Statutory Safeguarding Adults Review (SAR) Report in respect of an adult woman to be known as Heather. A S44(4) Care Act; Discretionary Review

1. Introduction:

The person at the centre of this review will be referred to as Heather, but this is not her real name. She was an 80-year-old white British woman who lived alone in her privately owned house in Stoke-on-Trent. She had several health concerns including a history of breast cancer, diabetes, vascular dementia, leg ulcers and recent chest infections. She had been in hospital for a short period at the end of 2019 which was followed by a stay in a 'discharge to assess' unit where it was determined that she was able to be cared for at home. She was discharged to her home address on 16th March 2020 with a self-funded a care package consisting of a full-time carer who lived at the home address with her.

It must be pointed out that her discharge was the week before the period of the first lockdown in response to the COVID-19 pandemic, and at that time there was no vaccine, testing was in its infancy, together with uncertainty about the effects of the virus and how to respond to it.

At the end of April 2020, a community nurse made a routine visit to attend to Heather's legs which had recently recovered from infection, but still needed dressings. It is now known that Heather was presenting with signs of sepsis, but this was not picked up by the nurse in attendance.

The following day the carer called Heather's GP with concerns that Heather had sepsis. An ambulance and paramedics attended, and she was taken to hospital but sadly died the following day.

2. Safeguarding Adult Reviews (SARs):

In April 2015 the requirement to undertake SARs became statutory through the Care Act 2014, Section 44 which states:

> (1) A Safeguarding Adult Board (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—
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> (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
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> (b) condition 1 or 2 is met.
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> (2) Condition 1 is met if—
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> (a) the adult has died, and
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> (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).

(3) 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.

(4) An 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). This is referred to as a discretionary review but is still a statutory SAR.

(5) 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

This review was conducted under S44(4) Care Act 2014 i.e. a Discretionary Review

The purpose and underpinning principles of this SAR are set out in **Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Safeguarding Adult Review Enquiry Procedures.**

The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice.

3. The SAR referral:

A SAR referral reporting the circumstances leading up to the death of Heather was received by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board on 15th May 2020 and considered for a Safeguarding Adult Review at a scoping meeting held on 24th July 2020.

The SAR Sub-group recommended that this case met the criteria for a SAR at a scoping meeting and the Independent Chair of the Board determined that the case would be reviewed under Section 44(4) as a discretionary review in a letter sent to the Chair of the scoping meeting on 25th August 2020.

4. The review process - including the impact of the Coronavirus COVID-19 pandemic:

A collated chronology was produced from those submitted by all involved organisations. The period considered was from 01.05.2019 to Heather's death on 30th April 2020. This consisted of 218 pages and included a critique of each point of contact with Heather matching the activity against the policies, procedures, and process of the relevant organisation. The

chronology was very detailed and used at the scoping meeting to identify several learning points and areas for improvement.

It was proposed that as the circumstances were not overly complex, that the lessons to learn were clearly made out and because the critiqued chronology had provided much detail there was no requirement for an Independent Reviewer to conduct the review.

This overview report has been prepared by the SSASPB Business Manager and has taken into consideration the feedback from Professor Michael Preston-Shoot's Analysis of SARs (September 2020) and the Social Care Institute of Excellence SAR Quality Markers (to be launched on 7th December 2021) which, together with the demands placed on the SSASPB by COVID-19, has contributed to the delay in the production of it.

In mid-March 2020 the COVID-19 Coronavirus pandemic caused an unprecedented response which impacted massively on the SSASPB partner agencies in both demand for their time and the ability to communicate as a partnership across one platform. At the time of writing (November 2021) partners have become very used to non-face to face (or virtual) working. It took a while to put in place the necessary infrastructure to work remotely; including the development of new communication platforms, an expansion to the IT network to cope with the demands placed by home-working and the supporting hardware. It is important to recognise that the activity following identification of the learning, and consequent actions required to address this, continued.

The organisations which contributed to this review were:

- Care Broker
- District Nursing and Community Health Provider
- Mental Health, Social Care, Learning Disability and Substance Misuse Services Provider
- Out of Hours GP Services
- Clinical Commissioning Groups
- Fire and Rescue Service
- Police
- Local Authority
- Acute (Hospital) NHS Trust
- Ambulance Service

4. Involvement of Family Members:

Heather had one adult daughter who was estranged from her and who chose not to be involved in the SAR.

5. Background /summary:

Heather was an 80-year-old white British female who lived alone in her privately owned house in Stoke-on-Trent and had several health concerns including breast cancer, diabetes, vascular dementia, leg ulcers and recent chest infections.

She had been in hospital for a short period at the end of 2019, this was followed by a stay in a 'discharge to assess' unit which determined that she was able to be cared for at home. She

had asked for no intensive treatment for her cancer and was assessed as able to make this decision.

She was described by several agencies as difficult, non-compliant with her medication-taking and at times she would lash out at others, including carers. This was believed to be because of the onset of dementia.

As a result of Heather having been assessed as lacking capacity to make decisions around her care and support needs, a Best Interest Meeting was held on 13th February 2020. The outcome of the meeting was that the Multi-Disciplinary Team agreed that they needed to honour Heather's previous wishes to remain at home and not enter 24-hour care. An advocate was present at this meeting.

The decision was made to discharge Heather to her home address, to be supported by a self-funded full-time live-in carer. The allocated social worker identified the care broker believing them to be a care provider when in fact they acted as a broker and were not a registered care provider. This meant that on discharge the responsibility to manage the care provided lay with the social worker and it has since been recognised that both the social worker, carer and broker were not sure of each other's roles and responsibilities in this case. It is important to note that she was discharged on 16th March 2020, very shortly before the first national lockdown resulting from the COVID-19 pandemic which occurred on 23rd March 2020 and at a time when instructions were coming out from the government to discharge as many patients home as possible owing to the uncertainty surrounding hospital capacity for COVID-19 patients.

Despite being invited to the Best Interests meeting which was held at the nursing home the district nurses who were based near her home address and who had previously attended to Heather's leg dressings when she was at home did not attend. This was because it was then usual policy for district nurses who are attached to homes in their area to be invited and attend, and they also felt that the nurses at the home could provide the necessary clinical nursing input. The home was in another area of Stoke-on-Trent, not covered by those who had tended to her dressings previously. This was identified by the organisation who provides District Nursing as a missed opportunity to provide continuity of care and they proposed that they take steps to learn lessons from this.

The privately commissioned live-in carer was known to Heather as she had worked at the discharge to assess unit. Usually, in this situation, the carer would take extended rest days after several weeks of work but as this occurred during the first COVID-19 lockdown it was decided that the carer would remain living with Heather. This was less than ideal for several reasons including there was no respite for the carer and little support from the broker or the Local Authority. It must be remembered that these were very challenging times, and much was unknown about the potential impact of COVID on everyone, especially the most vulnerable and frontline workers who cared for them.

During the Police investigation the carer described a difficult relationship with Heather, including verbal abuse. She was not trained as a nurse and therefore community nurses attended to carry out her assessed nursing needs which included changing the dressings on Heather's leg ulcers.

On the 28th April 2020 the Community nurse made a routine visit to dress Heather's legs which had recently recovered from infection, but still needed dressings. Although the room was warm Heather's temperature was lower than normal and she was shivering. This is an indicator of systemic infection which, together with other signs, ought to have raised concerns about possible sepsis with further acute interventions sought. It appears that this was not considered as no further medical attention was sought by the attending nurse. The trust that employs the district nursing services have mandated that district nurses must complete Level 1 sepsis awareness training; sepsis awareness has also been included in other training packages including Basic Life Skills and Clinical skills training to provide further opportunities to raise awareness of sepsis. Recommendations from the review were put into an action plan for the organisation.

On 29th April 2020 the carer called Heather's GP as she identified that Heather may have sepsis. An ambulance and paramedics attended. The carer stated that Heather had been sleeping in a chair whilst waiting for a special bed to be delivered but had kept falling out and so had been made comfortable on the floor. Heather was very unresponsive with rapid, shallow breathing, low oxygen levels and a low body temperature. The dressings on her lower legs showed signs of purulent discharge striking through the bandages. Sepsis was suspected and she was taken to hospital but sadly died the following day.

The initial Police response was to detain the carer for neglect under Section 20 of the Criminal Justice and Courts Act 2015 (Ill Treatment or wilful neglect of care worker) as Heather was found on the floor in very poor health and with some bruising. Enquiries quickly revealed that the bruises were not caused by assault and that she had been placed on the floor because she kept falling off the chair and also a suitable bed was on order and due to be delivered soon. The carer was released from Custody and the Police took no further action. Better information seeking and sharing at the earliest opportunity may have prevented the arrest of the carer.

During the scoping panel's consideration of the chronology, it was identified that record keeping could be improved as in some instances there was insufficient information made to justify decision-making. It is important that the rationale for decisions is recorded so that handover of care is as efficient as possible.

Although Heather was believed to have capacity to determine that she no longer wished to receive treatment for her cancer and to be cared for at home there was no formal Capacity Assessment. This assessment could have given a more accurate indication of exactly what she was able to make decisions on.

Through the review of multi-agency held information it was apparent that there could have been fast-tracked for consideration for Continuous Health Care (CHC) funding for Heather's complex needs.

The review of the critiqued chronologies identified that there had been confusion over people's roles in the multi-agency safeguarding process for adults with needs for care and support. One professional was believed to be a qualified Social Worker which was not the case, this assumption led to unmet expectations.

At the time of the SAR referral, it was not clear to what extent the COVID-19 pandemic had impacted upon any decision-making with regard to Heather and her care.

6. Cause of death:

There was no post-mortem nor inquest into the death of Heather and death was recorded as 'natural causes'.

7. Recommendations:

- **i.** The Board are to be assured that where there is a best interest meeting for an adult with care and support needs (who has significant health needs) a nurse or other health representative will be present in compliance with current policy.
- **ii.** The Board is to be assured relevant agencies have communicated to their staff the message that Safeguarding Adult Reviews and audits have repeatedly identified that there is often insufficient rationale recorded on case management systems to justify decision making.
- **iii.** Assurance to be sought by the board that front line professionals are aware of sepsis flags.
- **iv.** Staffordshire Police to consider what information is available to better support situational decision making during the response and investigation of neglect cases.
- **v.** The Board should be assured that professionals will introduce themselves and their roles within a multi-agency context and how they are best able to support the adult with care and support needs.

8. Action Plan Governance:

An action plan was developed and activity in support of it was monitored at the bi-monthly SAR sub-group meetings. At the SAR sub-group meeting dated 14th July 2021 the evidence put forward to support the action plan was agreed to and signed off.

This report has been prepared under the statutory requirements of the Care Act 2014 by Helen Jones, the Staffordshire and Stoke-on-Trent Adult Safeguarding Board Business Manager

Helen Jones

SSASPB Business Manager,

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