Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Abuse must stop

Statutory Safeguarding Adults Review (SAR) Report and Findings in respect of an adult female to be known as Anne.

1. Introduction:

This Safeguarding Adult Review (SAR) was carried out so that the agencies involved in providing services could learn lessons and improve practice. The report is anonymised and will use the pseudonym Anne to ensure no individuals can be identified. Agencies have looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight and importantly, to improve services as a result of that learning.

The adult at the centre of this review is Anne, a divorced white British woman in her late eighties who lived alone in social housing in a 2 storey, 2 bedroomed, semi-detached house with a downstairs toilet. Anne had no close family and had been divorced for over 40 years. She did have friends and neighbours who maintained contact with her and those nearby helped with her shopping and other errands.

From the information shared by the relevant organisations it seems that Anne had enjoyed good health and independence until the summer of 2019 when there appears to have been a fairly rapid decline impacting upon her ability to take good care of herself. She previously had no identified needs for care and support. When Anne needed support from a domiciliary care provider this was arranged and funded by herself.

Anne experienced falls at home in the summer of 2019 resulting in hospital visits via ambulance. On the second occasion, following assessment in the Accident and Emergency department she was not admitted and returned to her home address. The domiciliary care package was not reinstated as it was the belief of the provider that Anne would be admitted to hospital. Anne was discovered deceased in the lounge of her home address following an alert made by friends who had travelled to deliver a Birthday card to her several days after her return home.

The circumstances of Anne's death were distressing for her friends and all involved in the review, especially those who had personal contact with her. Anne had been described as independent and strong minded and all efforts were made to personalise her during the review.

2. Criteria for undertaking a SAR:

A Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances under Section 44 of the Care Act 2014 which sets out the criteria for a Safeguarding Adults Review (SAR). This includes circumstances 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 there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died.

Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to apportion blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

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

A SAR referral was submitted by the Police on 26th September 2019. The circumstances were considered by the SAR sub-group in November 2019 and, as a result, detailed and critiqued chronologies were requested from which to determine whether or not a recommendation that the criteria for a SAR would be made to the SSASPB Independent Chair. The timeline for the chronology was between 1st June 2019 and 1st September 2019. The organisations contributing were:

- Housing department of a district council
- Domiciliary Care Agency
- Clinical Commissioning Group
- District Nursing and Community Hospital Health Provider
- Out of area Acute (Hospital) NHS Trust
- County Council Adult Safeguarding and Brokerage teams
- Police
- Ambulance Service

The scoping meeting was held on 2nd December 2019, and a recommendation that the criteria was met under S44(1) Care Act 2014. The SSASPB Independent Chair responded that he supported this recommendation.

The review panel consisted of the members of the Safeguarding Adult Sub-group and senior managers in organisations which held significant information and had provided a chronology.

The Independent Chair also supported the scoping panel's recommendation that the very detailed and critiqued chronologies could be used as the basis from which to analyse how agencies had worked together and to assist in the identification of lessons to learn leading to the production of an action plan. This was owing to the very detailed critique of entries made

in the chronology and the fact that there was a clear indication of the areas that needed more focus and from which to learn lessons.

The SSASPB Business Manager was tasked with the production of a concise overview report which will be published on the SSASPB website and shared with the Regional and National SAB Business Managers networks so that the learning may be shared widely.

On 27th February 2020 a review meeting was held to start the process of action planning. Three Critical Friends were also appointed. These were experienced SAR sub-group members whose organisations were not involved in the review. Their function is to provide real time challenge to any aspect of the process and action planning. This is normal practice for SSASPB SARs and is included in the SAR protocol.

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 (April 2021) partners have become very used to non-face to face (or virtual) working, but from March to June 2020 it took a while to put in place the necessary infrastructure to work remotely; including the development of new communication platforms (Microsoft Teams being the most commonly used), 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.

Following the production on an initial action plan a review of the contents was undertaken by the SSASPB Business Manager and the vice-chair of the SAR sub-group (September 2020). That review refocussed several of the actions resulting in the need for more detailed assurance from the partners involved. This self-challenge was good practice and will be undertaken in future to ensure that the actions and resultant activity are sufficiently rigorous.

4. Involvement of Family Members:

Anne had no known close family, but following enquiries made by Police, the District Council and a private heir tracing company a great nephew was located. He had never met Anne and felt that he could not add to the review but did ask that the overview report and findings/actions were shared with him once finalised.

5. Background /summary:

Anne lived alone in social housing. She was described by those who knew her as determined and independent and had friends in her community who often assisted her with shopping and the facilitation of bill payments. The District Council tended to her lawns and general maintenance of the property. There is mention in the chronologies of a working telephone (landline).

Anne had chosen to use only the ground floor of her home, preferring to sleep in a reclining armchair in the living room. There was a downstairs toilet.

Anne was known by two names, the variation in her first name being as a result of a familiar derivative of the original and her surnames that were held on records were either her maiden or married names.

In June 2019 she called 999 following a fall in her home. It is thought that she may have lay on the floor for up to 24 hours. The Ambulance Service attended and took her to the out of area Acute (Hospital) NHS Trust. This hospital is located outside the Staffordshire area but is often used by those living in Staffordshire. The Ambulance Service submitted a safeguarding concern and assessed that Anne did not have capacity, possibly due to an infection. She was not in receipt of care and support at this time. There were no injuries found but there were reddened areas in the spine and sacral area, she was described in the notes made at the time as being very unkempt. As there were no safeguarding concerns the referral was treated as a request for assessment. It was noted that Anne was not in possession of a pendant alarm which she could have used to raise alarm in the event of a fall.

At this time, it was recorded that one of her neighbours was Anne's 'Next of Kin'. This is believed to have been an assumption as they were not related, nor did the neighbour agree to this designation and asked for this to be removed from any records. The consequences of this inappropriate designation were felt later in the summer of 2019 when the neighbour withdrew some of her contact with Anne in an attempt to reinforce their wishes.

Anne regained capacity and asked to go home when she could. Arrangements were put in place for an assessment of need so that a care package could be agreed. The assessment determined that Anne would be responsible for paying for this means tested social care.

Anne's GP was sent a letter with information regarding her discharge, this included her hospital number and date of birth. It was not filed correctly by the GP as it did not give her NHS number or the name that she had on her NHS file. It was noted that some agencies were able to link Anne's names together into one file and that other organisations were unable to do this. Everyone has an NHS number but not all have a hospital number.

Anne was in hospital for 23 days and discharged following several assessments to be able to propose the most appropriate care package to meet her needs. On the 9th July 2019 records stated that the care package should consist of 4 calls per day and that a key safe and alarm pendant had been proposed and agreed to by Anne.

She was returned home by patient transport on 17th July, but they felt unable to leave her there as the carer had mentioned that there was no food in the house, the toilet was very dirty, the house unkempt and there was no key safe. The ambulance staff believed that Anne was unable to clean it herself and took her back to the hospital where she was returned to the ward despite there being no medical concerns.

There was confusion about access to Anne's home address so that her carers could let themselves in. The package that had been agreed through assessment and brokerage stated that carers were needed four times a day. It had been assumed that the neighbours and/or

the person believed to be the Next of Kin (NoK) would let them in. This was not the case and the person who had been previously referred to as the NoK reiterated once more that she did not want to take on this responsibility. A key safe was discussed and Anne agreed to pay for it.

Anne remained in this original (acute) hospital for a further 8 days and was then transferred to a Hospital where she remained for 26 days whilst assessments continued, and the new brokerage process completed (a full re-assessment was required as Anne had been in hospital for a while). A care agency accepted the care package and agreed to commence visits on the 20th August 2019.

On the 19th August 219 a male neighbour took the care agency representative into Anne's home to show them the layout and where Anne slept. The toilet was still covered in faeces (from 17th July 2019). The Care Agency representative were concerned about the state of the toilet but there was confusion over whose responsibility it would be to clean the toilet. A commode had been provided (at cost to Anne) in the care package and it is believed that the toilet was not cleaned. Cleaning had not been included in the care package, but the review panel believed that this should have been cleaned by the care agency on this occasion and in these circumstances.

Anne was released to her home address at about 1800hrs on the 20th August 2020. The carer noted that there was no telecare option as the landline was not working, there was also no alarm pendant. The phone (landline) had previously worked as Anne had used it to call the District Council and the review could not confirm why and when it had stopped working.

On 21st August 2019 a carer found Anne with unexplained blood loss when supporting her continence needs and reduced mobility, so an ambulance was called after consultation with the 111 service and Anne's GP. An ambulance conveyed Anne to the original acute hospital. The carer believed that Anne would be admitted – this was not the case and she was returned home after assessment in the emergency department. It was documented within that assessment that Anne had capacity and was 'in good cheer' and able to move around with assistance from her walking frame and content to return home. She was returned home the same day by the patient transport crew who were informed by Anne that her carers would be visiting later that day.

The care package was not reinstated and no care was received by Anne.

On 1st September 2019 a friend who had travelled to deliver a Birthday card to Anne raised concerns via 999 as she could see Anne lying on the floor through the window. Entry was gained and Anne was found to have died.

6. Cause of death:

The post-mortem investigation concluded that Anne had acute pyelonephritis (acute kidney infection) and hypertensive heart disease.

7. Analysis/Learning points:

(i) The discontinuation of Care: The main area of focus in this SAR was the discontinuation of the care package when the care worker made the incorrect assumption that Anne had been admitted to hospital. It will never be known exactly when Anne died and there is no comment about malnutrition or dehydration in the post-mortem report.

The Care Agency agreed to submit their very brief chronology and participated in the early stages of the SAR, attending the scoping meeting and making a good contribution. They only provided care for one day as Anne was discharged on the evening of the 20th August and taken into hospital having been found with unexplained bleeding by the carer the following day. Latterly they decided to cease providing care in the Staffordshire area and despite invitations to do so didn't engage further in the SAR process.

The manager involved in the SAR acknowledged that the carer should not have assumed that Anne had been admitted to hospital and should have continued visiting until it was confirmed that there had been an admission. It was agreed by the review team that the Accident and Emergency staff would not be expected to make enquiries whether there was continuance of a care package. That said, there is a Track and Triage team which is separate from A&E and which should have followed this through. In this set of circumstances that didn't happen because Anne was considered to be 'out of area' as she lived in Staffordshire and the Hospital is in the West Midlands area.

Both of these 'safety nets' failed and care did not continue.

The County Council Care Commissioning Team confirm that care should continue to be provided until hospital admission is confirmed and that this is in the relevant care agency contracts.

Prior to withdrawal from the SAR process the Care Agency Manager confirmed that their company policy had been changed to specifically state that all care appointments are to be attended until an admission to hospital is confirmed.

(ii) Next of Kin nomination: Several agencies' documents recorded that a male and a female neighbour were Anne's Next of Kin. This is now known to have been an assumption as they were not related, nor did the neighbours agree to this designation and even asked for this to be removed from any records. The consequences of this inappropriate designation were felt later in the summer of 2019 when the neighbours withdrew some of their contact with Anne, believed to be in attempt to reinforce their wishes.

(iii) Use of NHS number: NHS numbers are unique and should be used by all relevant agencies to assist with correct identification, this becomes especially important when people change their name or are known by different names as in Anne's situation.

(iv) Falls: Assistive Technology: At the event of Anne's fall in June 2019 the Ambulance Service noted that she was not in possession of a pendant alarm which could have been used to make others aware of her need for help. On 9th July 2019 Anne agreed to fund her care package, key-safe and pendant alarm. The key safe was installed at her home address but the pendant

was never provided. On 20th August 2019 it was noted by the carer that the landline was not working, a working phone line is required for telecall support. It is unknown whether or not a working pendant alarm may have prevented Anne's death. Decisions to provide Assistive Technology in support of a care package must be followed through to completion.

(v) District Council support:

During the scoping meeting the District Council representative said that if they had been contacted about Anne they could have helped with her well-being and supported any multi-agency response. Options included passing attention when her lawns were mown, support for a one-off cleansing (toilet) and help to understand why the phone was not working, facilitating the use of the pendant alarm and telecare.

(vi) Insanitary home conditions:

It was recorded that the downstairs toilet in Anne's home was insanitary. She was described as very unkempt on the day of her fall in June 2019. It was believed that it was Anne's 'choice' to live in this way. The SSASPB have undertaken several SARs now where insanitary home conditions have been recorded and thought to be a lifestyle choice. The SAR sub-group have recommended that where an adult with needs for care and support has Capacity but lives in insanitary conditions that efforts are made to explain why the conditions may pose risks to their health and well-being. District Council said that had they been made aware of these conditions they may have been able to assist with cleansing.

(vii) Mental Capacity Assessments:

At the time of the fall in June 2019 Anne was reported as not having capacity to understand her care and support needs, this may have been because of an infection. Her capacity was reported as regained a short while after but no formal Mental Capacity assessment was made. The lack of use of Mental Capacity Act assessments is a frequent finding in SARs both locally and nationally. Anne was described as 'independent and strong-minded' but may have had failing capacity to agree to the details of her care package.

(viii) Occupational Therapy home assessments:

The review identified that it would have been beneficial for Anne to have had an Occupational Therapy Home Assessment prior to discharge from hospital. This should have been triggered by her 'very unkempt' appearance and the fact that she lived alone with no known relatives which, put together, were potential indicators of her inability to take care of herself.

8. Recommendations:

- The SSASPB is to seek assurance that Commissioners, care agencies and Hospitals agree and document their role in ensuring that there is continuance of care in circumstances where an adult with care and support needs is discharged from A&E particularly as an out of area patient (i.e. not admitted to hospital).
- The SSASPB are to reinforce the need for clear documentation and record-keeping, particularly where more than one organisation may need to respond to or act upon the

comments. Decision-making is to be supported by clear rationale and acronyms explained on first use.

- The SSASPB is to seek an insertion in the West Midlands Regional Self-Neglect guidance to address the following finding 'Where adults with capacity are living at home in unsafe conditions that could put the adult's health at significant risk, steps should be taken to explain the potential risk to support the adult in making their own decision'
- The SSASPB are to task Commissioners with ascertaining the feasibility of adults (with care and support needs who appear unkempt, are assessed as frail and are living in isolation without a package of support) having an Occupational Therapy home assessment prior to discharge
- A briefing note is to be produced which will give an overview of the circumstances leading to the SAR and will include all the recommendations contained in section 7 of this report

9. Action Plan Governance:

The action plan was developed shortly after the scoping panel meeting and then revised to make the wording of the actions more focussed and assurance based in September 2020. Activity towards the action plan is monitored at the bi-monthly SAR sub-group meetings and progress reported to the quarterly Board meetings.

This report has been prepared under the statutory requirements of the Care Act 2014 Section 44 (1) by Helen Jones, the Staffordshire and Stoke-on-Trent Adult Safeguarding Board Business Manager.

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Approved by the SSASPB in January 2022.