Islington Safeguarding Adults Board

Safeguarding Adults Review in respect of the care and support of two adults

Ms BB and Ms CC

Ms BB died on 1st October 2015

Executive Summary

Safeguarding Adults Review Chair: Detective Chief Inspector Paul Cheadle
Safeguarding Adults Review report author: Jane Lawson
This Overview report is based on information taken from Individual Management Reviews (IMRs) and chronologies completed by each of the organisations involved. There is a presumption that when an organisation completed an IMR, all relevant people were consulted with.

The findings expressed in the report are those of the report’s author and the Safeguarding Adults Review Panel.

Names have been anonymised throughout this report.

The following abbreviations are used in the report:

A&E    Accident and Emergency Department
ASS    Adult Social Services (provided by London Borough of Islington)
BARTS  Barts Health NHS Trust
CHC    Continuing Healthcare
CMC    Coordinate my Care
DN     District Nurse
DNAR   Do not attempt resuscitation
DNACPR Do not attempt cardiopulmonary resuscitation
DoLS   Deprivation of Liberty Safeguards
IMR    Individual Management Review
LBI    London Borough of Islington Council
MATS   Memory Assessment and Treatment Service
MCA    Mental Capacity Act 2005
Met Police Metropolitan Police
OT     Occupational Therapist
REACH  Multidisciplinary rehabilitation team working with physically disabled adults, promoting health and maximising independence, particularly around mobility, falls prevention, communication and everyday activities.
SAB    Safeguarding Adults Board
SAR    Safeguarding Adults Review

SP1: Senior Practitioner (1)
SP2: Senior Practitioner (2)
SW1: Social Worker 1 (main social worker allocated to Ms BB)
SW2: Social Worker 2 (main social worker allocated to Ms CC)
1 Introduction & the circumstances that led to a Safeguarding Adult Review (SAR) being undertaken in this case

Ms BB died on 1 October 2015 in circumstances that give rise to concerns about the way in which professionals and agencies worked together with Ms BB and Ms CC. The cause of death was dehydration and infection secondary to a grade 4 pressure ulcer.

Ms BB died in hospital having been admitted on 18 September 2015 with a Urinary Tract Infection (UTI); hypotensive; malnourished and dehydrated. She had an infected pressure ulcer. She was admitted to hospital along with Ms CC. Ms BB and Ms CC had been receiving 24 hour care following Ms BB’s discharge from hospital on 20 August 2015.

Under section 44 of the Care Act 2014, the Local Safeguarding Adult Board (SAB) must arrange a Safeguarding Adult Review “when an adult in its area dies as a result of abuse or neglect (whether known or suspected) and there is concern that partner agencies could have worked more effectively to protect the adult”. The purpose of a safeguarding adult review is primarily to:

- provide useful insights into how organisations are working together to prevent and reduce abuse and neglect of adults
- promote effective learning and improvement action to prevent future deaths or serious harm occurring
- identify lessons and examples of good practice where this might be applied in future situations

“SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that...” It is emphasised that this process is not about blame.

In November 2015, the Islington Safeguarding Adults Board received a request to consider whether to commence a Safeguarding Adults Review (SAR) in relation to the death of Ms BB and which would also consider the care provided to Ms CC. The Safeguarding Adult Review sub-group of the SAB made the decision that the care received by Ms BB and Ms CC had met the criteria for their case to be progressed to a SAR under Section 44 of the Care Act. The criteria set out in section 1 are met.
Ms BB and Ms CC

Ms BB was born on 9 March 1924 and died 1 October 2015. Ms CC was born on 1 August 1930 and currently lives in a nursing home. They lived together in Islington for over 40 years. Their home was a second floor two bedroom flat. The tenancy of the flat was initially in the name of Ms BB's brother, Mr XX. On his death (1981) it transferred to Ms BB. At this time Ms CC was recorded as a friend and member of the household. On 20 August 1990 the tenancy transferred to a joint tenancy of Ms BB and Ms CC.

Both Ms BB and Ms CC had strong and supportive family relationships. Their families enjoyed spending time with them over the years. They received substantial support from both of their families when their care needs increased. Ms BB's younger brother lives in Potters Bar and offered significant support to Ms BB and Ms CC throughout the period under review. Ms CC's sister also offered significant support and lives in Kent. They visited at weekends carrying out numerous practical tasks and making sure money was available to carers for necessities.

Ms BB’s brother described Ms BB and Ms CC as “the most caring couple of ladies you could wish to meet”. He said that they were previously always spotlessly clean and they all enjoyed spending time together over the years. He said that “we feel like something is really missing now [Ms BB] is gone and they, [Ms BB and Ms CC] are not together”.

The two families (of Ms BB and Ms CC) remain close and Ms BB’s brother said that he and his wife and Ms CC’s sister had arranged to visit Ms CC together the following Sunday (after this conversation for the review took place ) and that Ms BB’s brother was to visit Ms CC that same day. Ms CC lives in a nursing home in Potters Bar.

Similar characteristics were conveyed by the GP who had primary responsibility for Ms BB and Ms CC. He said they were: caring, both within their own relationship and towards others; kind; independent; private; mutually supportive; spotlessly clean; well organised. The report provided by the GP gives insight into the life of Ms BB and Ms CC before their independence began to be eroded due to their increasing support needs. It stated: “They always consulted together never separately. They were 'model patients' in so much as they always attended the practice for their six monthly blood pressure check and annual blood tests. They didn't require a reminder letter. This was the main reason for them attending the surgery, prior to 2013. They usually walked round to the surgery but in the latter years Ms CC drove them both in their car. At Christmas time they would bake mince pies and bring some to the surgery to give to Dr A. Neither called nor consulted over minor self-limiting illnesses".
The GP reported: “They … had met while both working 'at the print' [reference to working together in a print factory] over 40 years ago and had lived together a similar length of time. They came across as very caring towards each other and shared a home, working as a team”.

Prior to July 2014 they lived largely independently. Ms BB had received professional support around mobility and an assessment from Services for Ageing and Mental Health (SAMH) when a likely diagnosis of vascular dementia was made.

The Islington Safeguarding Adult Board Safeguarding Adults Review subgroup has identified the purpose of this Safeguarding Adults Review as to understand what happened and to learn from the way local agencies and staff worked together including what did and did not work well. It has made a commitment to agree how this learning will be acted on and what is expected to change as a result. It is intended that through developing practice as highlighted in this review, adults who may be in need of safeguarding support will be better safeguarded from significant harm.

2 Analysis and learning from this review

This review considered the period from May 2013 until the death of Ms BB in October 2015.

There were five distinct periods within this:

- the period before and during Ms BB’s hospital admission on 15 July 2014
- the period between Ms BB’s discharge from hospital on 24 July 2014 and her re-admission on 22 March 2015
- the period during which Ms BB was again a hospital inpatient from 22 March 2015 until 20 August 2015
- the period following Ms BB’s discharge from hospital on 20 August 2015 up to the admission of both Ms BB and Ms CC on 18 September 2015
- this period in hospital for both Ms BB and Ms CC from 18 September until Ms BB’s death on 1 October and Ms CC’s move into a nursing home.

The panel scrutinised a lengthy integrated chronology (109 pages), bringing together the range of chronologies from involved organisations. Analysis of this alongside Individual Management Reviews from involved organisations and other relevant documentation forms a basis for defining key aspects of practice that require development.
Key themes and learning arising from the review

Examples of positive practice

The analysis focuses chiefly on areas for development. The Panel also wants to acknowledge some particularly prominent examples of good practice that emerged from the events of this case/review. There were other examples but these are the most striking:

- Islington council’s occupational therapist and her consistent communication across the multidisciplinary team as well as putting clear and planned measures/equipment in place.
- Allied Healthcare referrals to the GP regarding concerns about for example: the catheter, pressure ulcer, medication blister pack, swallowing difficulty, buying incontinence pads.
- A range of organisations recognising safeguarding issues and reporting these appropriately (Provider services; London Ambulance Service; Police; University College London Hospitals; District Nurses)
- Dementia navigator: sensitive, respectful, person centred engagement with Ms BB and Ms CC
- GP: sensitivity to the wishes of both Ms BB and Ms CC, this was underpinned with a person centred approach in getting to know them and what was important to them over 18 years of being their GP. This person centred knowledge was applied in decision making and in supporting planning ahead for future decisions or crises.
- At the end of Ms BB’s life the care at University College London Hospital took every possible care in ensuring that they were together. The end of life care of Ms BB and the compassion for Ms CC was very positive.
- Whittington Health NHS Trust in terms of the learning and action plan they have set out and begun work on following their own review of the practice and circumstances of Ms BB and Ms CC. This demonstrates a real commitment to learning necessary lessons. It will benefit other organisations to adopt a similar methodology and level of rigor.

The following areas are considered in detail in the review:

- Identification, assessment and management of the range of needs and risks that presented for Ms BB and Ms CC
  - A focus on Ms BB and Ms CC and their families
  - Practice in respect of assessment, care planning, monitoring and review
  - Practice in respect of specific aspects of the range of needs presented by Ms BB and Ms CC
Hospital Discharge Policy and Practice
Achieving a shared understanding and shared decision making and action within and across organisations
Safeguarding Adults from abuse and neglect
The role of commissioning and contract monitoring
The areas of similarity with the Serious Case Review in respect of Mr AA, Islington Safeguarding Adults Board, 2015

3 Conclusions

At the centre of this review is a focus on best practice in working with need and risk in complex situations and on ensuring that engagement with service users and their families is central to practice. University College London Hospitals modelled good practice in respect of bringing a clear understanding of the importance of the relationship between Ms CC and Ms BB into end of life care planning. The GP sought to empower Ms BB and Ms CC by encouraging planning for their future as their independence was gradually eroded, in part by the onset of dementia. However the insight into their wishes gained from this needed to be communicated more widely and acted upon by a range of professionals. These insights needed to be integrated into contingency planning and a clear personalised pathway of care for Ms BB and Ms CC in discussion with them and with their families.

There was a lack of rigor in carrying out and recording assessments, identifying key needs and risks and reviewing and monitoring these. Care plans reflected a similar lack of detail and accuracy. These were not provided in a timely way. The approach to progressing safeguarding referrals revealed similar issues relating to lack of clarity and structure in assessment, action planning and review around concerns.

There was an absence of holistic risk assessment in the case of Ms BB and Ms CC. This complex situation required clarity about the nature of the risks, constant review in keeping this assessment up to date, communication across all of the involved professionals and a willingness to act and to share accountability for managing the risks. Local guidance on working with risk needs to be updated and accompanied by development opportunities across agencies. The review indicated a particular need for a focus on balancing choice and safety in situations where individuals decline support/treatment.

There is a clear need for practice development in the context of the requirements of the Mental Capacity Act. This was particularly significant in a situation where problematic choices were made by Ms BB and Ms CC which potentially put them at risk. They needed to be supported to understand the risks as far as possible. Professionals needed to be clear about the decisions on which they lacked capacity in order to judge where assertive action in their best interests was indicated. Examples where capacity assessments were carried out indicated a tendency to apply the Act in order to facilitate necessary resource-led activity (such as hospital discharge) rather than to empower Ms BB and Ms CC.
There were specific aspects of the care and treatment of Ms BB and Ms CC which were problematic. Practice in the above areas on occasions compounded a lack of attention to procedures and available guidance. There are, in particular, significant implications in respect of the need to develop practice in pressure ulcer prevention and care across organisations. This learning arises from both the care and treatment of Ms BB in hospital and in the community. It ranges from attention to prevention; the links to safeguarding; communication on hospital discharge; communication with family members; review of the Continuing Healthcare assessment. There is a need too for training and awareness in the domiciliary care sector.

The focus on practice in respect of pressure ulcers connects with issues that arose in the review in relation to nutrition, hydration, and catheter care/continence. Nutrition is a critical factor in pressure ulcer care. It was not emphasised in notifications/referrals to professionals on discharge of Ms BB from hospital. There was an apparent lack of monitoring/review of weight despite the care plan stating that Ms BB was to be encouraged to eat and that her intake must be recorded. There was a delay in engaging a dietician and in asking the GP to prescribe dietary supplements. Ms BB’s weight reduced from 53.8kg on 19 August to 43.6kg on 19 September (on admission to hospital). This was a reduction in weight in the one month following discharge from hospital of around 10kg. There were failures too in implementing policy and procedures in respect of catheter care as well as confusion as to responsibilities in both catheter care and the provision of continence pads.

Ms BB’s deteriorating condition, particularly after acquiring a pressure ulcer, indicated a clear need to review the Continuing Healthcare assessment. This was intended but never carried out.

Attention has been drawn at a number of points in this review to the problematic discharges of Ms BB from hospital (in particular the discharge on 20 August 2015). All of the available guidance stresses that discharge planning begins before admission. Hospital discharge is built on a firm foundation of quality assessment, monitoring and review before and throughout an inpatient episode as well as on communication and joined up understanding of the person and their needs. It requires effective and meaningful communication with patients and their families. National guidelines repeatedly emphasise these core principles and aspects of practice in respect of hospital discharge. There is a real need for local multi-agency cooperation to improve joint working on hospital discharge. There is a specific need for learning from this review to be actioned by Barts Health NHS Trust.

All of the above rely upon effective communication. The review highlights some specific areas where communication must be enhanced. It highlights too some positive local initiatives which offer the potential for development. Communication is not simply about passing on information. It requires joint commitment and a shared understanding of responsibility and accountability to act. This communication needs to include honest and open discussion of competing agendas and pressures from individual to organisational level.

The six principles for Safeguarding Adults set out in the statutory guidance: empowerment; prevention; proportionality; protection; partnership and accountability
are fundamental in underpinning the necessary development in response to this review. The balance between empowerment and protection was at the heart of this situation. Sound practice in balancing choice and safety relies on a proportionate response. A robust, person centred and positive approach to working with risk will support this. Prevention is a key issue particularly in respect of pressure ulcers and nutrition/hydration. The need for accountability was clear, particularly the associated “I” statement in the guidance which explains accountability as: “I know what everyone’s role is and so do they”. In complex situations where there are a wide range of organisations involved this clarity is crucial.

4 Recommendations

Those recommendations marked (*) are similar to recommendations in the case of ZZ, Camden (2015). It may be possible to work across Boroughs on some of these actions.

Individual agency recommendations are included below where they underline highly pertinent matters and the Safeguarding Adults Board needs to be particularly alert to them.

* 4.1 Engaging with people who use services and their families/carers

Islington Safeguarding Adults Board will continue to develop its engagement as a whole partnership in Making Safeguarding Personal ensuring that person-centred principles are embedded in all relevant policies, procedures and guidance, in front line practice and in commissioning of services.

It will identify several basic and practical tools (such as the supported decision tool, Department of Health 2007\(^1\)) to support front line staff across agencies to begin to make this shift in practice (from completing processes and ticking boxes to having meaningful conversations with people about what is important to them and the outcomes they want from health and social care support.)

There will be a focus on this aspect of practice in case file audits.

The Board will seek assurance that training and other support is in place to develop the necessary skills so that staff can make this shift in practice: specific training courses; reflective learning opportunities; staff supervision.

The Board will seek evidence of engagement with carers and informal networks including seeking evidence of carrying out of carers assessments.

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\(^1\) Independence, choice and risk: a guide to best practice in supported decision making, DH 2007
* 4.2 Practice in the context of the Mental Capacity Act 2005 (MCA)

The areas of practice in the context of the MCA which are clearly indicated in the review as requiring attention are:

- understanding when and why an assessment of capacity is called for and how this must be carried out and recorded
- supporting people to make informed decisions and to understand the consequences of their decision making (including understanding the risks)
- assessing best interests and making decisions in a person’s best interests
- applying all of this in balancing choice and protection and making decisions as to where assertive action is required
- Do Not Attempt Resuscitation decisions
- application of Deprivation of Liberty Safeguards

Alongside a continuing emphasis on engagement in training across all organisations there will be:

- A focus in case file audit on practice in respect of the core principles of the Act and the above aspects of practice.
- All organisations must put in place support for all levels of staff to help them to understand how the principles of the MCA must be worked out in practice. Real examples must be used to convey this learning and to support staff/professionals in understanding their responsibilities under the MCA Code of Practice. The Islington Safeguarding Adults Board will hold organisations to account in this respect.
- The case of Ms BB and Ms CC will be used in MCA training to demonstrate the necessary learning, along with other relevant case studies referred to in this review.
- The Board will ask of commissioners that they have assurance of integration of the requirements of the MCA in practice.
- The Board will respond to the recommendations of the House of Lords Scrutiny Committee on the MCA.
- Barts Health NHS Trust and University College London Hospitals will audit practice in respect of Deprivation of Liberty Safeguards and address any gaps in policy/practice.
4.3 Working with risk

- Adult Social Services and Whittington Health will lead improvement in this area of practice with the re-development of the joint risk enablement policy. This will incorporate learning from this review as well as reference to practice development elsewhere from similar case reviews (for example Camden ZZ; Slough DD).

- The above will incorporate the development of tool(s) for recording risk assessment and risk management in line with the new policy/guidance.

- The existing risk enablement policy includes reference to working with people who are reluctant to engage with services/support/treatment. This must be redeveloped in the light of this review including reference to good practice in the context of the Mental Capacity Act.

- The guidance must reflect the need for coordination and communication so prominent in this review.

- The Safeguarding Adults Board will develop an implementation plan to include staff training and the support and development of front line staff in working with risk.

- Specifically training in risk assessment and risk management will be reviewed in the light of this Serious Case Reviews across agencies.

The above will be a focus in case file audit.

4.4 Improving practice in respect of assessment, care planning and review.

Member agencies to the Safeguarding Adults Board (SAB) will specifically ensure that key assessments, reviews and any changes to agreed care plans are robustly recorded and communicated across all relevant agencies so that all are clear about the key issues and risks and all understand their roles and responsibilities.

- The SAB will disseminate the learning in respect of multidisciplinary assessment and on carrying out reviews as set out in this Safeguarding Adults Review (in particular in 4.4.2). This will include drawing attention to the need to bring in specialist assessments/expertise where indicated (for example Tissue Viability Nurse; continence adviser)

- Adult Social Services will review practice guidance and recording formats for assessment, care planning and review to reflect the lessons from this Serious Case Review. Guidance locally will reflect the lessons highlighted in this review and this will be :
  - supported through training and staff support/ supervision, and
  - monitored through a focus on these aspects of practice and recording in future case file audits.
• Locally commissioning and procurement will support providers in reviewing this area of practice and recording and focus on the regulatory requirement in respect of coordination and communication between commissioners and providers on care plans and reviews.

• Individual organisations involved in this review will have a focus on recording in their individual action plans.

4.5 Achieving a shared understanding; shared decision making and action within and across organisations

All agencies must be sighted on key issues, keep track of developments, agree responsibilities and accountabilities and offer support to achieve positive outcomes.

• The Adult Social Services Integrated Quality Care Meeting (IQCM) (the Panel that made decisions about care options for Ms BB and Ms CC) protocol and practice will be reviewed in the light of learning from this review. Issues highlighted in section 4.6 of this report must be addressed. The Board will seek assurance that this has been actioned.

• An analysis will take place across organisations as to what went wrong in the context of multiagency communication. This will scope existing forums and protocols including the Integrated Care Network Service; Care Coordination Policy; Integrated Patient Units; GP practice weekly meetings; the IQCM. Best practice will be developed to respond to the learning in this review.

• Specifically this review will directly inform the development of the new Integrated Network Coordination Service (INC)

• These forums and others where relevant will, as part of their protocol, make explicit reference to the requirement to deal transparently with the sometimes competing interests of the organisations and individuals. Clear assessment of need and risk and the clarity that flows from that in advocating for individuals are key in finding a right balance in this context. (This tension between individual perspective/needs and organisational constraints/needs was evident at a number of points. For example, the clear protocol for the IQM favouring avoidance of placing people in residential care directly from hospital settings; the competing demands surrounding hospital discharge; the policy for block contracts above a specified cost ceiling).

• The role of the community matron will be clarified in the context of this review so that partner agencies are enabled to make appropriate referrals to the community matrons who can oversee service provision when there are multiple agencies involved.

• The shared approach to working with and recording risk in 6.3 will support this.
• Practice in respect of the Coordinate My Care record will be reviewed and reported back to the Board.

• Roles and responsibilities in respect of Continuing Health Care will be clarified across organisations. There will be a particular focus on this within Barts Health NHS Trust where there was a failure to review a Continuing Health Care assessment when necessary.

4.6 Hospital discharge policy and practice

Islington Safeguarding Adults Partnership Board will in the light of this Safeguarding Adults Review, through the Quality Audit and Assurance subgroup, influence the development of single and multiagency policy and practice on hospital discharge. In particular the issues listed in this report in respect of hospital discharge practice must be addressed with reference to resources and guidance which are current nationally and referenced in the Safeguarding Adults Review report.

Existing discharge policies will be audited by the Quality, Audit and Assurance subgroup against the issues raised in this review. A multiagency audit of several cases will be carried out after one year.

Commissioners will monitor practice in this respect against core expectations.

Specifically Barts Health NHS Trust will update its discharge policy in line with current national guidance and the Board will seek evidence that this has been achieved. The Board will link with other relevant Safeguarding Adults Boards in highlighting this need (Tower Hamlets; Waltham Forest).

4.7 Practice in respect of safeguarding adults

Practice and guidance must address the issues set out in section 4.7 of this review. This will be addressed by Adult Social Services and assurance offered to the Board.

The issue of the circumstances in which pressure ulcers must be referred in to safeguarding and the anomalies across local authority areas will be resolved. This action must engage all four Boroughs (Islington; Waltham Forest; Tower Hamlets; Newham). This will be raised with Barts Health NHS Trust, evidencing from this review the benefits of external scrutiny for future learning and practice improvement.

4.8 Practice in relation to Pressure Ulcers

The Independent Chair of the Islington Safeguarding Adults Board will initially approach the 3 Safeguarding Adults Boards in Newham; Tower Hamlets and Waltham Forest (Boroughs having the most dealings with Barts Health NHS Trust), highlighting the findings of this Safeguarding Adults Review in this respect. A joint review (and associated actions) of issues that are highlighted in respect of the Barts Health NHS Trust approach to pressure ulcers and the links to Safeguarding Adults
will be suggested. Links will be made more broadly as appropriate in the context of pan London procedures.

Barts Health NHS Trust will analyse the reasons for an increasing trend in hospital acquired pressure ulcers grade 3 and 4 over the past 12 months (5 in 12 month period). This analysis will be presented to the above Boards alongside comparative figures from neighbouring Health Trusts.

The Board will coordinate awareness raising across organisations and for the public on prevention and management of pressure ulcers. National publicity material is available.

This to include awareness raising across domiciliary care providers through Adult Social Services procurement and with the support of relevant Health professionals. This to include:

- the need to identify early signs and symptoms
- how/when to escalate concerns
- who needs to be involved where there is a risk identified?
- links between pressure ulcers and nutrition/continence/immobility

This to be supported by commissioning and to form a key focus in contract monitoring.

### 4.9 Risk in relation to nutrition

The Board will seek assurance that those at risk of malnutrition are identified and work is undertaken to mitigate the risks. There must be a particular focus on those with dementia and on communicating risk and identifying accountability across organisations (including on discharge from hospital).

The Board will seek information from Dorset County Council, who have implemented a highly successful strategy and programme to identify and address malnutrition and dehydration in adults following a Serious Case Review in 2012 (JT), with a view to scoping the potential for a local pilot.

### 4.10 Management; Islington Adult Social Services

Islington councils Adult Social Services management will identify the scale of issues in relation to the quality of care plans provided by Adult Social Services care management to care providers. Findings will indicate necessary actions within care management.

Islington Adult Social Services management will take steps to address the implications of the block contract raised in this review. In particular steps will be taken to offer flexibility in high risk situations where a sudden change of provider is indicated due to the cost ceiling on spot purchase.
4.11 Engagement in the Safeguarding Adults Review process

There has been a range of levels of engagement and transparency in this Safeguarding Adults Review process. Examples are set out of good practice (particularly in respect of Whittington Health NHS Trust) but also of a reticence either to learn lessons or to offer transparency in other organisations. This is evidenced by the extent to which additional information had to be sought and analysed as it was not included in Individual Management Reviews and the scant action plans set out by some organisations. The Chair of the Board will meet with relevant chief executives to consider and address the reasons for this and to enhance engagement in future Safeguarding Adult Reviews.

4.12 Single agency action plans

Progress on the range of action plans which have been set out by individual organisations (in addition to the above recommendations) will be monitored by the Islington Safeguarding Adults Board Safeguarding adults Review subgroup.