
  - Detective Superintendent, Kent Police
  - Head of Safeguarding, Trust 1
    - Designated Nurse for Adult Safeguarding, CCG1,
  - KMSAB Board Co-ordinator and Admin Support (non-participating role)
- 5.4.5 None of the Panel Members should have had direct involvement in the management of Violet's case.
- 5.4.6 The Panel can co-opt specialist advice, including legal advice, as needed.

#### 5.5 Participation by Family Members

- 5.5.1 The SAR Panel will seek to identify the name and contact details of Violet's close family (parents, children, siblings). These relatives will be advised of the SAR at an early stage, by the SAR Chair. The family will be advised of the SAR purpose, how it will be conducted and how they may be involved, such as being able to have direct communication with the Independent SAR Chair.

- 5.5.2 The SAR Panel Chair will contact family members during the period when IMRs are being conducted. The purpose is to enable them to express any views they may have about agency involvement with Violet, or lack of it.
- 5.5.3 The SAR Panel Chair will contact family members after completion of the Overview Report to advise of conclusions, lessons learned and recommendations. Where, or if, a family or its members have been perpetrators in a safeguarding enquiry, such communications may need to be both cautious and selective.

#### **5.6. Safeguarding Adults Review Governance**

- 5.6.1 The Chair of the SAR Panel will be responsible for regularly advising the KMSAB Chair of any emerging findings that require attention before the SAR Overview Report is drafted.
- 5.6.2 The IMRs and draft Overview Report will be sent to the KMSAB Chair, prior to listing it as a confidential KMSAB agenda item, for the KMSAB's Independent Chair's views.
- 5.6.3 If the KMSAB Chair is satisfied with the Overview Report and completed IMRs, the SAR will be presented to the next KMSAB for sign off.
- 5.6.4 KMSAB will be responsible for the co-ordination of any media management in relation to this SAR, in line with an agreed media strategy.
- 5.6.5 Decisions about publication will be made by the KMSAB at the final presentation of the Overview Report.

## **6. Summary Chronology**

- 6.1 Trust 1 was involved with Violet from July to September 2013, following a referral from GP Practice 1 (GPP1) about memory problems. As part of the investigation into her memory problems, in August 2013 GP Practice 1 (GPP1) referred Violet for a CT scan.
- 6.2 Between 3 October and 30 November 2013, Violet accessed the Community Trust Minor Injuries Unit in Town E on 10 occasions for wound care on a leg injury.
- 6.3 On 27 May 2015, Violet was admitted to Hospital 1 due to "poor oral intake for a few days and general unwell and off legs". Hospital 1 is an acute hospital managed by Trust 2.

- 6.4 Two days into Violet's stay in Hospital 1, LA1 became involved in assessing her and preparing a post-discharge plan.
- 6.5 On 23 June 2015, Violet was discharged from Hospital 1 and went to stay at Care Home 1 (CH1) in Town B. For the duration of her stay there, she was registered with GP Practice 2 (GPP2) in Town B. LA1 remained engaged with Violet during her time at CH1, which was run by them.
- 6.6 Violet was visited 12 times by Community Nurses or Health Care Assistants from the Community Trust, Town E Community Nursing Team (CNT) during her 10-day stay in CH1. They dressed wounds on the back of both her legs and requested antibiotics to help treat the wounds. Antibiotics were prescribed by GPP2.
- 6.7 On 1 July 2015, Violet was transferred from CH1 to CH2 in Town A. During her stay at CH2, Violet was under the clinical care of the Town A CNT, whose staff made five visits.
- 6.8 On 9 July, Violet became unwell and carers at CH2 called 999 to request an ambulance. She was taken to Hospital 2 in Town C, where she was found to be suffering from sepsis, bilateral leg ulcers and cellulitis.
- 6.9 On 14 July, while at Hospital 2, Violet was found to have a hip fracture, which an independent expert later assessed as being three to six weeks old.
- 6.10 Violet died in Hospital 2 on 29 July 2015.

## **7. Conclusions**

- 7.1 Although the review period is from 1 September 2013 until 29 July 2015, the relevant period in terms of safeguarding is from Violet's admission to Hospital 1 on 27 May 2015 to her death in Hospital 2, just over two months later. Her journey through the health and social care system was short and one that many elderly people and their families experience. It is the journey from independent living to end of life.
- 7.2 Admission of an elderly person to hospital, either because of a deterioration in a chronic illness or an incident giving rise to an acute condition, results in assessment. This leads to the conclusion that although hospital treatment is not required, the person needs social care, which cannot be delivered in their home. They remain in hospital until a care home bed is found and they are transferred. If it transpires the home is not suitable for their long-term care needs, they are transferred to another. Their condition deteriorates further to the time when re-admission to hospital is required until end of life.

- 7.3 If the treatment and care the elderly person receives at each stage is both professional and compassionate, the journey can be an experience during which they feel cared for, supported and safe.
- 7.4 A SAR, as its title states, is a review, not an investigation. It identifies good practice and examines how shortcomings can be addressed, not what caused them and who is to blame. It is for the organisations to establish the reasons for the shortcomings and put in place measures needed to ensure they do not happen in future. Notwithstanding this, when shortcomings are fundamental, KMSAB will want to be reassured that an organisation understands what went wrong, why it went wrong and how it is going to change to improve the safeguarding of adults in future. Things can go wrong in the best of organisations: if the causes and solutions are identified and shared, it may prevent the same in other organisations.
- 7.5 It is unclear how aware Violet was of her surroundings, and her care and treatment at each stage. Her son David, when visiting her in Hospital 1 said that she thought she was in a care home, perhaps indicating a low level of awareness. However, had she been fully aware of what was taking place, there were parts of her journey that may have caused her distress. She might have felt, that as well as not being cared for, she was not cared about.
- 7.6 The deficiencies in the treatment and care of Violet were fundamental. A Safeguarding Adults Review is not a backward-looking investigation and does not attempt to establish why these deficiencies happened. The responsible organisations must do that and put in place measures to ensure all those in Violet's situation in future receive an acceptable standard of care and treatment, in order that their wellbeing is safeguarded. The recommendations from this review arise from information provided by those organisations, who will decide how best to implement them to achieve the purpose of the SAR.

## **8. Lessons To Be Learned**

The Review Panel has identified that the following lessons should be learned from this review:

### **8.1 Having policies in place is not a guarantee they will be implemented.**

- 8.1.1 Policies are usually written, and always approved, at a senior level in an organisation, by those who work strategically. In contrast, most policy is implemented by practitioners.

- 8.1.2 Unless policy is clearly understood by those who deliver it, it is of little value. Put another way: the language of strategy for senior management is of little help to service deliverers, who need to know exactly what it is they are to do, how, when and where. In addition, the best organisations include why – they explain the rationale for a policy to those delivering it.
- 8.1.3 This Review has quoted from policies, usually where practitioners have not adhered to them. The policies seem thorough and comprehensive; there must be reasons why staff are not implementing them.
- 8.1.4 Organisations need to be sure that:
- staff who must implement a policy know that it exists;
  - the policy is accessible (both physically and in terms of its language) to them;
  - it has been explained to them;
  - their understanding of it is tested in the workplace as well as the classroom; and
  - it is quickly apparent to supervisors and managers when policies are not being adhered to.

## **8.2 Accurate record keeping is important in ensuring effective safeguarding.**

- 8.2.1 Many actions referred to in this report are prefaced by, *‘There is no record of...’* or *‘There is no evidence that...’* In each case, this will mean either that something was not done, or it was done but no record was made of it. The quality of Violet’s safeguarding might have been different if the action was done but not recorded, rather than not done.
- 8.2.2 The purpose of accurate and complete record keeping is two-fold. The first, which is the most important to a person’s safeguarding, is to ensure there is a history of their health treatment and/or social care. Violet’s case, in which her treatment and care was entrusted to numerous different teams, is an example of this.
- 8.2.3 Failing to comprehensively record Violet’s condition, noteworthy events (e.g. her fall) and actions taken, played a part in putting her at greater risk of harm.
- 8.2.4 Although less important, the recording of decisions and rationale can help when trying to understand why things went wrong and how they can be done better in future. Accurate and comprehensive records provide an audit trail.

- 8.2.5 This is highlighted in a 2015 article in the Journal of Community Nursing entitled *'If it's not written down, it didn't happen'*, which is copyright of the Wound Care People Ltd but available via the weblink:

<https://www.jcn.co.uk/files/downloads/articles/jcn-v29-is5-08-not-written-down-not-happen.pdf>

The relevance of the journal and the name of the copyright holder to Violet's case is coincidental, but it reinforces the point.

- 8.2.6 In 2012 UNITE, the trade union, produced a paper containing frequently asked questions about record keeping, aimed primarily at health professionals. It remains a comprehensive, easy to understand document that may help practitioners understand and appreciate not just the importance, but the value of record keeping. It can be downloaded from:

<http://www.unitetheunion.org/uploaded/documents/Job%205408%20Record%20keeping11-7737.pdf>

### **8.3 Sharing information within and between organisations entrusted with people's safeguarding is important.**

- 8.3.1 This lesson is about sharing accurate, comprehensive records within and between the organisations treating or caring for a person. Shared IT systems make this relatively simple; the use of paper records, which must be scanned or copied, makes sharing information more onerous for staff.
- 8.3.2 In Violet's case, there are examples where organisations did not question why records were not passed to them. This may have been because the expectation that information known or produced by one organisation should be passed to another, is not embedded in the workforce culture.
- 8.3.3 Information sharing should be embedded in all organisations with responsibility for safeguarding adults and each should ensure that its staff understand its principles and purpose.

## 9. Recommendations

9.1 The Review Panel makes the following recommendations from this SAR:

	<b>Recommendation</b>	<b>Organisation</b>
1.	When a GP visits a patient and knows they are also being treated by other clinicians, that GP should consult with those clinicians to ensure he or she has the most complete recent history of the patient's condition.	All CCGs
2.	Community Trust must ensure that, when its staff are treating a patient who has just been discharged from an acute hospital and they do not receive a discharge letter, they must contact the hospital and obtain a copy of it.	Community Trust
3.	Community Trust must have processes in place to ensure its staff understand the Trust's policies and are implementing them.	Community Trust
4.	Community Trust must ensure that, when a patient has mental capacity, their staff must ensure the relevant care plan provides evidence that the patient understands the proposed treatment, in collaboration with the family where appropriate.	Community Trust
5.	Community Trust must ensure that, when their staff believe a person lacks mental capacity to consent to treatment, a mental capacity assessment is carried out before the treatment is given, unless there is documented evidence that a previous relevant mental capacity assessment has confirmed this.	Community Trust
6.	Community Trust must ensure their staff understand how to accurately and comprehensively document their actions.	Community Trust
7.	Community Trust must produce an effective handover process, which will be applied when a patient is handed from one CNT to another.	Community Trust
8.	Community Trust must ensure CNT staff have a clear understanding of when a doctor should be called to examine a patient whose condition is deteriorating.	Community Trust
9.	Trust 2 must ensure that when patients are discharged they	Trust 2

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	correctly utilise the electronic notification system. If it is necessary to give a hard copy of the discharge letter and any dressings/medication to a person for delivery to a care home, they must be confident that these will be delivered in a timely manner.	
10.	Trust 2 must ensure their staff are aware that, when giving information about a patient to another health or care professional, this is done with reference to the patient's notes rather than relying on memory.	Trust 2
11.	Trust 2 must ensure that its staff are aware of the requirement to submit a safeguarding alert on the day that the concern is identified.	Trust 2
12.	LA1 must ensure their care home managers have formal procedures for sharing information with clinical staff who are treating residents.	LA1
13.	LA1 must review the falls risk assessment template used in its care homes, making changes as necessary, and ensure staff understand and implement its instructions.	LA1
14.	LA1 must ensure that, when an elderly person suffers a fall in a care home, appropriate medical intervention is requested.	LA1
15.	LA1 must ensure that, when a resident is transferred from a care home managed by them to another care home, any current DoLS authorisation or application (with any associated documentation) is included in the handover.	LA1
16.	LA1 must ensure that social care professionals understand what behaviours and presentations might indicate a requirement to seek medical intervention.	LA1
17.	LA1 must ensure that the transfer of residents from their care homes to other establishments is done using trained staff and vehicles best suited to the task.	LA1
18.	LA1 must ensure social care professionals, who are involved in making decisions about the care of adults, understand the principles of the Mental Capacity Act 2005 and implement them.	LA1



## Glossary

This glossary contains explanations of acronyms and terms that are used in the Report.

### Acronyms/Abbreviations

CCG	Clinical Commissioning Group
CH	Care Home
CN	Community Nurse
CNT	Community Nursing Team
GP	General Practitioner
GPP	GP Practice
IMR	Independent Management Report
KMSAB	Kent and Medway Safeguarding Adults Board
MCA	Mental Capacity Assessment
LA	Local Authority
NHS	National Health Service
SAR	Safeguarding Adults Review

### Terms

#### **Community Nursing Team**

The Community Nursing Team (CNT) is team of professionals who include community nurses, district nurses, community matrons, specialist nurses, health care assistants and therapy assistants.

The CNT cares for patients in their own homes, including residential homes, with the aim of ensuring they do not have to go into hospital unnecessarily. CNT professionals look after people who are housebound and need nursing and carry out procedures including giving medicines, taking blood, changing dressings. They also provide end of life care.

The CNT works closely with other agencies, such as out-of-hours and social care services and in many places, operate 24-hours a day. In some parts of LA1, the CNT operates a rapid response service, which aims to assess patients quickly and prevent unnecessary hospital admissions.

The CNT provides intensive personalised care to patients with complex long-term conditions so that they can stay safe and healthy at home or in their chosen environment and provides rehabilitation to people aged 18 and over who need help to maintain and enhance their quality of life.

## **Sepsis**

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Early diagnosis is necessary to properly manage sepsis, as initiation of rapid therapy is key to reducing mortality from severe sepsis.

## **Mental Capacity**

Mental capacity is a person's ability to make their own decisions. When a person makes a decision, they need to be able to:

- understand all the information needed to make that decision,
- use or think about that information,
- remember that information, and
- be able to communicate that decision to someone else.

Communicating a decision is not just telling someone. It can be communicated in any way, such as using diagrams or pictures. Making an unwise decision is different than not being able to decide.

## **Mental Capacity Assessment**

A mental capacity assessment is a formal assessment of someone's, ability to make their own decision. It will usually be conducted by a health or social care professional.

## **Deprivation of Liberty Safeguards (DoLS)**

Deprivation of Liberty Safeguards (DoLS) came into force in England and Wales in April 2009, under an amendment to the Mental Capacity Act 2005. These safeguards are intended to protect individuals, who lack the capacity to consent to care or treatment, from being deprived of their liberty unless there is no other, less restrictive alternative, and a deprivation of liberty is assessed to be in their best interests to protect them from harm, or to provide treatment.

The definition of what constitutes a deprivation of liberty was amended following a Supreme Court Judgement in 2014, P v Cheshire West and Chester Council (2014), which created

an 'acid test' for what constitutes a deprivation of liberty. The 'acid test' is fulfilled, and an individual is considered to be deprived of their liberty, if they:

- lack the capacity to consent to their care/treatment arrangements and
- are under continuous supervision and control and
- are not free to leave

The following are not relevant to the application of the test:

- the person's compliance or lack of objection
- the relative normality of the placement and the reason
- the purpose for the placement having been made

Statistics by the Health and Social Care Information Centre illustrate a continued increase in the number of DoLS applications received. '195,840 DoLS applications were reported as having been received by councils during 2015-16. This is the most since the DoLS were introduced in 2009 and represents 454 DoLS applications received per 100,000 adults in England".

In March 2017, the Law Commission issued its report following review of the DoLS legislation. The Government will determine how the recommendations will be taken forward.

The main highlights are:

- DoLS will be replaced by the 'Liberty Protection Safeguards'
- This will apply to individuals over the age of 16 years
- It will apply in any setting
- The Supervisory Body will be replaced by the 'Responsible Body'
- Responsible Bodies will include NHS and Local Authorities