Barking and Dagenham Safeguarding Adults Board

WILLIAM

A Safeguarding Adults Review (SAR)

Author: Karen Rees

Presented to Barking and Dagenham Safeguarding Adults Board (BDSAB) 30 NOVEMBER 2022

CONTENTS

1. INTRODUCTION

1.1. The Terms of reference for this Safeguarding Adults Review (see appendix 1) indicate the circumstances that led to the review. In summary and with additional information gathered, William was a 68-year-old white British male who had not come to the attention of services until just prior to the timeframe for this review. During the timeframe, he had multiple hospital admissions for various reasons. On the first admission a safeguarding referral was made due to apparent self-neglect. In the six-month timeframe, he spent his longest period at home in month five and six (see appendix 2). On his sixth admission a safeguarding alert was raised due to two necrotic ungradable pressure ulcers to his right foot and heel in addition to two category 3 and one category 4 pressure ulcers on his sacrum and buttocks[1]. William subsequently died in hospital. The cause of death was sepsis and septic shock. It is not known whether it was the urinary tract infection or the pressure ulcers that were the primary cause of the sepsis.

2. PROCESS, SCOPE, AND REVIEWER FOR THE SAR

2.1. The Terms of Reference, scope and methodology for the SAR can be found in Appendix 1. The review set out to cover a six-month period prior to the death of William, being the time that concerns were being raised and services were trying to engage him. BDSAB commissioned an independent reviewer to chair and author this SAR[2].

3. FAMILY INVOLVEMENT IN THE REVIEW

3.1. A key part of undertaking a SAR is to ensure that families are integral to the review process. Families can provide views and insights that professionals may not have. A more complete picture of the person, their life and culture are often available from families who can provide a unique perspective. BDSAB wrote to William's family member who had been the main point of contact to inform them of the review and tried on many occasions to make contact. This was followed up by a letter from the author expressing the benefits to the review of seeking their views; a reply was not received. The review therefore has been undertaken with no family involvement which may limit some of the learning and only presents agency and service views. Factual accuracy regarding the background has not been supported by a conversation with family and is therefore based on what agencies have recorded in their records.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. At the start of the learning and reflection workshop for this review (see appendix 1), practitioners were asked about what they knew of William prior to the time that they worked with him. There was little known; professionals understood that he was a divorced man who had four children who he had brought up by himself following his divorce. It was thought that he had alcohol issues historically. It was confirmed by the GP practice that problem drinking was recorded on his GP record 10 months prior to

[1] All pressure ulcers should be graded using the European Pressure Ulcer Advisory Panel Classification System (EPUAP 2009). https://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf

[2] Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of BDSAB and its partner agencies.

the review period. It is also recorded by the GP that William had alcohol dependency syndrome but had stopped drinking following a period of support and treatment. Professionals did not note any problem drinking during the timeframe of the review. Information recorded suggested that as well as type 2 diabetes that William also had some cardiovascular related illnesses, epilepsy and was a person who smoked. William is also recorded as having retinopathy, but it is not recorded what his visual acuity was in relation to this.

4.2. It was noted by professionals, that the family member who was a carer for William, tended to do a lot of the communication and that information forthcoming from William was limited; he usually referred to the family member for information. It was identified that during an assessment by the psychiatric liaison team whilst William was in hospital that William had 13 grandchildren and that those and his children were his motivation to get better.

4.3. It was understood that prior to the first referral to the District Nurses, that William was self-caring and managing his own diabetes, self-administering his insulin and managing diet accordingly. It is recorded by professionals that William was unable to read or write. There is nothing else recorded about William's background life or working; without the involvement of family in this review, it has not proven possible to understand any more about William.

5. TIMELINE OF WILLIAM'S HOSPITAL ADMISSIONS DURING THE REVIEW PERIOD

5.1. For ease of reference, William's hospital admissions and discharges of various lengths of time are displayed graphically in Appendix 2. The learning and review workshop with professionals focussed thinking on William's various hospital admissions and time spent at home. From there it was possible to discern where areas of learning were found that then informed the analysis.

5.2. The following table therefore identifies those admissions, time receiving care at home and key issues only, that occurred during those times. These key issues will inform the analysis in section 6 that lead to learning.

Admission/home	Source/reason	Key events	Discharge arrangements
Admission 1- 30 days (12th Month 1 of timeframe)	Ambulance- possible Sepsis/diabetic ketoacidosis/Covid 19	Ambulance crew concerned regarding property. Emergency department doctor states very, very unkempt' and 'covered in faeces and urine' 'historic non-compliance with social services and health.' Noted family member supporting laundry and groceries. Redness to sacrum but intact. Low mood, referred to psychiatric liaison. Recorded as having capacity. Various levels of compliance with treatments, tests and care.	William keen to go home. Following assessment recommended package of care four times a day. Mental Health follow up in community.
Home- 8 days (12th month 2)	Fit for discharge	Care Agency 1 visited four times a day. Carers reported that William's flat was very dirty and needed a deep clean; reported to adult social care intake team. Had mobility issues due to previous stroke and postural hypotension. Poor compliance with care tasks. Red areas to sacrum noted. Referred to community mental health team for older adults. Often no food in flat. District nurses administering insulin and caring for catheter.	Readmitted
Admission 2- 3 days (21st month 2)	Daughter called ambulance as William not eating therefore low blood sugars; administration of glucose had no effect.	Chest infection; assessed fit for discharge 3 days later. Package of care remains in place.	
Home- 1day		Only at home for one district nurse visit.	
Admission 3- 7 days (25th Month 2)	Family called ambulance as had chest pains, fatigue and reduced appetite.	Classed as failed discharge as less than 48 hours since discharge. Increasingly anxious about being alone. Fear of dying during night when no one there. Documented looked unkempt. Red Cross Befriending referral. Change of Care Provider organised by social	Discharged with alternative care providers as requested

		worker. William understood that he had to go home due to funding and that care home not an option.	
Home - 1 day		Visits by district nurses and new care agency as planned.	
Admission 4- 20 days 3rd Month 3	Admitted via ambulance fitting.	Further failed discharge. Fits due to low blood sugars. Treated for severe constipation.	Discharged with Package of care from original previous providers.
Home- 5 days		District Nurses continued to visit twice a day for insulin injections. Care provider changed to Care Agency 3. Ambulance services were called on one occasion when William reported to be feeling unwell. Had too many blankets and improved when removed and given cold water to drink.	NB No access to care Agency 3 records due to multiple complexities when they went out of business.
Admission 5- 38 days. 28th Month 3	Admitted via ambulance. Family at house. Chest pain and diarrhoea.	Grade 2 sore redness to on Sacrum on admission. Intermittent compliance with assessment, investigations, treatment and medication. Does not want to stay at home as bored of staring at walls. Pressure areas intact two days prior to discharge. Original plan to go to nursing home but then declined.	Discharged home with increased package of care.
Home- 45 days	Longest period at home.	Care Agency 1 reinstated as care providers. Delays in referral for district nurses. Insulin now once a day- blood sugars stable. Development of pressure ulcers noted Grade 2 to Grade 3. Development of pressure ulcers in more at-risk areas. Air mattress ordered, initial reluctance due to risks of smoking with air mattress. Further deterioration in pressure ulcers, reported as required and referred to tissue viability nurse on day 16 month 6. Son agreed to help with care. Communications issues between DNs and carers regarding whether dressings had been changed.	

		Deterioration generally over the last week at home. District nurse called the ambulance service to assess and admit if necessary.	
Admission 6-20th Month 6 (Died on 10th day of admission).	Admitted via ambulance. Low blood sugars, ulcers to feet, immobile and possibly had sepsis.	On admission found to have two large necrotic pressure area damage on right foot, and one ungradable on sacrum and left foot. Safeguarding referral raised. Deteriorated over next few days and passed away whilst asleep.	

6. ANALYSIS AND LEARNING

6.1. The analysis section takes a strengths-based approach identifying what went well and then building a picture of areas where learning has occurred. Systems and services that worked with William may have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this case. Where that is the case, reference will be made to those changes.

MEETING WILLIAM'S CARE AND SUPPORT NEEDS

6.2. William had a significant medical history, however despite this he lived in his home in warden-controlled accommodation with the support of his family members, manged his diabetes, administering his own insulin and other medications.

6.3. The NHS Community and Mental Health Trust carried out a Serious Incident Investigation under the NHS England Serious Incident Framework[3] as a result of William's death. The learning from that process and the action plan has been shared with the author of this review and has supported the further multi agency learning that this SAR has identified.

The Covid Impact

6.4. In order to add context to the care delivery and issues that affected William during his time in receipt of care, it is important to be reminded of the stage of the Covid pandemic that the world was facing at this time. During the timeframe of the review, there were ongoing restrictions to the daily lives of the United Kingdom population and constraints on the way that statutory and non-statutory health and social care delivery providers were able to carry out assessments and administer care. There was also an impact on staffing levels with many of the professionals who would usually be working in those roles, either off sick themselves with Covid or on the list of those people with pre-existing medical conditions who were shielding and not at work. This also affected senior clinicians and leaders so there were fewer senior colleagues to consult with and seek advice from.

6.5. This put immense pressure on professionals who were working. The emotional impact of working through the early stages of the pandemic are well written about. Many health staff were being directly infected and becoming very ill with some dying as a result of the pandemic. The fear of the disease at that time, when there was no vaccine and where doctors and researchers were still trying to identify effective treatments, cannot be underestimated.

6.6. The Coronavirus Act 2020 provided provisions for local authorities to ease their statutory Care Act duties during the pandemic[4]. There was also an ethical framework for adult social care[5] to use to make

[3] https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

[4] Care Act easements: guidance for local authorities https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities.

[5] **Responding to COVID-19: the ethical framework for adult social care** https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care#:~:text=This%20principle%20is%20defined%20as,their%20care%2C%20support%20and%20treatment

decisions on how care would be provided. In the local authority area that William lived in, Care Act easements were not in place, but the Ethical framework was being followed. Further comment will be made on this later in this report.

6.7. For social care workers, assessments were being undertaken over the phone using information given by the person and their family. For patients in hospital too, it was a difficult time with no visitors allowed.

6.8. For family carers, those who were vulnerable may not have been visited with a 'stay at home' order in place. All of this had an impact in this case and was often the reason put forward during the workshop and within reports as explanations for where there was learning.

6.9. All issues regarding the impact of the covid pandemic were well known and reported widely to local single agency and multi-agency governance groups at the time.

Points for future practice

- In times of national crisis that impacts on frontline services, learning from the Covid 19 pandemic is useful to inform future care delivery during such events.

Hospital Care

6.10. On William's first admission to hospital, he was generally unwell and had Covid 19 diagnosed. At the point of this admission, it was noted by the ambulance service that he was not coping at home and was self-neglecting. His family member, who had been his main carer, stated to hospital staff that they could not continue to provide full time care as William was difficult to engage with and he would often reject his family's help. William's family carer stated that they had tried previously to get help from social care and the GP. The review has not been able to find evidence of this so any learning from not hearing the voice of a struggling carer has not been able to be analysed. It appears that William's intermittent refusal of care from his family resulted in self neglect. It is not clear if William's family carers had been visiting him during the first national lockdown which in was in place at this time and that was the reason for the neglect of the property and William's appearance on admission. With no other carers in place at that time it is also likely that William was less able to manage his diabetes, and this led to his hospital admission.

6.11. The ambulance service and the hospital emergency department made safeguarding referrals in respect of neglect/self-neglect owing to the presentation of the flat and William at that time. This was excellent practice and in line with policies and procedures. The allocation of the hospital social worker was timely. It was noted that William was only intermittently compliant with his care in hospital, which is the same as his family carer had reported. Hospital staff therefore found it difficult on occasions to be able to fully assess and treat his needs. Over his many admissions it was noted that William, was

reluctant for medical and surgical investigations to take place.

6.12. Hospital staff had recorded and considered why William refused care however recognise that his non-compliance could have been understood and mitigated for through more robust multi-disciplinary team discharge planning. There were other areas where hospital professionals recognised that more questioning could lead to improved care in the future. It is recorded in the records at the hospital that William could not read or write; this had been recorded by the psychiatric liaison team as a result of the assessment with William. It is not known whether this was highlighted to ward staff. There was no evidence, however, that other means of communication were used where necessary in consideration of appointments, care plans etc. On one occasion it was noted that a significant investigation was required to have a more in depth look at his bowel. There was a discussion that concluded that William understood the risks and had mental capacity to decide on his care and treatment. The reason for refusal, however, was not explored further. It is not clear if on some occasions, the inability to sign a consent form or read information related to investigations and examinations were a barrier to William undergoing treatment and investigations. It was not known how much not being able to read and write impacted on William or on the services that were delivering care to him and is therefore an important learning point. It was also noted that William did not like to take tablets; there was no discussion with a pharmacist to see if liquid alternatives were available or a discussion with his family carer about how this was managed at home.

6.13. Each of these elements alone are minor elements of consideration of that would be part of good care delivery; together they provide learning for the importance of professional questioning to understand a person better, and therefore to deliver an improved approach for personalised care. The author suggests that these elements may have well been impacted by the pandemic given how busy and distressing this time of caring for patients in hospital was. This learning has been addressed by the hospital safeguarding team to ensure that staff are aware of the importance of understanding patients' literacy levels and how else they may communicate important information, signing consent and reading other information with patients.

6.14. The social work element of hospital care was delivered by the local authority and had the purpose of ensuring that the needs of William could be fully met in the community. The assessment was carried out by phone with William's family carer. Face to face contacts were not always taking place due to the pandemic and the allowance of proportionality and flexibility of the ethical framework in place as previously discussed. William had no access to a phone on the ward, so he was not spoken to. Whilst applying the ethical framework, it would have been reasonable, especially given the referral on admission was related to self-neglect, that assessment should have been face to face with William to ensure that robust person centred assessment could have been carried out and that William's wishes, and feelings could be taken into account. The package of care that was put in place took account of the face-to-face assessments and views of the occupational therapist and physiotherapist and resulted in Care Agency 1 being commissioned to provide care by two carers four times a day. On each admission this was reassessed and on occasions resulted in slight changes e.g. increase of allocated time or change of care provider at William's request. William was not seen face to face by a social worker during the review timeline and leads to learning.

6.15. The author raised the question as to why a referral of the death of William was not made to the coroner. At first glance and on discussion with medical staff, this was because William's death was expected. The updated coroner's guidance[6] does include the circumstances where cases of neglect and self-neglect should or should not be referred to the coroner. The author has suggested that when a safeguarding referral has been raised, a conversation with the coroner may be warranted to ensure that the coroner is fully appraised of the circumstances that precede an expected death.

Points for future practice

- Application and recording of reasons why a person may be non-compliant with care may offer insights and lead to improved compliance and evidence professional curiosity.
- When applying new frameworks for practice, whether temporary or permanent, it is best practice that the rationale for not seeing a person face to face for assessment is recorded.
- Understanding literacy levels may support patients to be more fully informed where decision making is required; including care plans related to communication for those with reduced literacy is as important as for those who have other communication difficulties.
- Conversations with the coroner may provide clarity where there are ongoing investigations following an expected death.

Care at Home

6.16. In the first four months of the timeframe of the review, William spent very little time at home. Each time he was discharged, he was quickly readmitted in anything from one day to one week with the longest period at home being nine days. On each discharge, a referral was made to the district nurse team for administration of insulin and monitoring of William's permanent suprapubic catheter. On all but one occasion these referrals were timely and ensured that William did not go without his insulin. On the time that there was a delay, William's family carer contacted the district nurses, the situation was quickly resolved, and his insulin was given. This displayed good practice and a proactive response to the needs of William.

6.17. The fact that William spent very little time at home in the first four months meant that the contact that carers and district nurses had with William was limited. There were some early communication issues that emerged that were not resolved. It was not always clear to the carers if the district nurses had changed the dressings and the district nurses were not always aware of the times that William had refused to let the carers carry out his care. This became a significant issue in the last period at home when the pressure ulcers were developing. William was becoming less compliant and the two services that were delivering care to him needed to be able to communicate effectively to ensure that there was clarity each day as to what William had or had not allowed carers to undertake. It does seem that William would tell carers that the District nurses had changed his dressings and vice versa if he did not want to be disturbed. There were also occasions where William would not let the carers wash him and he needed persuasion on many occasions to allow care.

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062499/registered-medical-practitioners-notification-deaths-regulations-25-march-2022.pdf

6.18. In the final period at home, this lack of communication between the carers and the district nurses meant that the pressure ulcers were developing rapidly, not least because of William's underlying health conditions and immobility increased his risk of developing pressure damage. People with diabetes are at increased risk of developing neuropathy and therefore may not feel pain associated with pressure damage in the feet. Learning from the Serious Incident investigation has sought to ensure that the feet of people with diabetes are checked regularly during visits by community staff.

6.19. It has not been possible for this review to discern why there was not an earlier approach to the tissue viability service for early assessment and advice based on the development of the pressure ulcers and the complexities of William's needs. The Serious Incident investigation could not find a reason and the nurses involved have now left the service. There were some record keeping issues identified in the Serious Incident investigation report that may have contributed to a lack of referral, but the author would question whether it was in fact the pressure of the pandemic that led to district nurses not always practising in the way that would be expected. Time for visits was under pressure as well as a reduced workforce. There was a question raised by the panel for the SAR as to whether the tissue viability service had been redeployed during the pandemic. It was stated that the tissue viability nurses were supporting general nursing services within community teams, the tissue viability service was still functional and taking referrals but was a very depleted service during the pandemic. It is not clear if there was a belief therefore, that referrals should not be made. There was also a dearth of senior nurses to lead and advise services as discussed earlier. Systems and processes have since been put in place to enable further communications between district nurses and carers to ensure a holistic approach to care delivered at home. This review will look to strengthen this requirement.

6.20. It is also of note that there were three care agencies that were commissioned to deliver care. On the first discharge Care Agency 1 was delivering care, this changed to Care Agency 2 when William complained that he did not like the first carers. On the next discharge Care Agency 3 were commissioned. There is little known about interventions of Care Agency 3 as there are no records available to the review (see previous table). On the final discharge in month 5, care reverted back to Care Agency 1 who continued to deliver care for the seven-week period that William was at home. This also meant that carers were not consistent until the last period at home.

Points for future practice

- Adherence to policies will assure patient safety in times of national crisis.
- Communication methods between those delivering care at home will afford continuity of care and effective communication.

Hospital to Home Interface

6.21. When the map of hospital admissions is viewed, a question arises as to how it was that William could have been deemed fit for discharge one day, and then readmitted very quickly (within 24 hours on two occasions). When a patient is readmitted within 48 hours of a discharge, it is recorded as a failed discharge. This leads to a patient being immediately referred back to the medical team rather than the emergency department clinicians. This is noted as expected practice and it was good to see that this happened.

6.22. There was no suggestion that William was discharged when he was not fit on any occasion, with the care package in place at home, it was thought that he was indeed fit for discharge. There were however, at the time, huge pressures on hospital beds in the face of the pandemic. This was for a few reasons. One was that patients were contracting Covid in hospital and therefore there was a need to discharge patients as soon as they were fit and that there were a large number of covid and other patients needing hospital beds. All of this was well documented at the time and may have been unconsciously having an impact on William's discharge timings.

6.23. Where a person is discharged and readmitted on many occasions it is good to see agencies in hospital and the community working together to identify why this might be happening. In the case of William, this did not happen. William verbalised on several occasions on admission that he had fears of being discharged back to his home. On one occasion, he feared not being able to look after his diabetes sufficiently well and that he might suffer from a low sugar episode and die alone at home as a result. William also stated that he was very lonely at home and was fed up with staring at the four walls.

6.24. Social workers and ward staff did not ignore William and listened to his fears. Several measures were undertaken to ensure that his fears could be alleviated; he we referred to a befriending service, his care hours were increased and as a result of William feeling low and depressed, he was seen by the psychiatric liaison team. In terms of William's mental health there were no concerns that he had a treatable mental illness; he was assessed as motivated to get better as he missed his children and grandchildren.

6.25. On each occasion that William expressed a desire to not want to go home, by the time of discharge, he had changed his mind from the conversations that professionals had with him regarding not needing that level of care at that point. There was also a possibility that as William felt better physically that he did see that he could manage at home. On the final admission there were more conversations this time from professionals who thought that William would now benefit from being admitted to a residential care home setting. On this occasion, William refused and was considered as having mental capacity to make this decision (without an impairment of the mind or brain and his reasons clearly stated, there was no requirement to formally assess William under the Mental Capacity Act). His stated reasons were that if he went to a care home, he would not be able to see his family as there were restrictions on visiting care homes. It was presented within the media that many care home residents were dying of Covid; it is unknown how much that may have had an impact on his decision.

6.26. So Covid is again seen as having an impact on William. In usual times, a day centre may have been considered and the befriending service would have been face to face, but day centres were closed, and befriending services were offering telephone contact only.

6.27. At the workshop, the professionals considered what would work well in the future. Discussions led to a belief that discharge planning meetings that included hospital and community staff would have been beneficial. It was stated that William's needs did not obviously meet the need for a discharge planning meeting but there were some nuances that did lead professionals to believe that this could be the case for a meeting in the future for people like William who have multiple admissions and failed discharges.

6.28. On William's initial admission to hospital, a safeguarding referral in respect of significant self-neglect was made by both the ambulance service and the hospital emergency department. This was amended to a welfare concern that was being addressed by his hospital admission and home care support package. Despite this, Care Agency 1 were concerned that the flat that William was living in was still in a very bad state on his first discharge. On the following admission it was believed that the issues had been resolved because his family had cleaned and that he was not admitted again in the unkempt state that he had been previously. There were still elements of self-neglect that professionals recorded that were not addressed in the timeframe of the review. The request for a deep clean by the care agency to social care was not recorded and therefore was not undertaken. It is not clear why the district nurses did not flag this as a concern. Other professionals did not see William at home. It is likely that the package of care was ensuring that in terms of self-care, William did not again present to hospital in an unkempt state.

6.29. The assumption therefore that William was no longer self-neglecting meant that this was not addressed. It is clear now that William refusing to comply with care, investigations, and treatment both in hospital and at home were an element of self-neglect that was not recognised or understood. If staff working within the community who were seeing William at home and those based at the hospital as well as those who were not seeing William face to face due pandemic restrictions, had the opportunity to pool their information it may have brought to light the extent to which William's non-compliance was having an impact as well as considering the state of the flat that William was living in. That in itself would have ensured that the missing request for a deep clean would have been identified and may also have led to more enquiries and understanding of why William was not compliant. Issues that were known by some but not all, such as his inability to read and write and his dislike of tablets may also have been understood and managed appropriately. Coming together as a professional group may have led to less assumptions and more professional curiosity.

Points for future practice

- An understanding of the part played by non-compliance in medical and other care delivery will ensure a deeper understanding of self-neglect and lead to increased professional curiosity across the hospital and community interface.
- Where there are several failed hospital discharges and/or multiple admissions with several services involved both within and out of the hospital setting, a full discharge planning meeting would be beneficial for improved patient care and understanding of the issues.

7. SUMMARY AND CONCLUSION

7.1. The care of William was impacted by the way services were delivered during the early stages of the Covid 19 pandemic in the UK.

7.2. This review has evidenced that the only way to be able to fully assess, understand and deliver care to people with care and support needs is to be able to have the freedom to undertake those assessments and deliver care face to face. This is particularly important when a person is seemingly non-compliant and living in circumstances that could be considered as dirty and unpleasant. It is not possible to fully assess the needs of a person in such circumstances without being able to undertake that within their

environment and with their voice.

7.3. The voice of the person who may have usually been advocated for by other services was not reliably heard due to other pressures. The NHS Serious Incident investigation highlighted much of the single agency learning for the district nursing service and the progress against these actions is well underway.

7.4. This SAR has also highlighted that a deep understanding of self-neglect as well as the circumstances that may warrant a discharge planning meeting where there are multiple admissions and circumstances that may be affecting the way that assessments of need are being made.

7.5. It is not always the case that a SAR can state whether a person may or may not have died if the circumstances had been different. In this case William, certainly had declining health and a personality of being non-compliant with care reasons for which were not understood. Notwithstanding the findings of the serious Incident investigation, this review ponders on whether the life of William could have been prolonged with day centre provision, face to face befriending, as well as the freedom to enter residential care without the restrictions of contact with friends and family.

8. RECOMMENDATIONS

The recommendations are built around the noted areas that require consideration of stronger practice.

1. Single Agency Recommendations

- BDSAB should seek assurance that single agency action plans from their own recommendations are underway/completed.
- BDSAB should request an update on actions from the NHS Community Trust's Serious Incident action plan.

2. Learning from Previous SARS

- BDSAB must assess any ongoing work from previous SARs and other related processes regarding discharge planning. BDSAB should take appropriate action to ensure that there is a robust multi agency discharge planning process for complex cases and/or where there have been a number of failed discharges.

3. Covid 19 Impact

- BDSAB should request the that the Integrated Care Board provide an update on Business Continuity plans and any learning from the Covid Pandemic.

4. Visibility of BDSAB multi-agency procedures.

- The Board's web pages should include all multi agency procedures, guidance, training information and any other Board related documents.
- The BDSAB website should contain the logo of the board to distinguish it from the local authority web pages.

5. Self-Neglect and Non-Compliance

- BDSAB should ensure that there is an up-to-date Multi Agency Self Neglect Guidance. The guidance should be easily accessible on the BDSAB web pages and include:
    - Importance of professional curiosity and history.
    - Flow charts of the process
    - Links to Complex Cases Group
    - The non-compliance of medical and nursing care as part of self-neglect.
    - Learning from other SARs

6. Understanding literacy levels in assessments

- BDSAB to request that a question such as "how do we communicate with you? "with prompts about literacy, BSL etc are added to assessment documentation?

7. Coroner conversations

- BDSAB should ask partner agencies who are involved in certification of deaths, to ensure that a conversation with the coroner takes place where there has been a safeguarding referral/open Section 42 or other Serious Incident investigation at the time of an expected death. This will ensure that the coroner is fully appraised of the circumstances and can make an informed decision regarding their involvement.

8. General Learning Briefing

- BDSAB should provide a full briefing containing the learning from this SAR.
- The newly formed Learning and Development subgroup should identify multiple media to disseminate learning e.g. videos/podcasts etc.

Appendix One: **Safeguarding Adults Review**
William
Terms of Reference and Project Plan

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and the London Adult Safeguarding Multi Agency Policies and Procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

William was male and 68 years old when he passed away. He lived on his own in supported living accommodation. William was supported by family members who visited him regularly. At the time of his death William was receiving a package of care from a domiciliary care provider and daily visits from district nurses to administer insulin. William was admitted to hospital due to pneumonia and sepsis of an unknown origin. Upon his discharge from the hospital William was referred to the district nursing service for administration of insulin twice daily, moisture damage monitoring and suprapubic catheter care. During a Care Act Assessment, a move to a care home was discussed. William stated his preference to live with support at his current address where his family would be able to visit him without the Covid 19 restrictions in place at care homes. William began to develop pressure ulcers and these worsened over a number of weeks prior to his death. Due to the severity of these and the deterioration in his health William was readmitted to hospital. The hospital raised a safeguarding concern to the community health

trust and the care agency due to the patient's poor presentation. The patient had two necrotic ungradable pressure ulcers to his right foot and heel in addition to two category 3 and one category 4 pressure ulcers on his sacrum and buttocks. William subsequently died in hospital. The cause of death was sepsis from the pressure ulcers.

3. Decision to hold a Safeguarding Adults Review

The Safeguarding Adult Review Committee of the Safeguarding Adults Board met on 7th December 2021. It was agreed that the criteria for a Safeguarding Adults Review were met and made a recommendation to the BDSAB Independent Chair that there was likely to be learning in the way that agencies worked together to safeguard Adult William and that the criteria for a statutory mandatory SAR were met. The Chair of the SAB endorsed this decision on 23rd December 2020. There was an agreement to delay the SAR until the completion of a Serious Incident investigation within the Community NHS Trust and to allow for the commissioning of a suitable SAR author.

4. Scope

The review will cover the period May 2020 to October 2020. This period represents that time that William was referred back to Adult Services after a two-year period of inactivity, until the date of death. Key background history and information from agencies will also form part of the review that will inform the more contemporary elements of William's life.

5. Method

In determining the methodology to be used for this Safeguarding Adults Review the BDSAB considered the Care Act 2014 Care and Support Statutory Guidance which states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

Agencies will be asked to review their own involvement with William and his family. Professionals who worked with William and their first line managers will be invited to a learning and reflection workshop. A panel of senior managers for involved organisations will oversee the production of an analytical report that will identify areas for learning and improvement. Strong Practice will be shared as learning along with areas of learning that will lead to recommendations and action.

6. Key Lines of Enquiry to be addressed

The following case specific key lines of enquiry will be addressed.

6.1. Contact, Assessment, Care and Review

6.1.1. What contact and subsequent assessment did your agency undertake of William's holistic needs, inclusive of physical and mental health? (Please include specific reference to management of Pressure Ulcers if relevant to your agency)
6.1.2. How robust was this?
6.1.3. How did this inform care planning and interventions?
6.1.4. What services were offered, and/or referrals made as a result?
6.1.5. What difference did contact with William make to his life?
6.1.6. Please analyse the effectiveness of any escalation noted?

6.2. Engagement

6.2.1. How well did your service engage with William?
6.2.2. Please analyse any strategies used that encouraged William to engage.
6.2.3. What actions were taken if your service were not able to engage with William?
6.2.4. Analyse the impact of any non-engagement or compliance on William's well-being.

6.3. Mental Capacity Act

6.3.1. Was the Mental Capacity Act applied robustly at points where it should have been?
6.3.2. Please evidence how the Mental Capacity Act was applied at various decision points.
6.3.3. What part did Mental Capacity play in understanding the how William managed his life?

6.4. Housing Circumstances

6.4.1. What did your agency understand of the living arrangements for William?
6.4.2. Was your agency aware of any risks to William's living arrangements?

6.5. Safeguarding and Self-Neglect

6.5.1. What evidence does your agency have of William self-neglecting?
6.5.2. What was your agency's response to any self-neglect?
6.5.3. Please analyse how your agency worked with William towards understanding risk to wellbeing from pressure damage.
6.5.4. What part did safeguarding referrals, processes and procedures play in protecting William from serious harm through pressure damage and/or self-neglect?

6.6. Family Involvement

6.6.1. How did your agency engage with William's family?
6.6.2. What did you understand of the relationship between William and family?
6.6.3. How were family included in plans and assessments?
6.6.4. What evidence does your agency have of how family carers' concerns were listened to?

6.7. Communication

6.7.1. What examples of strong communication & information sharing were evident during the scoping period?

6.7.2. Where did communication and information sharing fall short of what was expected and why do you think this was?
6.7.3. How were concerns any shortfalls noted above escalated?

6.8. Support and Supervision

6.8.1. What evidence is there of positive support and supervision for professionals involved in this case?
6.8.2. How did this support professionals to engage and what impact did it have on support for CW?

6.9. Covid 19 Pandemic impact

6.9.1. What evidence is there of any positive or negative impact of the Covid 19 restrictions on either professionals and/or William and his family

6.10. Equality and diversity

6.10.1. Was practice sensitive to any protected characteristics in line with the Equality Act (2010)

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this Safeguarding Adult Review is Karen Rees.

8. Agency Review Reports will be requested from:

- London Borough Council:
  - Housing or provider of sheltered accommodation
  - Adult Social Care
- Clinical Commissioning Group (CCG) for GP- Summary Report
- The Community and Mental Health Foundation Trust
- The University Hospitals NHS Trust
- Police,
- Ambulance Service.
- Care Provider 1
- Care Provider 2- summary report
- Care Provider 3- summary report

Information reports will also be requested from CQC and the Local authority Provider Quality Assurance Team.

9. Family Involvement

A key part of undertaking SAR is to gather the views and experiences of the family and share findings with them prior to finalisation of the report. William's family will be invited to be involved with the review.

10. Project Plan: (all meetings via MS Teams unless indicated)- Timeline takes account of public and summer holiday periods.

1.	Scoping Meeting	13/05/2022
2.	Terms of Reference agreed	13/05/2022
3.	Agency Authors' briefing	23/05/2022
4.	Agency Review Reports submitted	24/06/2022
5.	Review of reports by Independent Author	27-30/06/07
6.	Distribution of reports & workshop details to all workshop attendees	11/07/2022
7.	Learning and Reflection Workshop- Face to Face	18/07/2022
8.	First Draft Overview report to all attendees	30/08/2022
9.	Recall Workshop (review V 1 of report)	07/09/2022
10.	V2 Overview report circulated to attendees for info and panel	21/09/2022
11.	Panel meeting 1	28/09/2022
12.	V3 and Recs to Panel	7/10/22
13.	Panel meeting 2 to finalise report and build Recs	12/10/2022
14.	V4 and final Recs to Board	November 2022

Appendix 2: Hospital Admissions by Month

Home / Hospital

Month 1

SUN	MON	TUES	WED	THUR	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Month 2

SUN	MON	TUES	WED	THUR	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Month 3

SUND	MON	TUESD	WEDN	THURS	FRIDA	SATUR
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Month 4

SUND	MON	TUESD	WEDN	THURS	FRIDA	SATUR
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Month 5

SUNDAY	MON	TUESD	WEDN	THURS	FRIDA	SATUR
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Month 6

SUNDAY	MON	TUESD	WEDN	THURS	FRIDA	SATUR
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31