SAFEGUARDING ADULT REVIEW ‘MR PETER SMITH’

Overview Report of a statutory Safeguarding Adult Review under s44 Care Act 2014 commissioned by the Barking & Dagenham Safeguarding Adult Board

Final Report
January 2020

Independent Reviewer
Lorraine Stanforth

Introduction

1.1 This report was commissioned following the unexpected death of Mr Peter Smith a 75-year-old man that met the Barking & Dagenham Safeguarding Adult Board (SAB) criteria for holding a Safeguarding Adult Review (SAR). The name in this report has been changed to protect the individual's identity. Mr Smith was found deceased on October 3rd 2018 on an unplanned visit by an Integrated Care Assistant (ICA) from the Community Health and Social Care Service Barking & Dagenham East (CHSCS). Mr Smith had been discharged from hospital on 10th September 2018 where he was undergoing rehabilitation with follow up in the community by the CHSCS. Mr Smith was also assessed for a community alarm which had yet to be installed. The last time Mr Smith was seen alive was 28th September 2018.

1.2 Given the circumstances of Mr Smith's death an inquest was held at an East London Coroner office who issued a report under schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 on 3rd July 2019. The coroner concluded the cause of Mr Smith's death as follows, ***"Mr Smith died as a result of starvation ketoacidosis following a likely fall in his home address."***

1.3 The purpose of this report is to:

i. Establish what lessons are to be learned from the work carried out by local professionals and organisations either individually or together to safeguard people in need of care and support
ii. Set out recommendations for consideration by the Barking & Dagenham Safeguarding Adults Board based on the findings and analysis identified in the report
iii. Identify preventative strategies that might be utilised to safeguard other vulnerable groups

1.4 The Terms of Reference set by the SAR committee that the Safeguarding Adult Review is to address is replicated below:

- ***To undertake the Safeguarding Adult Review in line with the SCIE SAR Quality Markers.***
- ***To review the circumstances leading to the death of Mr Smith and any related reports (to date). This may require a limited direct investigative part in order to be sure of lessons for the future.***
- ***To explore the actions of individual agencies, service provision and professional practice of those who knew Mr Smith prior to his death and during the scope of the review, inclusive of highlighting areas of both good and possibly more questionable practice.***
- ***To review the decisions made and communications relating to any equipment related assessments, reviews and care plans for Mr Smith and their outcomes in terms of potential or actual impact.***

- ***To review any wider system and communication issues in relation to Mr Smith's care.***
- ***To identify any system issues which may arise for agencies and for the consideration of Safeguarding Adults Board partnership as a whole, with particular reference to the assessment, supply and ordering of equipment.***
- ***To identify any barriers to effective multi-agency and collaborative working issues for the local partnership arising from the review particularly in terms of timely information sharing and multi-agency safeguarding approaches.***
- ***To identify any practice or policy issues for individual agencies arising from the review.***
- ***To prepare a report for Barking and Dagenham Safeguarding Adults Board that identifies any lessons to be learned and makes recommendations for future policy and practice.***
- ***To produce a SMART action plan in addition to providing recommendations.***

1.5 The Review Methodology involved:

- Discussions with the SAR Chair and SAB Business Manager
- Reviews of reports as listed below
- Sight of NELFT discharge policy
- Barking & Dagenham SAB Information Sharing Protocol
- Thematic analysis of the learning themes emerging from reports
- SAR Panel meetings for discussion and analysis of recommendations and quality assurance

1.6 Documents made available to the overview report writer.

a) SARAR Decision Making Form 19th July 2019
b) Regulation 28 Request for Report 3rd July 2019
c) NELFT Serious Incident Root Cause Analysis 4th April 2019 and Addendum Report
d) Safeguarding Enquiry Chronology and Report 11th June 2019
e) Case Information Summary 4th October 2018
f) Telecare Referral 4th September 2019
g) Witness Statement from Care Line Manager 21st June 2019
h) Telecare referral for installation procedure (undated flow chart)
i) Medical Reports on Mr Smith
j) Barking and Dagenham Complex Case Panel Policy

1.7 The above documents are quoted throughout the report. Any additional information requested by the Overview Writer is referenced within the report. All documents used in this report are subject to the strictest confidentiality.

1.8 The Overview Writer has not had contact with Mr Smith's next of kin and their contribution to the review is a matter for the SAR Committee. The next of kin,

did however meet with the Investigating Officer (IO) of the Serious Incident investigation, listed as Final Root Cause Analysis 4th April 2019.

1.9 Following good practice, the IO had asked the family what their views and concerns might be. Support for the family was also explored and the family confirmed that they were receiving support from their GP surgery, Talking Therapy and Eden's Trust Charity. The IO provided details of Cruse Bereavement Service and the opportunity to talk about their experience in a safe environment.

1.10 The individuals and bodies involved in the review are responsible for ensuring that it is conducted according to the Department of Health Care & Support Statutory Guidance (updated October 2018) are as follows:

Individual/Organisation	**Role**	**Responsibility**
Lorraine Stanforth Independent	Overview Report Writer	Produce report to standard set by the SAR chair and committee Make SMART recommendations
Mark Gilbey-Cross Deputy Nurse Director NHS Barking & Dagenham, Havering and Redbridge CCGs	Chair SAR Committee	Overall quality assurance of report Report to SAB
SAR Committee	Health and social care professionals	Terms of Reference Selection of overview writer QA report and recommendations
Safeguarding Adults Board (SAB) - Independent Chair Senior management of partner organisations across LB B&D	Accept/reject recommendations Ensure lessons are taken forward	Ensure compliance with s44 Care Act 2014 Sign off report Review recommendations and monitor action plan Oversee dissemination of report and lessons learnt
North East London Foundation Trust Occupational Therapist Japonica Ward staff Community Health & Social Care Service CHSCS	Contribution to Serious Investigation Provide information to SI investigation Provide support to Mr Smith at home. Provide information to Serious Incident investigation.	Discharge Home

		Participate in learning
Barking, Havering & Redbridge University Hospitals NHS Trust	Assessment Risk Assessment & transfer to hospital	Participate in learning
Care Line Elevate East London LPP	Contribution to Coroner Report Provide information	Participate in learning
The Joint Assessment & Discharge Team	Prepare chronology based on NELFT and London Borough of Barking and Dagenham data bases.	Contribute to Quality Assurance through SAR committee
Metropolitan Police Service	Merlin Report (first fall leading to admittance to hospital) Case Information Summary	Participate in learning

1.11 The Overview Writer would like to thank the contributors and support from the SAR Chair and Committee members, and the Safeguarding Adults Board Business Manager.

1.12 Publication and dissemination of this report is a matter for the Safeguarding Adults Board but the Overview Writer would advocate that public interest is served.

2. Review of the circumstances leading to the death of Mr Smith and any related reports (to date)

2.1 The Care and Support Statutory Guidance (updated 2018) states that a SAB must conduct any safeguarding adults review in accordance with s44 of the Care Act 2014. The Barking & Dagenham SAR criteria is based on the Act and determines whether or not this SAR should be conducted and was discussed by the SAR committee at an Extraordinary meeting on 19th July 2019. The meeting concluded that the circumstances of Mr Smith's death met the Barking & Dagenham criteria on the basis of positive responses to the following questions:

- ***Has an adult at risk had died (including suicide)? - Yes***
- ***Because of (or suspected to be because of) abuse or neglect? - Yes***

- ***Is the case likely to be: complex; run alongside criminal proceedings, and/or generate public interest? - Yes***

2.2 In addition to the Barking & Dagenham criteria the Guidance states that a Safeguarding Adult Board must conduct a SAR where there is concern that partner agencies could have worked more effectively to protect the adult. The SAR committee might consider reviewing its current policy against the updated Guidance.

2.3 Hospital reports summarised in the Safeguarding Enquiry Chronology and Report (11th June 2019) note that Mr Smith suffered from significant pain due to his spinal conditions. He also had difficulties with his sight due to age-related macular degeneration. Both these conditions compromised his general ability and caused some limitations on his mobility.

2.4 The Serious Incident Root Cause Analysis report notes that prior to the fall resulting in Mr Smith's hospital admission he had experienced a number of falls in the past few months (early 2018). Following the fall at his home address in July 2018 Mr Smith was unable to get up and had laid on the floor for 4 days calling out for help. He was found by the police and admitted to hospital on the 19th July 2018. Mr Smith had developed an acute kidney injury and grade 2 and 4 pressure ulcers as a result of lying on the floor.

2.5 The clinical decision was made that Mr Smith was medically fit and would benefit from a period of inpatient rehabilitation and he was subsequently transferred to hospital also over-seen by Barking, Havering and Redbridge University NHS Trust; however, the inpatient rehabilitation ward that is based at this site (Japonica ward) is managed by North East London Foundation Trust.

2.6 Japonica ward is a Community Inpatient Rehabilitation facility providing care to patients with intermediate rehabilitation needs. The aim of the inpatient rehabilitation is to promote and maximise independence, facilitate early discharge from hospital and prevent unnecessary admission to acute general hospitals.

2.7 Mr Smith was transferred to Japonica ward on 24th August 2018 with the agreed goal of improving his mobility and was subsequently discharged on 10th September 2018.

2.8 Whilst on Japonica ward Mr Smith was seen by physiotherapy and occupational therapy services. The rehabilitation ward therapy summarised in the chronology, is that Mr Smith needed the assistance of one person for transfers or mobility due to limitations, but there is a gradual improvement as Mr Smith becomes more independent.

2.9 Conversations between the occupational therapist and Mr Smith are recorded about his returning home and the support that might be available to him. Discussions with Mr Smith indicated that he was a private individual who preferred to self-manage rather than depend on family or services. He refused all services with the exception of a telecare alarm system and community nursing services. He also refused for hospital staff to contact his family about his hospital discharge.

2.10 Mr Smith accepted the need for an alarm but wanted to return home prior to the alarm being fitted. Other recommended equipment was also delayed until after his return home, this was pressure relieving equipment recommended for his pressure ulcer treatment plan.

2.11 The referral for nursing support was accepted by Mr Smith and the CHSCS. Nursing tasks were identified as the main reason for the referral due to Mr Smith's pressure ulcers that required ongoing monitoring and dressing.

2.12 Nursing and ancillary staff visited on the 11th, 12th, 19th, 25th and 28th September and 2nd October 2018. On the 11th September Mr Smith did not answer the door, the reason is unknown but at all other visits in September he was seen. On the 2nd October 2018, an agency nurse visited Mr Smith but their visit did not elicit a response. Following a handover meeting on the 3rd October 2018 the failed access the previous day was identified and an ICA was allocated to make a further unplanned visit that day.

2.13 The ICA telephoned ahead of their visit with no response, neither was there a response when they arrived at the property. They peered through a hole in the door and saw Mr Smith on the floor in the sitting room. They had prised the door open which was weak due to earlier situations. The ICA alerted emergency services. Mr Smith was pronounced dead by a paramedic of the London Ambulance Service. A police constable also attended the call.

3 **Facts**

3.1 Telephone discussions with the GP by the IO of the Serious Incident investigation confirmed that Mr Smith had not been seen at the surgery since July 2018 but had had regular medication reviews. Whilst he was known to the surgery no concerns were raised by them. The GP was in receipt of the discharge summary from the hospital. They were also advised that due to non-attendance Mr Smith had been removed from the ophthalmic clinic list. The GP was also telephoned on 11th September 2018 by the nurse who was unable to gain entry on a planned home visit.

3.2 A historical entry on the Smith Safeguarding Enquiry Chronology and Report 11th June 2019, notes that in 2014 Mr Smith had contacted adult social care

as he felt the need for support. When social services tried to contact him, they experienced difficulty in doing so and contacted the GP. The GP agreed to follow up with a letter as they also had been unable to contact Mr Smith, the content and outcome is unknown.

3.3 Mr Smith did not receive any care and support from social services and it is not known if he was assessed, although under the Care Act 2014 he would have been eligible. In 2014 he was admitted to hospital following a fall. It is not known if he was referred, assessed or spoken to about support at home.

Multi-Disciplinary Team

3.4 The Multi-Disciplinary Team on Japonica ward consists of consultant, doctors, ward manager, nursing staff, occupational therapy (OT) and physiotherapy. Patients are discussed on regular ward rounds. The decision was taken by the Consultant that Mr Smith could return home as he was medically fit, and it should be noted that Mr Smith was eager to do so.

3.5 The Safeguarding chronology based on NELFT chronology and Liquid Logic (social services database) leading up to Mr Smith's death states for 10th September 2018, ***"Seen by ward consultant, continue rehabilitation, TTA medication given, District Nurse referral made Patient discharge home"***

3.6 As Mr Smith was adamant that he did not want to accept further rehabilitation, it is unclear what "continue rehabilitation" refers to.

3.7 The physiotherapist had some intervention in respect of Mr Smith's mobility and considered by 30th August 2018 that he was, ***"making good progress, as reached baseline and functional ability."*** (Safeguarding Chronology)

3.8 The therapy review by Japonica ward occupational therapist included a kitchen assessment and consent was gained for a telecare referral for a care line alarm. He was observed to be stable, alert and orientated. A package of care was suggested through further reablement upon his provisional discharge on 4th September. There is also a suggestion that a planned home visit should take place on 7th September. In the event this did not happen.

3.9 The ward OT repeatedly outlined the risks Mr Smith may face if he were to have a further fall without the means of summoning help with no way of raising an alarm. Mr Smith however was insistent that the alarm was to be fitted only when he returned home. It is not known if these risks were discussed with the Consultant or with colleagues in a multi-disciplinary ward meeting.

3.10 On 6th September, ***"Patient A again declined re-enablement, declined waiting for Telecare pendent alarm to be installed prior to discharge***

home and he declined allowing Japonica ward staff contacting his family regarding his discharge home. Patient A said he had contacted a family member, not his sister as she was ill, and was waiting to hear from that family member." (Serious Incident Root Cause Analysis)

3.11 Mr Smith's sister told the IO of the Serious Incident investigation that her brother had contacted her to ask for clothes and said that he wanted to return home. He also said that he would refuse to return to the hospital if he were taken on the proposed home visit, which may have influenced the decision not to proceed with the plan if Japonica ward staff had known this at the time.

3.12 Japonica Ward staff use a London Borough of Barking & Dagenham local authority equipment order form titled 'Telecare Referral and Assessment Form' to request provision and funding of a pendant alarm. On 4th September 2018 a referral for the community alarm was sent from Japonica Ward.

3.13 The reasons for referral stated, ***"Patient had a fall and was on the floor for four days. Increased Risk of fall (secondary to macular degeneration and cervical myelopathy)"*** The form noted that the need for the alarm was high which meant that installation should be within 2 working days. ***"Patient is independently transferring and walking up to short distances with SO1, but as per previous history patient had a fall and long lie for 4 days and then he developed an AKI, Rhabdomylosis, Hypernatremia and hypocalcaemia and patient was not able to get up himself and was unable to contact in an emergency situation."***

3.14 According to the Careline manager, the initial referral from the OT was categorised as non-urgent by Careline, although it was marked high priority by the OT. The Careline manager in their signed witness statement to the Coroner's Court said, no reason for the urgency had been given within the associated email as would be expected by Telecare.

3.15 The form itself however was ticked 'high' under urgency and an explanation given about his medical condition and the fact that "***he had a fall and a long lie for 4 days ….. was not able to get up himself and was unable to contact in an emergency situation."***

3.16 "***PROPERTY (access, location of telephone line, position of key safe)". In the box adjacent to this question the occupational therapist (OT) wrote "yes". The OT doesn't comment specifically on the existence of a landline telephone in the property. Further in the form is another subsection titled Telecare Required. Here the OT requested a GSM Unit as mandatory."*** (Addendum Report written in response to the Coroner s28 request)

3.17 Information printed on the Telecare Form states***, "THE FOLLOWING INFORMATION SHOULD BE LEFT WITH THE SERVICE USER AS IT IS A REQUIREMENT UNDER TSA. If there is no landline telephone available a GSM Alarm Unit will need to be requested.***

Please note it is the responsibility of the Client (or NOK) to purchase and maintain the SIM card to be used within the alarm unit. They need to ensure it is 'topped up' regularly if it is a pay as you go SIM or payments are kept up to date if it is a SIM only monthly contract. Sufficient Network Coverage from the provider is essential within their property. The Monitoring Centre will not take responsibility for failed alarm activations due to insufficient funds or poor network coverage from the SIM card."

3.18 There is also a list of Questions and Answers regarding the service including questions the client may have for their provider.

3.19 The signed witness statement of the Careline Manager to the Coroner Court dated 21st June 2019 provides a helpful chronology of the action taken by officers to arrange a community alarm. Contact was made direct to Mr Smith by Careline to his landline and mobile on 5th and 6th September 2018. (Mr Smith was still on Japonica ward at this time) and there was no response. However, Mr Smith informed the occupational therapist that he had received a call on his mobile on 6th September according to the Serious Incident Root Cause Analysis report.

3.20 Further calls were made to Mr Smith by Careline on the 17th September 2018, initially with no response, and to Mr Smith's sister, who agreed to pass a message to Mr Smith to ask him to contact the service.

3.21 On 18th September 2018, a Careline officer attended Mr Smith's property and found the following difficulties:

- There was no suitable landline.
- Mr Smith was unable to wear a pendant due to the pains in his neck.
- A compatible SIM card was unavailable for Mr Smith's mobile.
- There was no keysafe, considered essential to speed access to Mr Smith in an emergency.

3.22 This led to a series of emails between LB from Careline, VJ from NELFT based on Japonica ward and JH Project Manager Major Adaptations Workflow Organiser.

Date	From	To	Issue
Sept 18th	Careline	Local Authority	Request for keysafe
Sept 18th	Careline	Adaptions Workflow Organiser JH	Need for GMS Unit and reassessment

Sept 18th	Workflow Organiser	Careline JB	GMS Reassessment Request
Sept 20th	NELFT VJ	LB direct cc JH	Information needed how to complete GMS assessment
Sept 27th	Careline LB	NELFT VJ	Advising how to complete GMS assessment
October 5th	NELFT VJ	JH cc LB	Completed GMS assessment form
October 5th	JH	Careline inbox	Request for installation paperwork sent

3.23 The witness statement highlights that the 20th September 2018 email from NELFT was sent direct to LB rather than a Careline inbox. LB was on leave from 20th September 2018 until 27th September 2018.

3.24 It is not known if VJ received an out of office response or if JH copied into the email made a response.

3.25 The Coroner's Report led to a Section 28 request to North East London Foundation Trust (NELFT), **"*During the course of the inquest the evidence revealed a matter giving rise for concern. In my opinion there is a concern that future deaths will occur unless action is taken."***

3.26 It should be noted that in response to the Section 28 NELFT drew up and implemented an Action Plan which was completed prior to this Review.

3.27 Specifically, the Coroner wrote, *"**The MATTER OF CONCERN is the evidence heard around the training provided to occupational therapists in relation to the emergency equipment available from Telecare. It is requested that the training for occupational therapists is reviewed to consider:***

i. The emergency Alarm Equipment available
ii. The order process required for such equipment
iii. The compatibility between the alarm system and the telephone system within the home setting.

It is noted that technology changes frequently and therefore it is requested that a form of refresher training is also considered."

3.28 The Japonica ward OT had the most consistent input with Mr Smith whilst on the ward. He also escorted Mr Smith home on 10th September 2018 as the access visit was cancelled and there was some concern about how Mr Smith would cope in his home environment. Mr Smith was adamant that he could cope whilst his sister was concerned that this was not the case.

3.29 ***"Patient A's sister told the IO that she spoke with the OT on Japonica Ward and explained that in her view patient A was unable to prepare food or look after himself properly because of poor mobility and wasn't ready to go home alone."*** Final Root Cause Analysis. This may or may not have been an opportunity to discuss the telecare referral with the family and perhaps gain further information.

3.30 The witness statement from the Careline manager was not in dispute and the Japonica ward OT was frank about their lack of knowledge in relation to the assessment for a GMS unit.

3.31 There were a number of missed opportunities to check whether or not Mr Smith had a viable landline to install Telecare. First, when the OT first broached the matter of an alarm to Mr Smith. If the OT had had a good understanding and workable knowledge checks might have been made about his provider and simple questioning of whether it was in working order. The OT would also be able to provide detailed information about the process and alternatives, giving Mr Smith a better informed choice in his decision making.

3.32 At the February 2019 interview with the sister, the IO of the Serious Incident investigation, ***"found no evidence that the presence of a landline was checked prior to the alarm being ordered but patient A's sister told the IO at interview that patient A hadn't had a landline phone. Whether patient A's mobile phone SIM was set up to accommodate the Telecare pendent alarm isn't known by the IO."*** Serious Incident Root Cause Analysis

3.33 There was opportunity on the 10th September 2018 to check that there was a working landline, when the OT assessed Mr in his home environment.

3.34 It is unlikely that he would be willing to return to the hospital on the 10th September 2018 once he was discharged. Even if the OT had learnt that there was no working landline it would not have been administratively easy for patients to return to wards once discharged. The advice from Careline however might have been sought sooner.

3.35 There were <u>no follow up conversations</u> between the Japonica OT, Careline or CHSCS. There was however, an opportunity for other staff to raise questions direct with Mr Smith and between CHSCS and Careline and/or community occupational therapy.

3.36 In the first instance on 6th September 2018, ***"Patient A told the OT that he had received a call on his mobile phone from Telecare regarding his pendent alarm referral however he wanted Telecare to assess him once***

he had got home." (Serious Incident Root Cause Analysis.) This is recorded on the Electronic Patient Record.

3.37 It may not be routine to ask or double check that there is a viable landline but it is an opportunity to do so.

3.38 On 12th September 2018 CHSCS documented that Mr Smith was waiting for a pendant alarm but no further enquiry was made about delivery time or why it was needed. The referral to CHSCS had not highlighted the risk of falls, and a falls assessment had not been undertaken by CHSCS, therefore the urgency was not appreciated.

3.39 It is documented that on the 18th September 2018 on a visit by CHSCS, Mr Smith reported that he was waiting for "British Telecom" to install his alarm. The continued delay was therefore known to CHSCS.

3.40 The Addendum Report findings note that, ***"Mr Smith's sister recounted during interview with the IO that she spoke with a Telecare engineer who told her that they couldn't install the alarm unit ordered because of the absence of a land line. According to the patient's sister the Telecare engineer did suggest an alternative however explained that funding had to be approved for a new unit. However, as outlined above, the OT had requested a GSM Unit which is, according to documentation attached to the Telecare Referral and Assessment Form, compatible with a mobile phone as long as the mobile phone has a SIM card. Patient A did have a working mobile phone so the reason the engineer was unable to install the GSM Unit is unclear."***

3.41 The NELFT Addendum Report concludes, "***The NELFT Discharge Policy outlines that staff must record a summary of the care and treatment provided and include an up to date risk assessment. Details of other care providers should also be forwarded. As outlined in the original report, when Japonica Ward sent the referral to the CHSCS team they didn't outline the fall risk and actions taken on the ward so there was nothing to alert CHSCS staff to the degree of risk. If CHSCS staff had known, it is possible they would have considered following up the order for the pendent alarm."***

3.42 The Coroner questioned training for occupational therapists, it may be prudent for a wider group of professionals, to have at the minimum, awareness about process and timescales, risks and benefits of telecare equipment.

3.43 Mr Smith was at high risk of falls. He was also at risk of a breakdown to his skin integrity, an associated factor to consider in the risk management planning of falls. The referral to CHSCS was the main mitigation plan to monitor his pressure ulcers which still required wound dressings.

Pressure Ulcer Management

3.44 "***The referral specified the need for category 3 and 4 pressure ulcer wound care however whilst a fall was recorded in the "Medical History" section it was not ticked as a "main problem/current diagnosis". No reference to or detail of the severity of the fall resulting in hospital admission was made or given****."* Serious Incident Root Cause Analysis, 2019.

3.45 The Serious Incident Root Cause Analysis Report, confirms that pressure ulcer assessments were carried out on the ward and when Mr Smith returned home. Care plans were drawn up and the care plan reviewed when he returned home by CHSCS.

3.46 Upon receiving the referral, the CHSCS contacted the ward about a pressure relieving mattress and cushion, requesting that Mr Smith remain on the ward until it was in situ. Unfortunately, Mr Smith had already been discharged. No satisfactory explanation was provided about why Mr Smith was discharged prior to the equipment being in place, despite the referral to CHSCS focussed on the management of his pressure ulcers and the risk levels identified to Mr Smith's skin integrity.

3.47 The CHSCS ordered a profiling hospital bed, an air mattress and cushion, bed rails and bumper. The CHSCS did take proactive steps in trying to reduce risks to Mr Smith of his pressure ulcers worsening by following this request up. At the time of his death the equipment was still not in place.

3.48 It was quickly identified by CHSCS that pressure relieving equipment was essential to Mr Smith for his pressure ulcer management and pain control. Like the pendant alarm, the delay was known to CHSCS.

3.49 The first visit by CHSCS on the 11th September 2018, Mr Smith did not answer his phone or the door. Following good practice, the trainee nurse associate who visited called the GP, Japonica Ward and the family.

3.50 The sister told the IO of the Serious Incident investigation that she [the sister] advised the nurse in their telephone call of her brother's recent fall and resulting injuries which led to his hospital admission and period of rehabilitation. Nobody knew where Mr Smith was at this time.

3.51 What is not known is whether the family information was recorded and the sister's concerns about Mr Smith not eating properly and looking after himself. It is known that Mr Smith was safely visited the next day and that there was no

escalation to a concern of no response on the 11th September 2018 as the CHSCS management were not informed.

Falls

3.52 ***"Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year."*** Falls in older people: assessing risk and prevention NICE (2013)

3.53 Mr Smith had a history of falls, known to his GP, hospital staff and family. ***"Patient A did have a fall in 2014 resulting in hospital admission and according to the discharge summary sent to Japonica Ward. Patient A had fallen between four to five times in a period of a few months leading up to the fall resulting in hospital admission on the 19.07.18."***

3.54 Two falls risk assessments were completed on Japonica ward. One by the Occupational Therapist, 'Therapy Initial Assessment Form' on the 28th August 2018, and one by a member of the nursing staff, 'Falls Assessment Risk Assessment' on 9th September 2018.

3.55 Both these assessments should be recorded on the NHS Electronic Patient Record (EPR) system available to all NHS staff with log in credentials.

3.56 Information about Mr Smith's recent fall had not been highlighted in the referral to CHSCS however, ***"older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s."*** NICE (2004) updated 2013

3.57 The initial assessment carried out by CHSCS should have included a falls assessment as per the NICE guidance and Barking & Dagenham's own Slips, Trips and Falls policy as outlined in the Final Root Cause Analysis Report. At the very least Mr Smith should have been asked about his medical history, and it is unlikely that he would not have shared the reason for his admission to hospital.

4. Findings & Analysis

4.1 Areas of good practice included, respecting the views of Mr Smith and acknowledging his right to make his own decisions. This however must be tempered with not being totally reliant upon mental capacity to provide adults with the right to make unwise decisions creating risks to their wellbeing.

Mental Capacity

4.2 Much was made about the fact that Mr Smith had mental capacity to make decisions. This was based on the Abbreviated Mini Mental State assessment carried out by a nurse on Japonica ward consisting of six questions. Mr Smith achieved the highest score 6/6. Whilst this test is easy to use and has been a valued tool since 1972 in screening for dementia, it is not a substitute for a mental capacity assessment under the Mental Capacity Act 2005 and should not be used to determine mental capacity on specific issues.

4.3 The Japonica ward OT and nursing staff all considered that Mr Smith had the mental capacity to make his own decisions but was also putting himself at risk. Where practice may be questionable is the lack of a robust risk management plan. Identifying the risk is insufficient and professionals had a duty to not only identify but implement a positive risk management plan on Mr Smith's risk of falls and not being able to summon help and weigh this up with his decision making.

4.4 Mental Capacity Assessments must take into account the 5 principles of the Mental Capacity Act 2005. Principle 2 states that every effort must be taken to encourage and support the person to make the decision for themselves. The Social Care Institute for Excellence (SCIE) has put forward questions that practitioners might find helpful to check:

- **Does the individual have all the relevant information needed to make the decision?**
- If there is a choice of options, has information been provided on the alternatives?
- Have the communication needs of the individual been taken into account? The needs to be presented in a way that is easier for them to understand.
- Have different communication methods been explored, including obtaining professional or carer support?
- **Consider the risks and benefits, including describing the consequences of making a decision, and making no decision.**

4.5 Good practice was shown in treating Mr Smith with dignity and respect. This included not sharing information without his consent. Additionally, principles of the Mental Capacity Act 2005 were implemented by not assuming that he did not have capacity.

4.6 The overview writer of this report, would advocate for further training to build on the work already carried out by the Clinical Commissioning Group on some of the more complex issues. ***"The key challenge for practitioners is to balance decisions about thresholds of risk (professional view) and of capacity with human rights considerations (adult's rights to choose and control). In overcoming this challenge, it is crucial to take into account an individual's assessment of their own risk; the rationale centred approach to risk, positive risk-taking aims to enable people to weigh up***

the risks and benefits of different options." (Safety Matters Third Edition, RiPfA, 2019)

4.7 Professionals failed to explore further, although they were concerned about Mr Smith's decision which they viewed as unwise. **Professional curiosity** is the capacity and communication skills to explore and understand what is happening rather than making assumptions or accepting things at face value, which is what professionals in this case did by basing their actions on the outcome of the abbreviated mini mental state assessment alone.

4.8 In this case Mr Smith presented as knowing what he wanted and did not want and being in control. This led to professionals to making the incorrect assumption that he was capable of managing his situation and did not require support.

4.9 Suzy Braye, David Orr, Michael Preston-Shoot, Self-neglect and adult safeguarding: findings from research Final Report to the Department of Health 2011 state, **"The perceptions of people who neglect themselves have been less extensively researched, but where they have, emerging themes are pride in self-sufficiency, connectedness to place and possessions and behaviour that attempts to preserve continuity of identity and control. Traumatic histories and life-changing effects are also present in individuals' own accounts of their situation."**

4.10 Whilst the impression of Mr Smith's behaviour across the reports used in this SAR might indicate some similar characteristics to the above, there was never any exploration of the motivation behind Mr Smith's decisions.

4.11 Why Mr Smith repeatedly refused help/services that could reasonably be expected to safeguard him is unknown. The Care & Support Guidance – "***Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult safeguarding enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected."***

Consent

4.12 As a regulated provider accountable to the Care Quality Commission (CQC) hospitals must abide by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for Consent, states, ***"When a person is asked for their consent, information about the proposed care and treatment must be provided in a way that they can understand. This should include information about the risks, complications and any alternatives. A person with the necessary knowledge and understanding***

of the care and treatment should provide this information so that they can answer any questions about it to help the person consent to it."

4.13 The recommendations from the Coroner focussed on training for occupational therapists. In this case, the occupational therapist did not have the knowledge and understanding about telecare processes and procedures and therefore was not best placed to discuss the options available.

4.14 The occupational therapist accompanied Mr Smith on his discharge which is not the usual procedure. This was good practice in the absence of being able to make a pre-discharge home visit with Mr Smith to see how he would manage. It was only at this point that the lack of a landline telephone was confirmed.

4.15 Confusingly the original referral did note that a GMS Unit was required but not picked up by Careline or the local authority. The impact of this missed information was not realised by the occupational therapist.

Risk Management

4.16 The CQC Regulation 17 states:

"***Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service***

- ***Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.***
- ***Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.***
- ***Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate***
- ***Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased."***

4.17 Mr Smith may have appeared challenging and professionals were concerned about what they viewed as an unwise choice but did not escalate into an issue to discuss at a multi-disciplinary meeting.

4.18 Failure to draw up a risk assessment and management plan resulted in a missed opportunity for practitioners and people to discuss risk <u>together</u>, (in

this case returning home without means of raising help) and how to mitigate or work with it.

4.19 The Serious Incident Root Cause Analysis report notes***, "When Patient A made the decision to leave Japonica Ward the High-Level Risk Reporting Protocol (HLRR) could have been considered. This would have prompted a discussion within the multi-disciplinary Team (MDT), an updated risk assessment to be written and shared and then if still necessary then the completion of a High-Level Risk Report. The reason a HLLR wasn't written isn't known but a lack of appreciation for the severity of risk might by a contributing factor in a lack of action and reporting.***"

4.20 A positive approach to risk enablement in partnership with the person, should be used whenever possible. However, sometimes when there are high levels of risk, formal structures can be helpful in resolving issues and facilitating multiagency working

4.21 Unfortunately, in this case, despite the fact that there was a multi-disciplinary team on Japonica ward, each profession appeared to stick to their particular specialism and a task centred approach dominated.

4.22 This was replicated once Mr Smith was discharged and the community nursing team focussed on wound care and did not look at other risks, rather they took the reason for referral – wound care as their only reason for working with Mr Smith.

4.23 The Serious Incident Root Cause Analysis documented that the management of Mr Smith's pressure ulcers was overall good (although there was concern noted when one of his pressure ulcers deteriorated). This was despite the lack of urgency that Japonica ward had given to ensuring that Mr Smith had pressure relieving equipment at home.

4.24 The CHSCS nurse accepting the referral made a positive stance to request that the patient remain in hospital until the equipment was in situ. What is unclear is why this was not followed up with community OT services who CHSCS would have had relatively easy access to.

4.25 The IO reports that bed rails were also ordered for Mr Smith, although Mr Smith had not been assessed for these on Japonica ward and the CHSCS nurse had not seen Mr Smith. This begs the question why they were thought appropriate?

4.26 Mr Smith received acute and rehabilitation services to improve his mobility whilst he was an inpatient. He was reviewed by both physiotherapy and occupational therapy but it is not clear how the two liaised, if there were any joint plans, or if they discussed assessments and outcomes.

4.27 When he was at home, all mobility rehabilitation ceased, albeit at the request of Mr Smith. The CHSCS acknowledge that in this case, Mr Smith did not receive a falls assessment and that this had further adverse contributory consequences for his wellbeing and safety. The identified falls risk should have been highlighted and may have prompted discussion and action in relation to the telecare equipment referral.

4.28 Preventing falls in older people overview NICE Pathways (2019) stress that, "**Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s."**

4.29 If Mr Smith was asked, he would likely have been offered a multifactorial assessment which includes:

- identification of falls history
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence.

4.30 Although the referral to the CHSCS had falls ticked in the medical history it was not highlighted as the main reason for the referral. This however should not have stopped the CHSCS from undertaking the falls assessment as per the NICE guidance or reviewing his Electronic Patient Record. The CHSCS continued the pattern of delivering care in a task focussed way.

4.31 Some members of staff had followed good practice when they did not receive a response from Mr Smith. They contacted neighbours to ascertain if he had been seen and his usual pattern of behaviour, they contacted his GP and his next of kin. On the day that Mr Smith deceased the ICA had taken steps to look through his door and taken prompt action to get to him. These members of staff made every effort to locate Mr Smith.

4.32 Unfortunately, some members of staff were not so diligent and failed to report that they did not receive a response. Regardless of whether or not they had access to particular technology at the very least they should have alerted their manager or team through a phone call.

Multi-agency working

4.33 Respecting the expertise that different agencies and professions bring, and showing a willingness to work holistically by placing the adult at the centre of all decision making so that there is a one team approach, supports the principles of partnership and accountability.

4.34 Good multi-agency working has consistently been identified in Serious Case Reviews and Safeguarding Adults Reviews as needing improvement. The need for effective multi-agency working and information sharing in order to secure improved outcomes is clearly stated in a number of reviews, policy documentation and statutory guidance.

4.35 The NELFT Discharge Policy states, ***"Clinical staff should engage with and communicate effectively and timely with others involved in the discharge process. This will include Trust staff, staff from other agencies i.e. social care or NHS bodies, patients, and their family and/or carers where feasible and with the patient's consent."***

4.36 ***"Recognising that every local area will face differing multi-agency challenges and that the safeguarding threats and issues will vary across areas this report does not endorse any particular model to deliver effective multi-agency approaches. Whilst certain factors (for example co-location) are cited as key success factors by many areas, Government is clear that good practice can take many forms and many effective areas will seek their own innovative solutions to overcoming any barriers identified to successful multi-agency working."*** Multi-agency working and Information Sharing Project Final Report, 2015 Home Office

4.37 All NHS Providers have the mechanisms in place to support good multi-agency working to support the safeguarding process by ways of appropriate information sharing and attendance at pertinent meetings.

4.38 Agencies that work with vulnerable adults play a significant role when it comes to safeguarding. To achieve the best possible outcomes people should receive targeted services that meet their needs in a co-ordinated way. There is a shared responsibility between organisations and agencies to safeguard and promote the welfare of vulnerable adults.

4.39 The Safeguarding Adult Board annual report (2018) notes that ***"NELFT continues to prioritise partnership working at both strategic and operational levels and ensure significant contribution to safeguarding learning and development within the multi-agency of London Borough Barking & Dagenham. The NELFT safeguarding team meets regularly with the designated safeguarding professionals at the CCG and to review the safeguarding strategy, safeguarding risks and review any learning and action plans from SAR/DHR/SCRs."***

Information sharing

4.40 Sharing the right information, at the right time with the right people, is fundamental to good safeguarding practice. Everyone working to safeguard

adults should view the use and safe sharing of information as part of their responsibility. Practitioners must think through these issues and make themselves familiar with any local information sharing protocols that sets out the principles for sharing information in the best interests of the person who is receiving services.

4.41 The Barking & Dagenham Safeguarding Adult Board have produced a 'Data Sharing Agreement' for the purposes of safeguarding adults at risk within the London Borough of Barking & Dagenham. There was no other information sharing easy access guidance for practitioners.

4.42 In this case concern about information sharing was not about information governance but on the fact that information was not always clear or shared in a timely manner. The referrals made to CHSCS and to Careline were made on the day of discharge in the first instance and a few days prior to the proposed day of discharge.

4.43 The telecare referral involved a number of agencies, each responsible for different parts of the process. The current arrangements are subject to review by the London Borough of Barking & Dagenham. As a key objective of that review it would be helpful if there was consideration to streamlining the system.

Family Involvement

4.44 This SAR notes that carers were not fully involved in discharge planning. It is ambiguous about how involved Mr Smith wanted his sister to be. On the one hand he willingly gave her phone number so she might be contacted, and he discussed his discharge arrangements with her. On the other hand, he told hospital staff that he did not want her to be contacted for clothes as she was ill.

4.45 An advocate might have been considered if (a) Mr Smith's mental capacity was in doubt and it was appropriate to provide an Independent Mental Capacity Advocate (IMCA) or (b) there was a safeguarding enquiry and s68 Care Act 2014 was appropriate to support the sister with a suitably experienced advocate. Neither of these options was a statutory obligation in this instance, but there may be a gap in ensuring that vulnerable people and their families are supported in decision making. In the event the family were not listened to or part of any discharge planning arrangements.

4.46 The sister voiced her concerns directly to the OT, although it is not known if she discussed them with nursing staff or doctors. Her main concern was Mr Smith's nutritional needs and weight loss and how he would be able to get more Fortisip. (Fortisip Compact is a nutritionally complete, high energy (2.4kcal/ml), ready to drink, milkshake style nutritional supplement, for the

dietary management of disease related malnutrition). The impression however from the limited information available is that she was afraid Mr Smith would not cope and experience further falls. The link between adequate nutrition and falls prevention has been identified by a number of scholarly publications by dieticians yet there were no details of a dietician assessment and ongoing advice.

4.47 Mr Smith allowed his sister to have contact with Careline but she was not considered a partner for discharge planning. Professionals were not clear about boundaries, and also not clear about the nature and length of the reablement service with the family. Once Mr Smith was discharged from Japonica it is unclear if the sister knew who to contact should she require any ongoing support for her brother and appeared to be abandoned by services.

4.48 In this case, the discharge was originally planned for Friday 7th as Mr Smith had voiced his views about not wanting an access visit. It was good that this was delayed until the Monday when services are more likely to be available and there is more likely to be more staff on duty.

Learning from incidents

4.49 Good practice following the death of Mr Smith by reviewing actions and taking lessons learnt forward is documented in the Serious Incident Analysis Report.

4.50 The Serious Incident Framework can be used to satisfy s42 Care Act 2014 safeguarding enquiry requirements and support the outcomes people want. Involvement and support for the person and/or their family is embedded in the Serious Incident Framework and supports Making Safeguarding Personal and may provide some opportunity for adults and their families to identify where lessons might be learnt from their experience.

4.51 In this case, the Serious Incident investigation took account of family and their views and time was spent in a positive way to support them. Staff also attended a debriefing session.

4.52 The report is of good quality and evidences a commitment to the **'Duty of Candour'**. The addendum to the main report is thorough in its investigation of further questions raised by the Coroner.

5. Conclusions

5.1 The NELFT Discharge Policy (2016) offers practice guidance key messages about discharge planning:

- ***Patients and Carers must be fully involved in discharge planning***

- ***Discharge planning should be a key component of any treatment/care plan***
- ***Onward referrals should happen in a timely manner***
- ***Information sharing needs to be robust.***

5.2 Although there were some areas of good practice there were also some areas where the practice was more questionable. Mr Smith was involved in his discharge planning, but it is debatable about whether or not he had the full information to make informed decisions.

5.3 The discharge was not coordinated. The tone was set on Japonica ward when not embracing a one team approach and by their failure to have a full multi-agency high level meeting about the risk to Mr Smith returning home without the Telecare equipment in place.

5.4 The referrals for Mr Smith did not happen in a timely manner and the key risks, falls and not being able to summon help in an emergency were not given precedence.

5.5 In this case, there were some serious shortcomings in discharge planning, risk management, multi-agency working and information sharing. These areas were all avoidable as the policies and procedures were available to a lesser or greater extent, but not implemented or audited for consistency.

5.6 The art of negotiation and communication with people needs to be person centred and strength based, utilising personal and community networks that are culturally acceptable to the individual. There was no evidence that any continued offer of help or monitoring of his abilities to manage without additional support.

5.7 Because an adult initially refuses the offer of assistance he or she should not be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that they can take up the offer of assistance at any time.

5.8 The fact that Mr Smith fell was to some extent unavoidable. Mr Smith would probably have benefitted from further rehabilitation to improve his mobility within the home but was unwilling to accept this. A falls assessment should have been carried out once he returned home that built on the work already carried out on the ward.

5.9 Finally, working with families and patients to manage risk was missed in this case. The family as willing participants were not considered within partnership arrangements by any agency, they were viewed only as an alternative or emergency contact.

6. Recommendations

6.1 The Serious Incident Root Cause Analysis Report and addendum following the Coroner request for a Section 28 report has detailed recommendations which the Overview Writer is in agreement with. It was reported at the SAR

Committee meeting on 17th February 2020 that all actions developed from the above reports are complete.

6.2 Braye S (2015) in an analysis of forty SAR's involving adults who self-neglect, extracted learning that can be applied in developing notions of good self-neglect practice, which might helpfully be applied to people who are high risk, refuse services and support, and make continuous unwise choices as in this case. Key challenges fell into four domains: the themes within these categories are extrapolated below and provide a framework for prevention work in safeguarding people similar to Mr Smith.

Who	**Actions**
Practice by the individual	Person-centred approaches to intervention Assessment of mental capacity Consideration of the individual's family and carers Securing or maintaining engagement History and patterns of behaviour
The professional team	Interagency communication and collaboration Information-sharing Assessment, care planning, monitoring and review processes Recording of information Safeguarding literacy
Organisations	Supervision and management Organisational culture Staffing Organisational policies
Interagency governance exercised through the SAB	The process and function of SARs Monitoring and action planning Interagency procedures and guidance Training

SAR Recommendations

1. Develop strategic plans to strengthen integration across agencies where mental capacity and risk assessments can be built into mental capacity training using evidence and intelligence from SARs, Serious Incidents and near misses.

2. Where an individual has the mental capacity to make decisions, yet there is an identified risk to safety, health and wellbeing implement a multi-agency approach to risk management planning to mitigate or reduce the risk in consultation with the individual and/or advocate ensuring contingency planning and escalation.

3. Review how safeguarding and safety is incorporated into discharge planning across multi-agency partnerships to include:

    - risk
    - mental capacity
    - emotional and mental wellbeing
    - health and functional ability
    - attitudinal constraints (personality, culture)
    - family and community involvement
    - telecare systems
    - equipment
    - referrals and contingency plans.

4. Ensure that all healthcare professionals implement the NICE guidance in relation to falls and older people and that there is quality assurance on compliance.

5. All ward and discharge planning staff to have at minimum a basic awareness of procedures and lead in times for Telecare systems and equipment.

6. The SAR Committee to develop targeted learning and dissemination.

References

3.52 Falls in older people: assessing risk and prevention NICE (2013)

3.56 NICE (2004) updated 2013

4.2 Hodkinson Abbreviated Mini Mental State (1972)

4.4 Mental Capacity the Social Care Institute for Excellence www.scie.org.uk

4.6 L Pike, P Skowron, L Stanforth, J Sutton, Safety Matters: Practitioners Handbook-Revised Third Edition 2019

4.9 Suzy Braye, David Orr, Michael Preston-Shoot, Self-neglect and adult safeguarding: findings from research Final Report to the Department of Health 2011

4.12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for Consent Care Quality Commission

4.16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 16: Risk Management Care Quality Commission

4.16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17: Good Governance Care Quality Commission

4.28 Preventing Falls in Older People Overview NICE Pathways (2019)

4.36 Multi-agency working and Information Sharing Project Final Report (2015) Home Office

4.39 Barking and Dagenham Safeguarding Adult Board Annual Report 2018

4.52 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 20: Duty of Candour Care Quality Commission

5.1 The NELFT Discharge Policy (2016)

6.2 Braye S, Serious case review findings on the challenges of self-neglect: indicators for good practice. The Journal of Adult Protection, 17(2)