Worcestershire Safeguarding Adults Board

Safeguarding Adults Review Report

“Alan”

Deceased 11th July 2016

Aged 68

Robert Lake

Independent Author.

Document Control

- **Ratified by WSAB** Date 28/2/18

Revision History

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Contact: Worcestershire Safeguarding Adults Board Manager

Location: www.worcestershire.gov.uk/wsab

Contributors to the development of the document

Name	Organisation
Various	Members of Safeguarding Adult Review Panel
Various	Members of Case Review Sub-Committee and LSAB
Anon	Family members

Actions

Required Actions	Date
See Individual Agency Action Plans	See report
See Section 6.2: Recommendations to WSAB	See report

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1. Introduction

Mr. AK was aged 68 at the time of his death. At the request of his family, Mr. AK is referred to as Alan throughout this report.

Alan lived with his wife in the western part of the County. He was an active man who was still driving his car. He had a son and two daughters. In the latter part of his life, Alan had care and support needs which were met by his wife and family with the support, as required, of primary and psychiatric care services.

Concerns have been raised, by his family and by safeguarding agencies, about the standard of care Alan received in the weeks prior to his death.

He was first diagnosed with Parkinson's Disease some 10 years ago. In August 2015, Alan was assessed by a Consultant Psychiatrist and found to be suffering from depression with memory difficulties. At the end of October 2015, Alan was admitted to acute hospital as there were concerns for his health and safety – he had been wandering and was agitated and confused. He returned home a month later.
In February 2016, the onset of dementia, related to the Parkinson's Disease, was diagnosed and the depression confirmed, for which medication was prescribed. In late March 2016, Alan was admitted to acute hospital, for physical and psychiatric assessment, following physical threats he made to his wife. It was determined that he was fit for discharge within the first week but remained in the hospital for a period of 10 weeks before being admitted to a specialist care home on a "Discharge to Assess" (DTA) basis on 9th June 2016.

Alan was admitted to (a different) acute hospital on 6th July 2016 in an unconscious state and found to be suffering from a chest infection and septicaemia. It was also found that he had pressure injuries to his heels and bruising to his ankles. Alan died 5 days later.

Following due process, the Chair or the Worcestershire Safeguarding Adult Board (WSAB) decided, in May 2017, that the circumstances surrounding Alan's death met the Safeguarding Adults Review criteria as laid down in the Care Act 2014. It was decided that the Review would focus on the period from the 30 October 2015 to the date of Alan's death, 11th July 2016.

I was appointed by the WSAB in June 2017 to assist them in the preparation of this Safeguarding Adult Review (SAR) report. I am an independent social care consultant and a qualified social worker having previously been a Director of Social Services for fifteen years in large county local authorities. Subsequently, I held senior Board level positions in the NHS and as a non- Executive Director with a large voluntary housing association. I have authored several SAR's and am Chair of a Safeguarding Adult Board and a Safeguarding Children Board in the South West. For this SAR I was assisted by a SAR Panel: the membership being drawn from relevant members of the WSAB.

The purpose of a SAR is to gain, as far as is possible, a common understanding of the events that led to death, to identify if partner agencies, individually and collectively, could have worked more effectively and to suggest how practice could

be improved. A SAR is about learning, not blaming, and aims to improve future practice.

When a Safeguarding Adult Review is to be conducted, family members are invited to contribute to the report. In this case, together with the Manager of the WSAB, I met with Alan's daughter and her partner at both the beginning and end of the process. I thank them for their assistance.

The Terms of Reference for this Review are given at Appendix 1. For the purposes of this report and in line with standard practice for Safeguarding Adult Reviews, the agencies and individuals providing information to the Review are not identified. It will be seen from the Terms of Reference that the SAR methodology was an investigative, systems focused and Individual Management Review (IMR) approach. This ensured a full analysis - by the IMR authors and by the SAR Panel - to show comprehensive overview and alignment of actions. Training was provided for IMR authors, with members of the SAR Panel in attendance. Separately, the SAR panel met on two occasions (one of these being a virtual meeting) to discuss the content of the IMR's and to identify learning points.

At the outset, I wish to record my thanks to all those who have assisted with and provided information for the review including the authors of the Individual Management Reviews (IMR's) and the members of the Safeguarding Adult Review Panel. Particular thanks go to the Coordinator of the Worcestershire Safeguarding Adult Board who has provided unstinting and outstanding professional and administrative support.

2. A Summary of Key Events

[Note: Of necessity, in the interests of brevity, the following section will only include key events. Some events, which pre-date the review period, are also given to aid a greater understanding of the matters under consideration.]

13th May 2015 Alan was referred, by his GP, to the local psychiatric services for assessment of cognitive impairment.

8th August 2015 Alan had an out-patient appointment with the Consultant Psychiatrist but went to the wrong location. The Consultant's staff arranged a second appointment on which Alan would be accompanied by his wife to aid the assessment.

26th August 2015 Alan was seen, with his wife, by the Consultant Psychiatrist. Depression was diagnosed, and medication prescribed. His cognitive functioning was not assessed due to the depression. To be reviewed in 6–8 weeks and GP requested to monitor.

26th October 2015 Alan's wife contacted the Police saying that Alan was missing. He returned on his own accord but was somewhat confused and frustrated when asked about his movements. He had also been missing for some little while the previous day. (The Police raised a vulnerable adult referral on the 30th October 2015.) Co-incidentally, later on the 26th October, Alan was seen by a Community

Psychiatric Nurse (CPN) for a dementia assessment. Appropriate liaison between the Consultant Psychiatrist and GP followed.

30th October 2015 Alan was admitted to the local acute hospital with increasing confusion. He remained in hospital until the **1st December 2015** when he returned home with some home visits being made by the Older Peoples Mental Health Team. During his stay in hospital, Alan was seen by specialists in psychiatry, and Parkinson's disease. (On the **27th November 2015,** the Patient Flow Centre had identified a Discharge to Assess (DTA) placement for Alan but this was declined by Alan's wife.)

23rd December 2015, Alan was seen by the CPN who found him to be much brighter, albeit still experiencing some hallucinations. No CPN further input was required.

10th February 2016, Alan attended an out-patient appointment with the Consultant Psychiatrist. Parkinson's Disease dementia was diagnosed. The Consultant offered advice on various support systems and prescribed new medication. The Consultant confirmed his findings and actions to the GP and offered a further out-patient appointment in two months' time.

1st March 2016, the local pharmacy checked with the Mental Health Team about the continuation of the prescribed medication. A Doctor from the Mental Health Team contacted Alan's wife and advised that if any problems or side effects were to arise, then Alan should stop taking the medication and advise the Mental Health Team accordingly.

11thMarch 2016, Alan's wife contacted the same Mental Health Team doctor to say that Alan was experiencing more falls and an increase in hallucinations. She requested that the medication be stopped: the doctor agreed that this was the right course of action. The GP and the pharmacy were advised of this.

30th March 2016, Alan's wife contacted the police as Alan had physically threatened her. He had also been expressing suicidal thoughts. An ambulance was called, and Alan was admitted to the local acute hospital for a full assessment of his physical and mental health. (The police correctly raised a safeguarding referral following this contact.)

30th March 2016 to 9th June 2016, Alan was in the local acute hospital. Throughout this period, Alan remained at a high risk of falls and, on occasions, was quite challenging in his behaviour, displaying violence and aggression towards staff requiring the need for several staff, security and, on one occasion, rapid tranquilisation to reduce the risk of harm both to him and the staff caring for him. Alan's mood and confusion would not have been aided by the fact that he moved wards within the hospital on at least two occasions.

The provisions of the Mental Capacity Act and the Deprivation of Liberty Safeguards were largely appropriately applied throughout.

It is to be noted that Alan's Consultant Psychiatrist and the Older Peoples Mental Health Team provided support to both Alan and medical colleagues for the entirety of Alan's stay in the acute hospital and maintained some contact with family members.

The acute hospital IMR recorded that "communication with [Alan's wife] was challenging" as she only visited on a limited number of occasions whilst Alan was an inpatient. (The family tell me that it was difficult for Alan's wife to visit during the official visiting times as she had a considerable distance to travel and could not drive. It should also be noted that relatives have informed me that staff were not always helpful and even confused Alan with other patients and, thereby, gave misleading information to them.) Alan's wife did contact the GP, the Consultant Psychiatrist and the CPN to discuss her husband's discharge. She also spoke, by telephone, to the In-Reach Liaison Team and the social worker at the hospital and attended, with other members of the family, a Discharge Planning Meeting on the 25th May 2016.

Alan was medically fit for discharge from hospital within a few days of admission and largely remained so throughout the period of hospitalisation. Relatives have told me that there was a plan that Alan should return home within the first week, but the unavailability of NHS domiciliary support services meant that this was not possible. On **1st April 2016**, the Patient Flow Centre were asked to identify a Discharge to Assess (to a care home) placement but, subsequently, on **9th April 2016**, the hospital team stated that this was no longer felt to be appropriate). A rehabilitation placement at a Community Hospital was identified in mid-April by the Patient Flow Centre but could not be effected because of an outbreak of norovirus in the acute hospital ward in which Alan was accommodated at that time.

On **25th April 2016**, the CPN recorded that a Discharge to Assess (DTA) bed was again being sought through the Patient Flow Centre (PFC) but by the 27th April there was again uncertainty as to the best discharge plan for Alan albeit a DTA bed was still being sought.

On **9th May 2016**, the hospital ward referred Alan again to the PFC for discharge home with a promoting independence team with one call per day. Alan's wife was reported to be happy to have him home. However, by the **13th May 2016**, the plan again reverted to discharge to a DTA bed. It was felt that Alan lacked mental capacity.

It was not until a Discharge Planning Meeting was held on **25th May 2016** that the family and all concerned finally confirmed that the Discharge to Assess (DTA) route was the best option. By now, Alan's relatives tell me, Alan's mobility had become poor and they believed that the DTA route was to enable Alan's mobility to be improved with a view to a return home. Several possible placements were then actively explored by the Patient Flow Centre but most of the care providers contacted felt that they could not meet Alan's needs. It was in early June that the care home to which Alan was eventually transferred confirmed that they would provide care for him and he was transferred there on **9th June 2016**.

There is one other matter of particular significance that occurred during the period that Alan was in hospital. **On 4th April 2016**, the Consultant Psychiatrist telephoned

Alan's wife. The Consultant recorded that Alan's wife *"reports they care for their granddaughter 4 days a week between the hours of 3.30 pm and 8.00 pm whilst their daughter is out at work. She also reported that on one occasion her husband tried to get into their granddaughter's bedroom in a disturbed state when she was in there. [Alan] was looking for his wife and wondering what she was up to. ….. I discussed my concerns about her granddaughter's psychological welfare [with Alan's wife] given that [the granddaughter] is in a house where there is a disturbed adult making threats and carrying out aggressive action. I clarified this was …. about psychological harm/potential physical harm towards her granddaughter. I mentioned that I would have to discuss this with Safeguarding Children's Services and get back to her on that but I stated that it would be my professional opinion that she should make alternative arrangements for her granddaughter to be cared for should her husband come back home."*

Later the same day, the Consultant discussed these concerns with the Access Centre for Children's Social Care and with appropriate hospital staff and it was decided that Alan should not be discharged home unless there were alternative provisions for the granddaughter. He telephoned Alan's wife to update her but the call went to answerphone. The Psychiatrist had a telephone conversation with Alan's wife on the **18th April 2016** but it would appear that the child protection issue was not discussed.

The decision that Alan should not be discharged home unless there were alternative provisions for the granddaughter caused some distress for both Alan's wife and his daughter: the CPN recorded, on the **29th April 2016**, *"[Alan's wife was] very distressed by potentially having to 'choose' between having Grand-Daughter around 'four times a week', and having her Husband home"* and, following a telephone conversation with Alan's daughter, who "initially sounded very upset and distressed", the CPN recorded that Alan's daughter stated *"she did not think her Daughter was at risk from her Father and that they "adored each other", and the incident was a 'one off"".*

These events, while very distressing to the family, had no bearing on the eventual outcome but may have contributed to the delayed discharge.

From 9th June 2016 to 6th July 2016 Alan was in the local Care Home.

Alan's admission to the care home was preceded by an assessment visit by a senior member of staff from the care home. On admission, the hospital discharge summary noted that Alan was at high risk of falls and that he had recently had a lower respiratory tract infection which had been treated with intravenous antibiotics.

On admission, Alan was initially visually observed at a minimum of 15minute intervals, especially as he had been assessed as being at high risk of falls and because of his challenging and agitated behaviour. He was found on the floor during the first evening, but no visible injuries were identified. During his stay Alan remained mobile (albeit this declined over time) and because of this, checks for any pressure injuries were not undertaken. He ate and drank well at first but could, on occasion, be reluctant to take his medications. If he should be witnessed to fall or be found on the floor, his wife was informed, and Alan was given a full body check for injuries. (There were three falls recorded, in total, during Alan's stay in the care home.)

On **10th June 2016**, Alan was seen by the community nurse and a request put in for a letter for covert medication which was issued by the GP.

A Deprivation of Liberty Safeguards application was put in place on **12th June,** but a full Mental Capacity Act assessment was not undertaken.
The Older Adult Mental Health Team visited Alan on **16th June 2016** to carry out a review and arrange a follow up visit for 5th July 2017.
On **21nd June 2016,** Alan was seen to fall to his knees - a body check was carried out but there were no apparent injuries. The next day he was visited by the GP who reviewed his medications and was happy with the level of medications prescribed. Later that day Alan was found on the floor again, but no injuries could be found. When the Community Nurse came to see Alan on **23rd June 2016**, she was requested to check him due to his mobility having reduced, a urine check revealed he was suffering from a urinary tract infection and an antibiotic was prescribed and relatives informed.
On **29th June 2016,** a new social worker was allocated to Alan's case and on the **30th June 2016** the new social worker discussed future care plans for Alan's wife: this included discussion of a possible return home or future long term continuing health care. A meeting was arranged for Alan's family and the social worker for 7th July. (The family tell me that from the point at which the DTA route was first decided upon, in late May, that they had felt under pressure to make decisions as to Alan's longer-term care at a time when Alan's overall health and mobility was poor.)

A redness was found on Alan's scrotal area on **3rd July 2016**: the home body mapped Alan and decided to refer the redness to the District Nurse if it continued. The redness was monitored but as it soon faded, no further action was deemed necessary.

On **5th July 2016**, Alan was visited again by the Older Adult Mental Health Team who completed their review by talking to staff - Alan was asleep - and the Team arranged to visit again on 19th July 2016.

At **06.30** the following day, **6th July 2016**, Alan was found to be very hot to the touch and suffering from a very high temperature and unresponsive. [Note: It was standard practice for Alan to be visually observed at 2hourly intervals during the night and this had been done.] The 111 Service was contacted immediately for advice and the care home staff were told to place Alan on his side and wait for an ambulance to arrive. On arrival, at **07.00**, the paramedics examined Alan, administered oxygen and diagnosed a chest infection. He was taken to the nearby acute hospital, leaving the care home at **07.35**. Alan's wife was contacted by the home and informed of what had happened: she thanked the staff and said she would arrange to go to the hospital to see him.

Alan arrived at the hospital at **08.31** on **6th July 2016** and it was suspected immediately that Alan was suffering from sepsis with a possible chest infection. At **10.00**, Alan's pressure areas were checked – pressure damage of 1cm x 1cm was found on Alan's right ankle. There were also injuries to the left outer ankle and the right outer ankle: "if caused by pressure would be described as Category 3 pressure damage[1]" (hospital chronology). It was also found that he had an ulcerated penis. At **11.08**, A&E staff completed a safeguarding form in relation to the pressure damage and this was dispatched to the County Council. At **12.55**, the medical consultant

[1] Pressure injuries are graded from Category 1 (least serious) to Category 4 (most serious).

spoke with Alan's wife on the telephone and it was agreed that it was in not in Alan's best interests for him to be resuscitated. Family members attended the hospital and were kept informed of Alan's condition – Alan was clearly dying.

On **7th July 2016**, the Lead Nurse Adult Safeguarding (LNAS) documented the pressure damage to both of Alan's ankles and his right heel. Later that day, a Last Days of Life Care Record was completed.

On **8th July 2016**, the County Council's Access Team logged that a Section 42 Safeguarding Concern had been received from the hospital. The Tissue Viability Nurse (TVN) was requested, by hospital staff, to review Alan but before this could be done, and at **20.08**, Alan died. The cause of death was formally recorded as sepsis, a collapsed left lung and Parkinson's Disease dementia. [Note: The TVN and the LNAS met on the 19th July to discuss the pressure damage identified on Alan's admission to hospital. The hospital chronology records: "Damage to the right heel would have started a while prior to admission as the photograph [taken on admission] showed the skin to be very dry. Alan's deterioration in condition, skin changes at life's end and travel in an ambulance should also be taken into account in relation to all pressure damage".

The Safeguarding Adults Coordinator (SAC) at the County Council commenced information gathering on the **11th July 2016**: The SAC contacted Alan's wife but there was no recorded discussion on who would/should act as advocate for Alan. Indeed, as the County Council's chronology of events records, record keeping, on a number of occasions, was not to the expected standard. In addition to the safeguarding concerns raised by the second hospital, the family also raised concerns about the care afforded to Alan during his lengthy stay in the previous acute hospital. This was followed up by the SAC but links to the enquiry were not made clear.

The SAC informed the County Council's Quality Assurance Team (QAC) about concerns relating to the care Alan received at the care home but there is no record of an alert being raised with the Care Quality Commission. (It is understood that, due to the volume of concerns received, unless very high risk, individual alerts are not made to CQC. The QAC would add to their risk profile and high-risk homes are discussed at a monthly multi-agency provider information and assurance meeting.)

The SAC made a decision that the S42 criteria were met and a formal, non-statutory enquiry was started: to consider the risk to others including the use of pressure relieving equipment by the residential care home at which Alan had been resident and his rapid decline while there. On **12th July 2016**, the SAC met with Alan's wife and daughter: the family asked that "Alan's untimely death be investigated, and appropriate actions taken" [County Council chronology]. On **13th July 2016**, the SAC updated the Quality Assurance Team and also requested the care home to complete a Root Cause Analysis relating to the pressure injuries sustained by Alan. This was subsequently submitted but threw no light on the matter. On **4th August 2016**, an Adult Safeguarding Planning Meeting was held attended by representatives from the first acute hospital, the care home, the Mental Health Trust and the Council's Quality Assurance Team. The matters under consideration were "the background of Alan's

period in hospital, discharge to DTA bed [and] subsequent rapid decline resulting in death" [County Council IMR]. It transpired that "the Care Quality Team had spent two days at [the care home] and during this visit had not found significant concerns regarding the quality of the care provided to its residents" and that "[the care home] needed to complete more detailed care plans and to complete body maps" [County Council IMR].

On **7th September 2016**, the SAC met again with Alan's family when the family's concerns dating back to November 2015 were reiterated. On the **26th September 2016**, the SAC informed Alan's daughter that a Safeguarding Adult Review was to be considered and after further information gathering and discussions with Alan's daughter, the appropriate referral was made to the Safeguarding Adult Board on the **21st November 2016**.

Subsequent to these events, and as stated in the Introduction, it was not until the early summer of 2017 (27th May 2017) that it was decided to commission this SAR. This apparent delay was of concern to the SAR Panel and it is discussed further in Section 5 (iii) below.

3. Areas for Consideration

Within the Terms of Reference for this Review, a total of ten Areas for Consideration were included.

To take each in turn:

a) How the agencies held Making Safeguarding Personal[2] at the centre of the services provided to Alan.
   - As far as can be ascertained, the principles of Making Safeguarding Personal were applied throughout by the agencies concerned. The only exception may be that the mental health staff did not raise a safeguarding alert when Alan went missing from home October 2015. Safeguarding alerts were raised by the police in March 2016 following Alan's attack on his wife and by the second acute hospital in July 2016 in relation to pressure injuries sustained by Alan.

b) How and when the Mental Capacity Act[3] (MCA) and Deprivation of Liberty Safeguards[4] (DoLS) were applied and how this was documented.

[2] Making Safeguarding Personal (MSP) is a care sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances

[3] The MCA enshrines the presumption of capacity in law for everyone aged 16 and over. Where there is doubt that a person does not have capacity to make a particular decision, the MCA sets out a two-stage test:
(i)Does the individual concerned have an impairment of, or a disturbance in the functioning of, their mind or brain, whether because of a condition, illness, or external factors such as alcohol or drug use? (ii)Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to?
Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make the specific decision

[4] The Deprivation of Liberty Safeguards (**DoLS**) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

- There is no evidence that mental health staff made any formal assessments under the MCA
- The first acute hospital ensured that Alan's mental capacity was assessed at regular intervals. An application was made to the local authority DoLS team on 31st March 2016 and a standard authorisation was subsequently received.
- The DoLS status was shared with the care home on admission from hospital and the home made a formal application on 12th June 2016. However, the care home did not make any formal assessments under the MCA.

c) Were there ways of working effectively that could be passed on to other organisations or individuals?
   - While Alan was a patient at the first acute trust there was excellent information sharing between professionals and evidence of good cross-discipline working.

[Note: As part of the events leading to this SAR, the family submitted a letter to the Safeguarding Board in which they listed their concerns about the events leading to Alan's death. These concerns were summarised and included in the "Areas for Consideration" and follow below.]

d) The circumstances and context in which anti-depressant drugs were prescribed to Alan on 10 February 2016: what advice was given to Alan and/or his wife. (The family are concerned that the medication concerned had contra-indications for falls.)
   - In February 2016 Alan was seen and his care reviewed by the Consultant Psychiatrist at the consultant's clinic. It was reported that Alan was 'still enjoying life' but struggling with worsening motor symptoms of Parkinson's Disease, his memory not being so good and continued hallucinations. Alan's wife was involved in this consultation. She felt that Alan was depressed and reported that incontinence was a problem. The Consultant noted that there appeared to be increasing carer stress. The options for medical management was discussed with Alan and his wife (the family dispute this) and a decision was made by the Consultant to start Rivastigmine. A recommendation was also made to increase Mirtazapine should Alan's depression worsen. A clear treatment plan was put in place and communicated to Alan's GP.

     (Rivastigmine is used to treat Alzheimer's Disease and dementia in Parkinson's. Mirtazapine is used to treat major depressive disorders.)

e) For Mental Health staff, the circumstances and context in which the anti-depressant drugs prescribed to Alan on 10 February were stopped. (The family are concerned that the sudden ceasing of the medication triggered

the aggressive outburst which led to Alan being admitted to hospital on 30th March 2016.)

- This is fully discussed in the chronology above, viz:

1st March 2016, the local pharmacy checked with the Mental Health Team about the continuation of the prescribed medication. A Doctor from the Mental Health Team contacted Alan's wife and advised that if any problems or side effects were to arise, then Alan should stop taking the medication and advise the Mental Health Team accordingly.
11thMarch 2016, Alan's wife contacted the same Mental Health Team doctor to say that Alan was experiencing more falls and an increase in hallucinations. She requested that the medication be stopped: the doctor agreed that this was the right course of action. The GP and the pharmacy were advised of this.

f) For the Mental Health staff, what contacts were there between Alan's family and the Consultant Psychiatrist on the specific issue of the potential need to safeguard Alan's granddaughter?
   - This is detailed in the chronology section of this report in the paragraphs relating to the 4th and 29th April 2016.

g) For the County Council, what advice was given to Alan's family on the specific issue of the potential need to safeguard Alan's granddaughter?
   - As far as can be ascertained, at no stage did staff from the County Council's children's safeguarding team have any contact with members of Alan's family – it is arguable that they should have done so. However, as mentioned in the Chronology in Section 2 of this report, the Community Psychiatric Nurse did have conversations with Alan's wife and, separately, with Alan's daughter on this issue. The detail is given in the chronology above.

h) For the first Acute Hospital, what information was provided to the care home at the point at which Alan was discharged to that care home? (The family are concerned that the discharge summary was not accurate.)
   - The hospital discharge summary noted that Alan was at high risk of falls and that he had recently had a lower respiratory tract infection which had been treated with intravenous antibiotics. His DoLS status was also shared with the care home. Senior care home staff had visited Alan prior to his move to the care home.

i) For the care home, what were the visiting arrangements for Alan's family to see him? (The family state that they were only allowed to visit by appointment.)
   - The care home states that they had a policy of open visiting: no appointment was necessary and, indeed, unannounced visits were encouraged. Alan received visits from family members on the 15th and 20th June 2016. It is not clear if these visits were by appointment or unannounced. According to the care home's records, there were six telephone contacts between the home and

Alan's wife (on the 9th, 11th, 13th, 16th June and the 4th and 6th July) – the call on the 11th June was initiated by Alan's wife when she was told that Alan had fallen, but all others were initiated by the home. However, Alan's relatives tell me that Alan's wife attempted telephone contact with the home daily.

j) For the care home, what information was recorded in the care record about Alan's pressure sores/ankle wounds and an ulceration to his penis? What treatments were provided?

- There is no record of pressure injuries/ankle wounds nor of the ulcerated penis during Alan's stay at the care home. He was largely mobile, but decreasingly so, during this time. He slept on a soft "comfort plus" mattress on a bed without side rails. A redness to Alan's scrotum was first noted on 3rd July 2017. It was monitored but as it faded, no further action was taken. Alan had been body mapped on the 3rd July and there is no record of an ulcerated penis nor of injuries to Alan's ankles.

4. Areas of Good Practice

There were six areas of good practice which should be highlighted.

(i) The Older Adults Mental Health Team in the community were responsive when Alan had immediate needs, making home visits at short notice and keeping good communications with Alan's wife and other professionals. Decisions about treatment plans were well documented and information appropriately shared (albeit, on one occasion, when Alan's medication was changed, there was a delay in typing up and dispatching the clinic notes to the GP).
(ii) Professionals worked well across organisational boundaries
(iii) Child safeguarding concerns were identified and acted upon in line with Policy and expected practice. These concerns were appropriately and proportionately shared with professionals involved and there was due diligence in information sharing.
(iv) Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were largely applied at appropriate stages.
(v) Safeguarding Alerts were raised at appropriate points.
(vi) The sensitive and caring approach taken by the second acute hospital when it quickly became apparent that Alan was dying.

5. Discussion of Areas of Concern

There are three particular areas of concern.

(i) Alan stay in the first acute hospital, from March to June 2106, was far too long. From a very early stage in Alan's stay in hospital, he was medically fit for discharge. As stated earlier, a number of proposals and plans were made for his discharge, including, as reported by Alan's family, a discharge within the first week which was prevented by lack of domiciliary support. At times, there appeared to be a lack of clarity of the best options for Alan and a number of community placements declined to offer Alan a place because of his progressive Parkinson's Disease and dementia. A transfer to a community hospital was cancelled because of infection control measures. Alan was in hospital for some 10 weeks.
Timely discharge is essential to not expose the patient to the risk of hospital acquired infections nor to the known adverse impact an acute hospital environment can have upon the mobility and well-being of patients with severe cognitive impairment.

On admission to the second acute hospital, Alan was found to have three pressure injuries to his ankles and an ulcerated penis, but these conditions had not been recorded by the care home. (A body map had not been completed prior to transfer from the care home to the hospital but allowing for the emergency nature of the admission to hospital, this may not be unreasonable

(ii) It is known that Alan was admitted to hospital with a chest infection and died as a result of sepsis and a collapsed lung. The SAR Panel has sought and received expert advice on sepsis and the impact that sepsis may have upon the development of pressure injuries.
The SAR Panel has been informed that sepsis can be difficult to identify and that patients can move from a minor infection to sepsis very quickly, especially if the immune system is weakened and the patient is elderly. In Alan's case, the onset appears to have been very rapid and may have been triggered by the pre-existing urinary tract infection and chest infection or by the ulceration to his penis.
In relation to the development of the pressure injuries, we are advised that any medical condition or co-morbidity that impacts on oxygenation of the tissues will impact on the potential for pressure injury development. At times of an oxygen crisis in the body (in addition to the sepsis, Alan had a chest infection/collapsed lung) the body will automatically divert oxygen to the vital organs – brain, heart, liver etc – at the expense of the skin and peripheral areas of the body, such as heels and buttocks. It is possible, therefore, that the development of Alan's pressure injuries, in common with the onset of sepsis, could have been very rapid indeed albeit the TVN was clear that the pressure injuries to Alan's right heel would have started prior to Alan's admission to hospital. This may also be true of the ankle injuries.

(iii) Alan died in July 2016, but this SAR was not commissioned until 27th May 2017. A SAR Referral was received from the County's Adult Safeguarding Coordinator on 21st November 2016. A scoping meeting was held on 5th December 2016, within the timescale set out in the SAR protocol. The minutes of the meeting state that the recommendation was pending due to

lack of information in key areas and was to be agreed virtually once the required information had been gathered. The deadline for the further information to be received was stated as 19th December 2016. The decision to pend the recommendation was submitted to the Independent Chair on 15th December 2016: The Independent Chair made her decision the following day and approved the recommendation of the subgroup. The outstanding information was received by 19th December 2016, the agreed date, and circulated to the subgroup for comment. (The subgroup had agreed to manage the decision making virtually as the next subgroup meeting was not scheduled until 31st March 2017.) However, it was not until the 1st March 2017 that the Safeguarding Board's SAR Sub-group reached a decision to recommend that a SAR should not proceed. (The delay was due to the limited capacity of Sub-group members to devote time to the Sub-group's work.) The recommendation not to proceed with a SAR was based on the view that while there were some learning points for individual agencies, the necessary actions were already being taken by the agencies concerned.

At a meeting of the Sub-group on the 23rd March 2017, when it was noted that the recommendation not to proceed had been ratified by the Director of Adult Services, on behalf of the Independent Chair of the WSAB, the Sub-group took steps to establish a process to audit the action plans of the individual agencies.

On 6th April 2017, a letter was sent to Alan's family informing them that a SAR would not be commissioned. On the 11th April 2017, the partner of Alan's daughter requested a meeting with WSAB staff to discuss the decision. A meeting was held on 18th April 2017 with Alan's daughter and her partner when information on the decision making was provided. Later the same day, an email was received by the WSAB staff asking for more clarification. This was provided on 28th April 2017. (It transpired that the family had not been told of the outcome of a much earlier Section 42 safeguarding enquiry and that the family had been provided with information documents relating to SAR's well before the decision to proceed, or not, with a SAR had been made. This had led to considerable confusion for the family.)

A further email was received by WSAB staff, from Alan's daughter, on 17th May 2017 requesting a further meeting – this was held on 24th May 2017. At that meeting, Alan's daughter provided a written report detailing their concerns and made a formal appeal against the decision not to commission a SAR. The appeal was submitted to the Independent Chair of the WSAB later the same day and she decided, on the 27th May 2017, that a SAR should proceed.

6. Action and Learning

Within the IMRs, the agencies were asked to identify learning points and make recommendations to improve future practice. Those accepted by the SAR Panel can be summarised as follows:

Mental Health Staff

(i) Ensure that the needs of Carers can be identified within holistic assessments
(ii) Raise the awareness of the benefits of an early offer of support from the Patient Advisory Liaison Service if concerns or conflict is recognised

The First Acute Hospital

To develop a process to progress discharges, when the patient lacks mental capacity to consent to discharge destination, and staff are unable to reach a consensus on the discharge plan with involved parties.

The Care Home

All residents to have a body map completed prior to hospital admission.

I would add that the home should re-examine their procedures and practice in relation to assessing "the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe". (Health and Social Care Act 2008 Regulation 12): this particularly to apply to maintaining the personal hygiene of residents and the identification and treatment of pressure injuries. I would **recommend** that the County Council's Quality Assurance team and the CCG makes an assessment against the findings of this SAR.

The Second Acute Hospital

There were no action points received.

The Adult Safeguarding Team at the County Council

(i) To ensure effective and timely record keeping – there were omissions in the recording within the safeguarding enquiry: records need to be maintained in a timely manner so that there is a clear chronology of events, discussions and decisions.
(ii) To clearly identify all outcomes to be achieved and to be realistic with family members about what is achievable – due to some omissions in recording it appears that family may have wanted other aspects related to Alan's care to be investigated but this is not clearly known or understood and the response to this request is unclear.

The WSAB (SAR Decision Making Process)

(i) Virtual decision making, by email, should be avoided if at all possible, especially when there are complex issues to consider.
(ii) Families must be kept informed of progress during the SAR decision making process
(iii) Information provided to adults, families, carers and friends about SARs needs to be clear

I would recommend to the Worcestershire Safeguarding Adult Board (WSAB) that the Board agrees the issues identified as requiring action by the agencies and the additional actions I have proposed and (if not already available) invites the agencies to submit associated action plans. The Board will wish to ensure that these plans are audited, over time, to be assured that the desired outcomes have been achieved.

I have not found any failings in the WSAB's Interagency procedures or policies.

7. Closing Remarks

A standard question to consider as part of a SAR is whether or not the person's death could have been avoided had agencies done more. Alan had a long history of a debilitating condition and following a long period of hospitalisation, he had become a frail man. In the last few days and weeks of his life, he had experienced significant urinary tract and chest infections, three pressure injuries and ulceration to his penis. As stated earlier, the onset of sepsis can be very rapid and very difficult to identify and could have been triggered by any of the infections he suffered. Sepsis is fatal in a significant proportion (40%) of cases and especially so when the person's immune system is already weakened. However, it is not possible to conclude that had Alan been discharged from the first acute hospital very early in his stay, or that had the infections he suffered while at the care home, including the ulcerated penis, been treated more effectively, then his death may have been avoided.

The first acute hospital did what it could, in difficult circumstances, to meet Alan's needs.

On the night of the 5/6 July, the care home monitored Alan very regularly - as soon as it became apparent that he was seriously ill, the 111 Service was called, and an ambulance arrived and transferred Alan to hospital promptly. The staff at the second acute hospital were highly efficient in diagnosing Alan's difficulties and carefully and sensitively explained the prognosis to family members. The origins of the pressure injuries and the ulcerated penis may be never known but may well be directly associated with the rapid onset of sepsis and, ultimately, Alan's death. We will never know with any certainty.

Alan's death was a real tragedy for the family. There are lessons to be learned from these sad events (as outlined above), lessons which may help avoid similar distress for others in the future.

Robert Lake
Independent Author
January 2018

APPENDIX 1

Worcestershire Safeguarding Adults Board
Safeguarding Adult Review of Mr AK

TERMS OF REFERENCE

1. Introduction:

1.1 Alan had care and support needs and was in receipt of care. He died while receiving care. Concerns have been raised, by his family and by safeguarding agencies, about the standard of care Alan received in the weeks prior to his death.

1.2. He was first diagnosed with Parkinson's Disease some 10 years ago. In August 2015, Alan was assessed by a Consultant Psychiatrist and found to be suffering from depression with memory difficulties. At the end of October 2015, Alan was admitted to acute hospital as there were concerns for his health and safety – he had been wandering and was agitated and confused. He returned home a month later. In February 2016, the onset of dementia, related to the Parkinson's Disease, was diagnosed, and the depression confirmed, for which medication was prescribed. In late March 2016, Alan was admitted to acute hospital, for physical and psychiatric assessment, following an attack he made on his wife. He was considered to be fit for discharge within a week but remained in the hospital for a period of 10 weeks before being admitted to a specialist care home on a "Discharge to Assess" (DTA) basis on 9th June 2016.

Alan was admitted to (a different) acute hospital on 6th July 2016 in an unconscious state and found to be suffering from a chest infection and septicaemia. It was also found that he had pressure sores to his heels and bruising to his ankles. Alan died 5 days later.

2. Supporting Framework:

2.1. The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

2.2. Section 44, Safeguarding Adult Reviews**:**

(i) 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.

(ii) 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).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.3. This Safeguarding Adult Review is being held in accordance with the Worcestershire Safeguarding Adults Board Safeguarding Adults Review Protocol criteria **1**. This states that "*the Worcestershire Safeguarding Adults Board must arrange for there to be a Review if the statutory criteria prescribed in section 44 of the Care Act 2014 are met. Statutory Guidance on these criteria is provided in Chapter 14 of the Care and Support Statutory Guidance, at paragraphs 14.133 and 14.134. Therefore, the Board **must** undertake a Safeguarding Adults Review under the following circumstances;*

> *when an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) dies and the Worcestershire Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it know about or suspected the abuse or neglect before the adult died)."*

3. Methodology:

3.1. This Safeguarding Adults Review will primarily use an investigative, systems focused and Individual Management Review (IMR) approach. This will ensure a full analysis - by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key front line staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of Safeguarding Adult Review:

4.1. Adult: **Alan:** Date of Birth: 17 April 1948
Date of Death: 11 July 2016

4.2. Timeframe

The scope of the SAR will be from 30 October 2015 to 11 June 2016

4.3. In addition, agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case

5. Agency Reports:

5.1. Agency Reports will be commissioned from:

- The local (Mental) Health and Care Trust
- The Acute Hospitals NHS Trust which cared for Alan in March to June 2016
- The care home to which Alan was admitted in July 2016
- The County Council's Adult Safeguarding Team

5.2. Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.3 Any references to the adult, their family or individual members of staff must be in a non-identifiable format as per the Caldicott Principals.

5.4 Any reasons for none cooperation must be reported and explained.

5.5 All Agency Reports must be quality assured and signed off by a senior manager within the agency prior to submission

5.6 It is requested that any additional information requested from agencies by the SAR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.7 It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the SAR.

5.8 SAR Panel members (or stated nominated member of that organisation) will monitor action plans as identified in section 8 of the IMR and provide WSAB assurance of their progression/completion prior to the completion of the SAR which will be fed into the final SAR report. Updates will then be requested until all actions are completed. Any issues in regards to lack of completion or lack of communication in regards to an action plan will be escalated by the SAR Chair to WSAB following the Escalation Procedure.

5.9 It should be noted by all agencies that Alan's family will be updated on the outcome of the actions identified in the SAR by the Chair of the CR Sub Group

6. Areas for consideration

a) How the agency held Making Safeguarding Personal at the centre of the services provided to Alan
b) How and when MCA and DoLS were applied and how this was documented
c) Are there ways of working effectively that could be passed on to other organisations or individuals?
d) The circumstances and context in which anti-depressant drugs were prescribed to Alan on 10 February 2016: what advice was given to Alan and/or his wife?
e) For the Mental Health Trust, the circumstances and context in which the anti-depressant drugs prescribed to Alan on 10 February were stopped.
f) For the mental Health Trust, what contacts were there between Alan's family and the Consultant Psychiatrist on the specific issue of the potential need to safeguard Alan's granddaughter?
g) For the County Council, what advice was given to Alan's family on the specific issue of the potential need to safeguard Alan's granddaughter?
h) For the first Acute Hospital Trust, what information was provided to the care home at the point at which Alan was discharged to that care home?
i) For the care home, what were the visiting arrangements for Alan's family to see him?
j) For the care home, what information is recorded in the care record about Alan's pressure sores/ankle wounds and an ulceration to his penis? What treatments were provided?

7. Engagement with the adult/family

7.1. While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in and across agencies and services, it is imperative that the views of the family and details of their involvement with the SAR are included in this.

7.2. All IMRs are to include details of any family engagement that has taken place or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the SAR.

7.3 This is in recognition of the impact of Alan's experience/death. In doing so it ensures that this enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Worcestershire Safeguarding Adults Board.

7.4. Worcestershire Safeguarding Adults Board are responsible for informing the family that an Independent Reviewer has been appointed.

8. Media Reporting

8.1 WSAB will prepare a media statement which must not be varied from without the specific authorisation of the Chair of WSAB's approval

8.2 During the SAR process any enquiries from the press in relation to the SAR are to be passed to the WSAB Coordinator

9. Publishing

9.1 It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

9.2 Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the family and time allowed to reflect on how they would like the adult to be referred to.

9.3 The media strategy around publishing will be managed by the Community Awareness and Prevention subgroup of the WSAB and communicated to all relevant parties as appropriate

9.4 Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date

9.5 Whenever appropriate an 'Easy Read' version of the report will be published.

10. Administration

10.1 It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account or the WCC Cisco system. Failure to do so will result in data breach.

10.2 The Board Co-ordinator will act as a conduit for all information moving between the Chair, IMR authors, Panel members and the Case Review sub group

11. Confidentiality

11.1 All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared without prior consent from the SAR Independent Author or the Case Review Chair.

12. Timetable for Safeguarding Adult Review

Letter to IMR agencies to identify authors and secure documents	26 June 2017
First introduction and discussion with the adult/family	July 2017
Panel Meeting and Authors' briefing	14 July 2017
Completion date for IMRs	11 August 2017
2nd Panel (scrutiny of IMRs)	18 August 2017
First draft of Report circulated to Panel members for feedback	August 2017
Final draft of report completed and 2nd meeting with adult/family to consider final draft and suggest amendments. Any amendments made to final draft following meeting with adult/family	October 2017
Safeguarding Adults Review Sub Group meets to consider final draft report and SAR recommendations	27th November 2017
Final draft report and SAR recommendations circulated to Worcestershire Safeguarding Adults Board members.	January 2018
Worcestershire Safeguarding Adults Board meets to consider final report.	15th January 2018

WSAB Sub Group Chairs meet (with SAR Author if required) to determine multi-agency action plan from the SAR recommendations	TBC