Brent Safeguarding Adults Board

Adult G Safeguarding Adults Review:

Overview Report

Author: Clive Simmons
Date: June 2022

CONTENTS

1 INTRODUCTION

1.1 The Brent Safeguarding Adults Board (BSAB) commissioned a Safeguarding Adults Review, starting in October 2020.

1.2 The review includes contextual information from 2000 and concentrates on the period from 25/02/16 to 25/02/19, shortly before the time that concerns escalated until the date that Adult G died.

1.3 A contribution by family has been enabled through meetings by the Independent Reviewer with Adult G's brother, who has been an enormous support to the review.

1.4 Representatives of agencies contributing to the review, through online interviews with the Independent Reviewer, are listed below (titles are those which applied during the reporting period):

- Home Manager – Care Home
- General Manager – Nursing Home
- Unit Manager, Clinical Lead for Disability – Nursing Home
- Associate Director of Safeguarding – Central London Community Healthcare NHS Trust (CLCH)
- Adult Safeguarding Lead – CLCH (Harrow and IT)
- Manager – Community Learning Disability Team, Central & North West London NHS Foundation Trust (CNWL)
- Professional Lead for Learning Disability – CNWL
- Designated Nurse for Safeguarding Adults – NHS Brent CCG
- Named Professional, Safeguarding Adults – London North West University Hospital Trust
- Head of Safeguarding – London North West University Hospital Trust
- Head of Safeguarding and Transformation – Brent Adult Social Care
- Safeguarding Adults Manager – Brent Adult Social Care, Safeguarding Adults Team
- Head of Commissioning – Brent Adult Social Care
- Team Manager – Adult Safeguarding Team, LB Harrow
- National Safeguarding Advisor, Children and Adults – Care Quality Commission (CQC) – via report
- Review Support Manager – Specialist Crime Review Group (SCRG), Metropolitan Police Service (MPS)
- Safeguarding Officer – London Ambulance Service NHS Trust (LAS), Quality Assurance Directorate.

2 CIRCUMSTANCES LEADING TO THE REVIEW

2.1 Adult G was a resident at a Care Home from 2000 and developed serious pressure ulcers from around June 2016. Despite the intervention of a range of services, these persisted and were a contributory factor in his death at the age of 47 in February 2019. A Brent Safeguarding Adults Enquiry report in July 2019 confirmed that Adult G had experienced neglect.

2.2 The Safeguarding Adults Review has been completed by an Independent Reviewer from October 2020 to June 2022, with delays attributable to the Covid-19 pandemic and additional time for scrutiny and follow-up information by involved agencies. It is anticipated that the full report will be published on the BSAB website, in line with national standard practice, following endorsement by the BSAB Executive Board.

2.3 The learning themes in the terms of reference are covered within the broad themes of multi-agency needs and risk assessment and communication; mental capacity, active listening, mental health and learning disability; the effectiveness of safeguarding adults enquiries; resource and environmental factors; and adherence to policy, procedure and guidance.

2.4 The overview report is presented in the format requested by the BSAB, focusing on a summary of key multi-agency learning.

3 PEN PICTURE OF ADULT G

3.1 Adult G's parents were born in Cork. His father was a caretaker in London, where both Adult G and his younger brother were born. His Irish identity and Catholic faith were very important to him and for many years he attended Mass with his father at a church in Brent. He embarked on pilgrimages to Lourdes more than 20 times and, aged 11, met Pope John Paul II. Adult G attended Coventry College at the age of 17 and enjoyed student life.

3.2 He was interested in music and attended rock concerts with his father. Also, he adored animals. His brother comments that he loved his mum's cooking, Guinness and 'ladies'. He adds that Adult G had a strong, happy character, that he lived life to the full and never seemed to worry about anything. Sometimes he had black hair, sometimes blue, and he usually wore black nail polish. The Care Home records also note that he liked to wear jewellery and sunglasses.

3.3 Adult G experienced a lack of oxygen at birth and his legs were paralysed. He was diagnosed with congenital cerebral palsy, learning to walk with the aid of crutches until the age of 10. Adult G did not meet most of the

developmental milestones in his early years. At the age of 12, he was diagnosed with scoliosis and had corrective surgery to straighten his spine, then mobilising with the use of an electric chair. At the same age, he lost the ability to verbalise, due to the impact of his condition on his lungs. In the Care Home care plan, it was noted that Adult G wished to be able to communicate his needs more clearly.

3.4 Adult G lived in a Care Home, a purpose built facility for people living with physical disabilities, in close proximity to his parents to whom he initially returned 3 days a week. This was until they had to move to non-adapted accommodation and he was no longer able to access the family home. His brother recalls that Adult G had desired more space and to be around people of his own age. On moving to the Care Home, he required support with personal care. His palsy and mobility worsened and his hands became stiffer. Also, his vocal chords deteriorated and it became more difficult for him to use his hands to communicate, using communication aids. His brother states that a learning disability had not been diagnosed and his cognitive functioning had not been formally assessed, as his physical disability appeared to account for his difficulties, until the final years of his life. Adult G received regular visits from his parents and brother. They were supportive and he enjoyed spending time with them.

3.5 A Priest delivered a moving tribute at his funeral and commented on his profound faith and love of life.

4 ANALYSIS & LEARNING

In this section, the key learning areas in multi-agency practice between February 2016 and February 2019 (with earlier contextual information) are considered.

4.1 How effective was multi-agency needs and risk assessment and communication?

4.1.1 Professional curiosity and placement suitability: Adult G experienced a complex range of physical and mental health conditions that caused him to be vulnerable to the development of pressure ulcers:

- Cerebral Palsy and Scoliosis which meant a loss of strength in his limbs, a difficulty for staff in repositioning and ultimately confinement in bed
- Potential and later diagnosis of a mild to moderate learning disability, a later diagnosis of depression, poor communication and uncertainty about mental capacity in relation to decisions about care needs
- Nutritional support needs in the form of a PEG feed
- Double incontinence and reports of urine leakage.

He moved to the Care Home in December 2000 and Brent Adult Social Care (ASC) held care management responsibility, with a record of involvement dating back to 2005.

Care management reviews: Annual care management reviews were completed by the Brent ASC Placement Review Team in July 2015, February 2017 and May 2018. Review Officers are linked to care providers within Brent but, as Adult G was placed in Harrow, this did not apply.

A review was not completed in 2016, which was a missed opportunity to identify potential concerns about care. Whilst the review in 2017 had not recognised the Care Home difficulty in meeting Adult G's complex needs, it was personalised and incorporated the views of Adult G and his family. However, it does not appear that there was a meaningful conversation with Adult G about his views on care received. There was no formal recording on the Mosaic system or sharing with other agencies. At the review in 2018, it was noted that Adult G had a reduced appetite and weight loss, depression, confinement to bed due to pressure ulcers and separation from his parents due to their frailty. The Review Officer recommended urgent transfer to a Nursing Home and a Continuing Health Care (CHC) assessment. It was noted that the Care Home were not managing and should have requested an earlier review, the Hospital had discharged Adult G back to the Care Home when a referral to the Brent Hospital Discharge Team to consider Nursing Home care was warranted, and the TVN and Community Nursing had not previously recommended Nursing Home care. A GP visited and concluded that Adult G's needs could not be met at the Care Home, due to multiple pressure ulcers which were not healing. This was a proportionate and personalised review, which contributed to the decision-making towards hospital admission.

Contract monitoring: A Harrow contract monitoring visit to the Care Home in January 2016, shared with CQC in March, noted a concern about caring for 'nursing level residents.' Whilst the Care Home Provider points out that admissions were based on Local Authority assessments, this was an opportunity for agencies to consider whether Adult G was suitably placed at the Care Home in terms of his specific needs. Brent ASC were advised by the Harrow Safeguarding Adults Team (SAT) in May 2018 that the Care Home was under a voluntary cessation of new admissions, due to serious concerns, as part of a Harrow Institutional Harm Enquiry. Whilst this information was shortly followed by admission to Hospital, he was discharged back to the Care Home in these circumstances.

Care Home records: These were on the whole maintained consistently though not detailed, refer to staff observing faeces on Adult G's dressings in February 2018. Rather than providing a specific risk assessment for skin care, this was incorporated marginally within a continence care risk assessment. In the opinion of the current Care Home Manager, this should have been a separate risk assessment, with detailed care requirements. The Independent

Reviewer considers that a specific risk assessment may have further focussed carers attention on pressure ulcer related care.

Care standards: There is some evidence of attentive care and close working between Primary Health Care Agencies. However, there was not an integrated, coordinated and reviewed clinical plan that identified and responded to the difficulty in meeting Adult G's complex needs. Whilst carers were regularly given advice on wider pressure ulcer care, including repositioning and catheter care, there appear to have been grounds to have more promptly escalated a concern about whether a Care Home setting could provide and enable the care required. The CLCH representatives state that there is documented evidence within Community Nursing records that Care Home Carers did not always follow nursing advice on how to care for Adult G. As an example, that Community Nurses observed Adult G sitting up in March 2018 and his pressure relieving boots had been put on incorrectly. The Independent Reviewer has not analysed this evidence within the scope of the review.

Multi-agency coordination: There was insufficient professional curiosity by all involved agencies in recognising, escalating and taking accountability to address the Care Home difficulty in meeting his complex needs by triggering a risk management process. There was not a sense of Health and Social Care agencies providing coordinated planning and oversight of treatment and care, enabling formal consideration of whether Adult G required care in a Nursing Home.

There were grounds to have considered a multi-agency risk management meeting, as a care management or safeguarding adults response, from December 2017 when a limited strategy meeting was held. The step may have been appropriate as early as February 2017, by which time Adult G was being nursed in bed.

Improvements in services: The Brent Safeguarding leads in this review state that the Brent ASC Commissioning Service was redesigned in December 2017. It is understood that individual care management reviews are now undertaken alongside a review of the provision they are accessing; with a close relationship between the commissioning service, social work teams and health partners.

CLCH leads stress that multi-agency working has significantly improved with the development of a High Risk Panel. Whilst they do not regard it as an appropriate forum to discuss pressure ulcers, the Independent Reviewer suggests consideration of whether this may be an appropriate use of the panel to mitigate risk.

4.1.2 Hospital care & discharge: Adult G was admitted to Hospital on 8 occasions in the review period; from February to March 2016, June to July

2016, June 2017, April to May 2018, June to October 2018, and on three occasions between October and November 2018.

June 2016 admission: On the June 2016 admission he was nursed on a bed without a pressure relieving mattress (contrary to his Hospital Passport) and he received repositioning, fluids and antibiotics. His skin was intact on admission and he developed a category 3 pressure ulcer on his sacrum (improving to category 2 on discharge), a category 4 pressure ulcer on his heel and category 2 pressure ulcers on his hip and buttock. A Hospital Root Cause Analysis (RCA) reported in January 2017 that Adult G's skin was intact on admission, that there had been a delay in receiving pressure relieving equipment, and that pressure ulcers had deteriorated in Hospital. A CCG LeDeR report stated that Adult G "should have been in receipt of appropriate pressure relieving equipment following risk assessments on admission to hospital". The pressure ulcers did not appear to noticeably heal from this time onwards. Assurance was provided that the Hospital was no longer reliant on an outside provider for this equipment.

April 2018 admission: On admission in April 2018, London Ambulance Service (LAS) records refer to ongoing pressure ulcers on both hips; that wounds to both hips were redressed as per the TVN plan and the right hip was dry and nearly healed. He had a category 4 pressure ulcer to his left hip and a healing category 2 pressure ulcer to his right hip. There is a daily record of continued treatment and care and 2 hourly turning was maintained throughout his stay. A TVN review on 23/04/18 noted a category 4 wound and two category 2 wounds, indicating a deterioration in hospital. A record of a medical round on 30/04/18 refers to his catheter leaking. The Discharge Summary on 02/05/18 incorporated a plan to manage the multiple pressure ulcers; involving turning every two hours and dressings by Community Nursing. Referrals were not made to Brent Hospital Discharge Team or to the CCG for a Continuing Health Care (CHC) assessment and he was discharged to a Care Home that had agreed to a voluntary cessation of placements due to concerns about a capacity to meet complex needs.

June 2018 admission: Following interventions by Community Nursing, the GP and Care Home, Adult G was readmitted to Hospital at the start of June 2018, due to infected category 4 pressure ulcers and also that the Care Home was unable to meet his needs. A 4 month period in hospital up to October 2018 caused distress to Adult G and led to his reduced engagement, declining food and a diagnosis of depression. A Hospital Discharge Social Worker was assigned in late June to arrange a Nursing Home on discharge. In early September, a Continuing Health Care (CHC) checklist was completed at a Decision Support Tool (DST) meeting, at which Adult G's brother attended. It is unclear whether medical circumstances or an unnecessary delay accounted for the period that had elapsed since admission. The CHC process was prompt from this point and CHC funding was approved from mid-September (within the 28 day period required by the national framework). The CLCH

representatives consider that the CHC checklist and process should be more streamlined between agencies. Adult G's brother recalls being informed that the lengthy delay in hospital was due to concerns that Adult G may have capacity to decide where he lives, yet there is no record that a Mental Capacity Assessment was completed.

October 2018 discharge: The Nursing Home and brother had been advised that Adult G would be discharged with a vac pump but it was decided by the Hospital on the day of discharge that this could not happen. Therefore, a referral was made to the CCG for a vac pump at the start of October 2018 (on the day of discharge), to support care of the category 4 pressure ulcer, and it was advised that this could take up to a week. Discharge to a Nursing Home in Brent proceeded, in the evening when a daytime discharge was requested by the Home, and the vac pump was delivered almost a week later. The Nursing Home Registered Managers state that the vac pump was necessary to drain the wound and reduce the risk of further wounds developing. A Safeguarding Adults Enquiry indicated that the pressure ulcer did deteriorate, leading to a further hospital admission. He also arrived at the Nursing Home with insufficient PEG feed, which was potentially significant as he required a high nutrition diet and this related to his pressure ulcer care, although this was promptly rectified. Guidance was not provided on the pressure care dressing protocol or training on use of the vac pump, as stipulated in the care plan, although the Nursing Home Managers state that staff at the Home are proficient in completing these tasks. It is unclear whether a referral to the Oxford Bone Unit (OBU) was actively pursued, when an appointment letter was sent to the Care Home in October 2018 at the same time that Adult G was in Hospital.

October and November 2018 admissions: Adult G was readmitted to Hospital on three occasions in October and November 2018, due in part to a deterioration in the condition of the pressure ulcers and possible sepsis. He developed a new category 4 pressure ulcer to his right hip and a Hospital TVN treatment plan was introduced on 17/10/18. A family meeting was held in Hospital with Adult G's brother and his wife on the same day to explain that another pressure ulcer had developed, that the bone was infected and it would be very difficult to cure due to his poor mobility. The Brent Community Nursing Team contacted the Hospital ward to raise the issue that the Nursing Home staff were not trained to use the vac pump. Adult G died in Charing Cross Hospital on 25/02/19. Adult G's brother recognises the care provided by Charing Cross Hospital as exemplary.

Summary of key points: There was a need for the Hospital and other agencies to have considered more thoroughly whether discharge to a Care Home setting was safe and also to have secured essential equipment whilst on the ward and prior to discharge. The decision-making that preceded triggering the CHC process was not sufficiently clear.

4.1.3 Gaps in service delivery: Community Nurses on the whole maintained regular attendance to provide pressure ulcer care to Adult G and advice to carers, with some gaps evident and one significant period of absence. In August 2017 the schedule of visits was unclear and there was a gap covering a 12 day period. A referral for Tissue Viability Nurse (TVN) support in August was not sent to the correct locality and this caused a significant delay although, once in place, the TVN plan was maintained through 2018. Due to an administrative error, Adult G did not appear on a new automated system in November 2017, leading to all appointments being missed for an 18 day period from 07/11/17 to 24/11/17. The outcome of a Root Cause Analysis (RCA) was provided to family by the Community Nursing Team Leader in June 2018, concluding that the deterioration in pressure ulcers was avoidable in the light of the lack of visits, due to an EMIS system error, and that the pre-existing wounds had deteriorated and a new wound was identified during this period. When Adult G's dressings were stained with faeces, it would not have been the role of carers to change these. Also, the Care Home did not record the missed Community Nursing visits or make contact to raise a concern. A monitored record of professional visits to residents would have reduced the risk of undetected missed appointments.

There was a further period of 5 days without visits in January 2018, when 3 visits per week was due, and the Community Nursing schedule was increased to daily visits in February 2018 due to deteriorating skin condition. There was a delay in the delivery of continence pads and dressings in March 2018 and it is unclear if these had a direct impact on care.

It is essential that the reliability of the electronic diary system is assured and that all agencies maintain a holistic view of care, to reduce the risk of gaps in service.

4.1.4 Regulation and inspection: The review highlighted that in this case there was not a clear audit trail of CQC decision-making and that this was a learning point. It was agreed that the consistency and robustness of the recording and audit trail around decision making pre-inspection could be improved, particularly in relation to cross-directorate working.

4.2 How effectively was mental capacity, the person's voice, mental health & learning disability addressed?

4.2.1 Consideration of mental capacity, active listening and mental health: Adult G was assumed to have the mental capacity to make decisions about his care throughout this period but, given the diagnostic concerns, it is not clear if this was based on a thorough assessment of his ability to contribute to decisions. The CCG representatives consider that there was a need for a Mental Capacity Assessment, as there had been reason to doubt Adult G's mental capacity to make complex decisions about the receipt of care. His brother considers that he had the mental capacity to make decisions about

his own life, but that professionals did not probe beyond asking 'are you happy here?' Also, none of the professionals said to him that they could not meet his needs, which meant that he did not have all the information available to make decisions about his care options.

Adult G's views on the care he received and the safeguarding concerns were not actively sought, although Care Home Carers and other professionals demonstrated sensitivity to his emotional wellbeing and established ways to communicate with him in providing care. It is acknowledged that he responded through non-verbal gestures and his communication aids to direct, closed questions, and it may be that there was more that he would have wished to say if further effort was applied to hearing his voice. Also, agencies did not communicate regularly with family members about his care needs.

Adult G did not attend the Strategy Meeting in December 2017 and his brother does not believe that he was spoken to after the meeting to seek his views or to relay the meeting outcome. He states that access to his communication aid towards the end of his life was not enabled and there was no follow-up by any external professional to check if he had access to it.

Adult G's mood was regularly recorded in the Care Home and there was an evident rapport with staff and enjoyment of activity. He was invariably described as happy, smiling and laughing, but at times as quiet, when staff tended to ask if he was feeling alright.

The prolonged Hospital stay from June to October 2018 is known to have had a detrimental impact on Adult G's mental health and there is no indication of meaningful engagement with him about the distress this had caused. The Hospital Discharge Team at the start of October 2018 documented that Adult G required a Mental Capacity Assessment on discharge. His brother feels that at this time, due to the considerable delay in discharge, Adult G "was pretty down, not happy, not in a good place."

4.2.2 Consideration of learning disability and communication:

A Speech Therapist completed an assessment at the Care Home in July 2014 and described Adult G's medical condition as cerebral palsy. He was unable to speak and used a communication aid with staff support, indicating 'yes' and 'no' by nodding or shaking his head and by a change in facial expression. Adult G presented a good level of understanding. The Speech Therapist concluded that there was no evidence of a learning disability and that the communication difficulty was due to his cerebral palsy.

During the period from 2014 to 2016, there is evidence of responsive input from the CNWL mainstream physical disability service, Harrow STARRS; with Adult G receiving therapeutic access, comprising Speech and Language Therapy, Occupational Therapy and Physiotherapy input.

A GP visited in September 2017 and completed a Learning Disability health check; the first of two GP Surgery references to learning disability, without a formal diagnosis. The Harrow CCG representative confirms that the GP Surgery 'understood that the patient had cerebral palsy with moderate learning disability and was non-verbal'. Whilst in Hospital, a Learning Disability Nurse visited Adult G and created a Learning Disability Care Plan, and a further review was conducted in August 2018 by the Learning Disability Nurse.

However, there was no formal assessment of learning disability until November 2018, when Brent CLDT completed an assessment and diagnosed a mild to moderate learning disability. Adult G had been referred to Brent CLDT in June 2018, which was interrupted by Hospital admission, and the Hospital SALT had re-referred in October 2018. He was accepted into the CLDT service, but was discharged due to hospital admission.

The decision-making and referral process into Harrow and Brent CLDTs by other services does not appear to have been sufficiently clear; including interfaces with the GP and other community services, hospital admission and discharge, physical disability services and the two boroughs. It is notable that the significant change in Adult G's presentation in the four years between the two assessments was a decline in his physical health and communication, representing a potential missed opportunity to have diagnosed a learning disability earlier and possibly to have triggered access to a more integrated service.

4.3 How effective were Safeguarding Adults Enquiries in reducing the risk of neglect?

Shortfalls in reporting concerns: Overall, agencies understood their responsibility to report suspected adult abuse and concerns had been raised by Community Nursing, the Care Home and Hospital from 2016 to 2018. This meant that Safeguarding Adults Enquiries and Safeguarding Plans should have been the primary vehicle for multi-agency risk assessment and management during the review period, more so than care management reviews or high risk network meetings.

There were 8 Safeguarding Adults Concerns relating to the care of Adult G at the Care Home in 2017. These should all have been reported to the CQC, which states that only 1 safeguarding adults notification was received in 2016, 1 in 2017 and 2 in 2018.

Particularly notable Safeguarding Adults Concerns from 2016 to 2018 are detailed below. These demonstrate some shortfalls in the requirement to conduct proportionate and personalised enquiries. Most significantly, this involved not progressing concerns to a formal enquiry when the Care Act Section 42 threshold was met; in summary that the person has care and

support needs, there are grounds to suspect abuse, and the person is unable to protect themselves from harm. There was also a practice of incorporating a concern within a broader Institutional Harm enquiry, without addressing the individual concern fully. Information and outcomes were not shared between boroughs in a clear and timely manner, as required in the ADASS inter-agency policy. Brent SAT considers that only 3 of 8 safeguarding concerns in 2017 were relayed to them, without a clear reason for this. There was a tendency for agencies to raise Safeguarding Adults concerns, without evidence of individually or collectively addressing these concerns proactively.

June/July 2016 concern: In June/July 2016, the Care Home raised a concern with Harrow SAT that Adult G was nursed in Hospital without a pressure relieving mattress. This was addressed as a complaint and a Root Cause Analysis (RCA) requested, when it appears that there were sufficient grounds to suspect abuse and proceed to an enquiry. The concern was notified to Brent ASC Duty by email.

October 2016 concern: In October 2016, the Care Home raised a concern about the development of the pressure ulcer in another Hospital. Whilst this concern did not meet the threshold for a formal enquiry, it was not relayed between Harrow and Brent SATs to prompt a care management response.

August 2017 concern: In August 2017, Community Nursing raised a concern about oral care at the Care Home. Whilst this was addressed as a non-safeguarding matter, the decision-making and whether Brent ASC was notified is unclear.

November 2017 concern: In November 2017, Community Nursing raised a Safeguarding Adults Concern in relation to the missed visits. A Safeguarding Adults Strategy Meeting in December was coordinated by Harrow SAT, approximately three weeks after the concern was raised. Due to a misunderstanding, Brent ASC were not represented and did not receive minutes and actions. The meeting led to a recommendation that Brent ASC complete a care management review, towards consideration of a Nursing home, and the Care Home was tasked to monitor Community Nursing visits and alert if missed. There is no indication that the action to consider a Nursing Home was followed up. Adult G's brother recalls that he was informed in the meeting about the missed visits and felt that the focus was on the omission rather than a wider consideration of whether the Care Home could meet his needs. Adult G was assumed to possess decision-specific mental capacity and there is no indication of involving him in the meeting discussion or outcome. This was a missed opportunity to consider Adult G's needs and risks holistically and to consider whether transfer to a Nursing Home was warranted. His brother considers that this is the most significant missed opportunity to have addressed Adult G's needs and risks and the Independent Reviewer supports this view.

March 2018 concern: In March 2018, Community Nursing reported a CNT-attributable grade 3 pressure ulcer to Harrow SAT. This was incorporated into the Harrow Institutional Harm Enquiry and Brent were forwarded a letter in May 2018 on the outcome of the broader enquiry. The rationale for deciding not to pursue an individual safeguarding enquiry is unclear.

April 2018 concern: In April 2018, the Hospital raised a concern about the deterioration of pressure ulcers in the community. Harrow SAT advised Brent SAT by email that the concerns had not progressed to an enquiry and recommended a care management review.

Early May 2018 concern: In early May 2018, the Community TVN raised a concern about the development of pressure ulcers in Hospital. Whilst this concern did not progress to an enquiry, Harrow SAT promptly asked Brent ASC to complete a care management review, which was actioned within two weeks. The response was proportionate and contributed to Hospital admission soon afterwards.

Late May 2018 concern: In late May 2018, the Brent ASC Review Officer asked the Care Home to raise a Safeguarding Adults Concern, due to a new, infected category 3 pressure ulcer observed on this day. A GP visit was undertaken on the same day due to the deterioration in physical and mental health and to consider whether hospital admission was necessary. A Community Nursing visit on the same day noted the pressure ulcer and also recommended Nursing Home care. Harrow SAT correctly voiced concern that Adult G had been discharged to a Care Home that was unable to meet his needs, that the Care Home had accepted his return, and that Community Nursing and the TVN had not recommended consideration of a Nursing Home.

Organisational concerns: There were organisational issues at the Care Home in 2017 and 2018, recorded by Brent; concerning poor management, unmotivated and inadequately trained staff and a difficulty in managing complex needs.

Service improvements: Subsequently, Brent ASC has introduced a safeguarding recording system on Mosaic from October 2019, a Multi-Agency Safeguarding Hub (MASH) from January 2021, and regular audits of safeguarding decisions. The West London Alliance enables a working relationship at a commissioning level.

The Hospital has established link persons with each local authority to follow up on service users in Harrow Homes who are admitted with grade 3 or 4 pressure ulcers.

4.4 What was the impact of resource and environmental issues on the decisions and actions of agencies?

Whilst resource provision is a constant concern within all public bodies, there is no clear evidence that service delivery was directly affected by financial or staffing considerations.

However, The CCG representatives in this review consider that the delayed hospital discharge in 2018, due in part to a delay in writing to the CCG for a CHC assessment, may have been affected by funding considerations. There was also a delay in the provision within Hospital of a pressure relieving mattress, which was out-sourced, and in the provision of a vac pump on discharge.

The CCG and CLCH representatives in this review do not consider that there were any cross-border issues affecting Health Services, including Community Nursing, as the Care Home, GP and Community Nurses were all located in Harrow.

The Brent and Harrow ASC Safeguarding Adults leads in this review relay concerns about cross-borough communication between the two safeguarding teams.

4.5 How compliant were agencies in meeting relevant legislation, policy, procedures and guidance?

CLCH have a Pressure Ulcer–Prevention and Management Policy. At the time, this required that Community Nurses visit a patient within 72 hours and the initial visit to Adult G was within this timescale. A referral to the TVN was made, as per the policy, but there was a considerable delay in the referral process.

The Care Act 2014 requirements of proportionate and personalised Safeguarding Adults Enquiries were not fully adhered to in response to all reported concerns. Also, the Care Act requirements for assessment and review of care needs were not fully adhered to by Brent ASC. The ADASS Inter-Agency Policy on Safeguarding, which sets standards for cross-border working, was not fully complied with in terms of the standard of communication.

The Harrow and Brent CLDT leads comment that the legal requirements in relation to the eligibility assessment include consideration of what a learning disability is. There is a CCG target of a 28 day period between referral for an eligibility assessment and completion. They consider that Harrow and Brent CLDTs met procedural and guidance requirements in 2018, as two attempts at completing an eligibility assessment were thwarted by hospital admissions, after which a referral was made to Brent CLDT and an assessment completed.

Adult G's brother attended this meeting to provide information and he does not recall this as a robust assessment, also commentating that Adult G was not directly involved. The Independent Reviewer considers that there may have been grounds to have considered an earlier assessment of learning disability, particularly as his physical health and communication appeared to be the primary changes when a learning disability was diagnosed.

5 FAMILY PERSPECTIVE & OVERVIEW OF LEARNING

5.1 Family perspective: In the view of his brother, Adult G was "let down by everyone that he came into contact with", aside from staff in two agencies that were latterly involved. He considers that there was "no feeling of professionals talking together about increasing concerns" and that agencies did not sufficiently engage with Adult G or his family about his care needs. Whilst acknowledging that no-one set out to neglect his brother, he feels that a failure to properly consider and address risk led to this outcome. His overriding reflection is that thoughts and concerns did not lead to actions by involved agencies. In particular, he believes that a coordinator should be agreed between agencies in high risk cases.

5.2 Overview: The Independent Reviewer considers that professionals and agencies endeavoured to address Adult G's needs and to do so in a dignified and personalised manner. However, he had complex physical health needs and experienced neglect of pressure ulcers on occasions over a two to three year period, with a considerable delay in consideration of Nursing Home care. The gaps in care primarily concerned being nursed in Hospital without a pressure relieving mattress in June 2016, missed Community Nursing visits in November 2017 and delayed Hospital discharge in October 2018 without essential equipment.

Also, Adult G was able to communicate at a basic level and there was insufficient effort to engage him in a joint consideration of his needs and risks, alongside insufficient clarity on his mental capacity to make decisions on the care that he required. Agencies were generally clear on how to raise safeguarding concerns and frequently did, but there was not a sense of individual agency accountability to address concerns or of effective safeguarding responses by the involved local authorities; or of multi-agency clinical and care management oversight and risk management.

It is unclear to what extent Adult G was distressed by his experience of neglect, as his views on the quality of the care that he received were not actively sought. However, these circumstances undoubtedly restricted his potential safety and wellbeing and it is known that a prolonged hospital admission was detrimental to his mental health.

6 EARLIER ANALYSIS & LEARNING

6.1 Overview: Prior to this review, a comprehensive Safeguarding Adults Enquiry and two specialist Health-related reviews were undertaken in respect of the neglect of Adult G. For completeness, the findings of the resulting reports are included here and addressed in the findings and recommendations sections.

6.2 Findings of Safeguarding Adults Enquiry: As identified in the Safeguarding Adults Report in July 2019, there is evidence of neglect by the Care Home, Community Nursing and Hospital in the care and risk management of Adult G's pressure ulcers, contributing to a significant deterioration in wounds over a prolonged period. In the report, it was recommended that "there is a need for a health professional with specialist expertise and knowledge in tissue viability to analyse whether (Adult G's) death could have been preventable." This was actioned by the CCG in commissioning a Clinical Nursing Review, which is detailed below.

6.3 Findings of a Clinical Nursing Review: An RNMH Specialist Nurse Practitioner in Clinical Nursing Practice (NW London Collaboration of CCGs), a health professional with specialist expertise and knowledge in tissue viability, provided an analysis and report (undated) on whether Adult G's death may have been preventable. The specialist report identifies omissions in risk assessment, care, treatment, provision of essential equipment, and nursing oversight. It concludes that on "the balance of probability if given timely treatment and care his death could have been avoided".

6.4 Findings of a LeDeR Initial Review: A Learning Disabilities Mortality Review (LeDeR) was completed by Brent CCG in November 2020. This identifies the cause of death as Aspiration Pneumonia and Sepsis. The report identifies shortfalls in Community Nursing care as missed visits, delays in the receipt of appropriate dressings and in the supply of a pressure relieving mattress; in the Care Home as a difficulty in managing the level of care and in not realising that there were missed Community Nursing visits; and in the Hospital as not considering the need for Nursing Home care and in poor discharge planning. He required the oversight of a Learning Disability Nurse on admission to hospital, which could have enabled more coordinated care, but there is minimal evidence that this had taken place.

The report states that there "is a lack of evidence of coordinated oversight amongst the Health professionals to show that there was a clear treatment plan, care plan or risk assessment in place for the management of the multiple pressure sores (Adult G) had sustained. The treatment appears reactionary rather than pro-active and there is no evidence of any Multi-Disciplinary approach. There is no reassurance that any one professional had oversight of the management of these pressure ulcers."

The report concludes that Adult G's death might be attributable to abuse and neglect and recommends a further multi-agency review within the same process. The Independent Reviewer understands that the further review has been put on hold, pending the outcome of this review.

7 FINDINGS

There is evidence of professionals and agencies endeavouring to provide a responsive and personalised service to Adult G and the findings of this review should be considered in this context.

7.1 Finding 1 - Could Adult G's death have been avoided: The Specialist Nurse Practitioner concluded that Adult G's death could have been avoided. The LeDeR report concluded that his death might be attributable to abuse and neglect, recommending a further LeDeR multi-agency review.

7.2 Finding 2 - Professional curiosity & multi-agency risk management: There was insufficient professional curiosity by involved agencies in recognising and proactively addressing concerns about the capacity of the Care Home to meet Adult G's complex care needs; most importantly in triggering a multi-agency risk management meeting and embedding coordination and oversight of health and social care.

7.3 Finding 3 - Hospital Care & discharge: Adult G was nursed in Hospital without essential equipment and developed significant pressure ulcers. The decision-making process involved in triggering a CHC assessment was not sufficiently prompt or streamlined. Hospital discharge planning was not subject to a coordinated risk assessment and Adult G was discharged to a Care Home that could not meet his needs and was under a voluntary cessation of new admissions, then to a Nursing Home without essential equipment or guidance in place.

7.4 Finding 4 - Gaps in service provision: Community Nursing missed all visits to clean and dress Adult G's pressure ulcers for 18 days in November 2017, due to an administrative and human error, causing a significant deterioration in the condition of the pressure ulcers and the development of a new pressure ulcer. There were also delays in arranging TVN support and in the delivery of essential equipment. There is no record of the Care Home alerting Community Nursing to the missed visits.

7.5 Finding 5 - Regulation & inspection: Recording of decision-making in response to safeguarding adults notifications, did not provide a robust audit trail. Reporting of incidents by agencies to the CQC was also not sufficiently robust.

7.6 Finding 6 - Mental Capacity, active listening, mental health & learning disability: Whilst agencies presumed that Adult G had mental capacity in regard to decisions about care, this did not appear to be based on an evidenced risk assessment. Agencies generally demonstrated a regard for Adult G's emotional wellbeing, but in the absence of a serious attempt to find out his views about his placement and care needs, notwithstanding his communication difficulty. His mental health deteriorated whilst awaiting hospital discharge in October 2018. The decision-making process to trigger a learning disability assessment was not sufficiently clear or streamlined and an earlier diagnosis, if applicable, may have meant access to a more integrated service.

7.7 Finding 7 - Proportionate and personalised Safeguarding Adults Enquiries: When agencies reported Safeguarding Adults concerns, these did not generally lead to proportionate, personalised, multi-agency Safeguarding Adults Enquiries and Safeguarding Plans, when the threshold for enquiries appeared to have been met. The Strategy meeting in December 2017 was a missed opportunity to develop an holistic safeguarding or risk management plan. Also, the individual safeguarding enquiries and the Harrow Institutional Harm Enquiry did not appear to be sufficiently aligned.

7.8 Finding 8 - Cross-borough communication on Safeguarding Adults Enquiries, care management reviews & contract monitoring: Information sharing between the respective boroughs was not sufficiently robust. Concerns were either not shared or were shared primarily by email, rather than involving close joint working. The Brent Review Officer links to Care Homes did not cover out of borough homes, including Harrow, and information sharing about concerns arising from reviews and contract monitoring was limited.

8 RECOMMENDATIONS TO IMPROVE SERVICES & REDUCE RISK

Overview: All recommendations of this review relate to the Safeguarding Adults Board and are intended to contribute to reducing the risk of a future death occurring in similar circumstances.

8.1 Recommendation 1 – Review By a Medical Examiner: NHS North West London has secured the service of a Medical Examiner to review the case of Adult G. The Medical Examiner role came into being in 2019 and is an independent senior doctor whose role is to enhance the governance and regulatory systems by scrutinising the deaths of patients not under review or inquest by the Coroner.

On behalf of NHS North West London the Medical Examiner will undertake a 'proportionate' scrutiny of medical records, looking at the quality of clinical management and the care provided by medical and other staff. He will

determine where there were any significant problems in the treatment or care of Adult G and will report the death to the Coroner should he feel it is necessary.

8.2 Recommendation 2 - Professional curiosity & multi-agency risk management: To agree and embed across agencies an enhanced risk management and escalation framework for high risk cases and practice shortfalls, when the safeguarding threshold is not met, incorporating multi-agency risk management meetings and the High Risk Panel.

8.2.1 To review and audit the existing procedure for multi-agency risk management meetings and the High Risk Panel, as part of a renewed risk management framework that incorporates the interface with safeguarding enquiries, care management reviews, contract monitoring and quality improvement (shared with placing authorities). The review should include procedural awareness and triggers, coordination, management and clinical oversight and recording. There should be consideration of adding high risk cases involving pressure ulcer care. A clear flowchart on the process should be circulated to all relevant agencies.

8.2.2 To consider the appointment of a Care Manager or Care Coordinator, on a case by case basis, to oversee care pathways and to ensure that the correct professionals are involved in high risk cases. This could be a role of the High Risk Panel.

8.2.3 To seek assurance that residents in Care Homes with a significant history of pressure ulcers have a robust multi-agency skin integrity care plan and risk assessment, which is regularly reviewed; that professional visits are recorded and monitored; and that joint care management and community nursing reviews are scheduled annually or more frequently when necessary to reduce risk.

8.2.4 To audit a sample of initial and annual care management placement reviews; with specific attention to timeliness, in-depth coverage of concerns, personalisation, actions and recording.

8.2.5 To develop a Commissioning-led, multi-agency provider concerns meeting, with cross-border participation, incorporating hard and soft data on safeguarding and quality concerns.

8.2.6 To seek assurance from partner agencies that staff have received relevant and up to date risk assessment and management training, incorporating an emphasis on professional curiosity and on an agreed procedure.

8.2.7 To share details of the Hospital link persons scheme with the SAB and

concerned agencies across Brent and Harrow.

8.2.8 To consider undertaking a further LeDeR multi-agency review, as recommended by the LeDeR initial review, with the aim of further learning about risk assessment and management.

8.3 Recommendation 3 - Hospital Care & discharge: To seek assurance that Hospital discharge planning is based on robust risk assessment and that provision is made for the timely provision of essential equipment.

8.3.1 To review inpatient risk assessment procedures; with specific attention to pressure ulcer care and the involvement of a Learning Disability Nurse where appropriate.

8.3.2 To review Hospital discharge policy; with specific attention to management and clinical oversight, risk assessment, decisions around the supply of essential equipment, training of Nursing Home staff in using equipment where necessary, and timing of discharge to ensure placement readiness to meet complex needs. To consider a flag for high risk pressure ulcer circumstances, triggering a check on the viability of the discharge location, the provision and assurance of care and equipment, and key contacts.

8.3.3 To audit the quality of pressure ulcer care and Hospital discharge planning in sample complex cases.

8.3.4 To provide assurance of a streamlined and timely CHC process in Hospital settings, joint with Hospital Discharge Teams, to avoid unnecessary delays in hospital discharge; including a flowchart illustrating the process for Hospital assessments and, as recommended by a CCG contributor to the review, training of relevant staff and a review of the process to include procurement and brokerage.

8.4 Recommendation 4 - Gaps in service provision: To seek assurance from agencies of robust case allocation systems and close monitoring to avoid gaps in service provision.

8.4.1 To review risk assessment procedures; with special attention to pressure ulcer care, personalisation and communication.

8.4.2 To consider a Community Nursing leaflet or other means of communication with contact details for family members, separate to the patient folder.

8.4.3 To audit and provide assurance of a safe and effective system for the scheduling of Community Nursing visits, incorporating management oversight

and monitoring.

8.4.4 To provide assurance of a clear referral pathway to the Tissue Viability Nursing service.

8.4.5 To incorporate a register in Care Homes of all scheduled professional visits and follow-up arrangements if visits are missed.

8.5 Recommendation 5 – Regulation & inspection: Learning from this SAR to be shared with the developers of CQC's Monitoring App and wider Regulatory Platform (part of CQC's Transformation programme) to enhance the development of audit trails of decision making and events chronology.

8.6 Recommendation 6 - Mental Capacity, active listening, mental health & learning disability: To seek assurance from agencies that the voice and wellbeing of service users are pivotal to practice standards.

8.6.1 To seek assurance from partner agencies that staff have received relevant and up to date Mental Capacity Act training and that accessible forms and guidance are available to relevant staff.

8.6.2 To audit recording of Mental Capacity Assessments across key agencies and, in circumstances of assumed capacity and high risk, identification in risk assessments of how adults at risk understand the risk and what risk management measures are in place.

8.6.3 To audit whether assessment and review documentation and practice across agencies is personalised, with specific attention to seeking and listening to the voice of service users and families in an agreed way.

8.6.4 To provide clear and accessible posters and leaflets in Care and Nursing Home reception areas on contact points when residents and families are concerned about quality standards or abuse and neglect.

8.6.5 To consider creative ways of strengthening personalisation through ideas such as service user scrutiny of new procedures, the use of pen pictures in some reports, and the provision of life story training across Care and Nursing Homes.

8.6.6 To review the referral pathway for learning disability assessment; with specific attention to multi-agency clarity on when and how to refer.

8.7 Recommendation 7 - Proportionate and personalised Safeguarding Adults Enquiries: To provide assurance of reporting and proportionate, personalised and outcome-focused Safeguarding Adults Enquiries.

8.7.1 To review the Brent Safeguarding Adults Procedure and Organisational Abuse Procedure (with recommendation to Harrow SAB to do the same); with specific attention to clarity on threshold decisions, proportionality, making safeguarding personal, reduced risk outcomes, timeliness and interface with Institutional Harm Enquiries.

8.7.2 To audit a sample of Safeguarding Adults Enquiries; with specific attention to these same areas within the new MASH structure.

8.7.3 To seek assurance from partner agencies that staff have received up to date safeguarding adults training at the appropriate level; including training on the interface between the *Safeguarding Adults Protocol: Pressure Ulcers* and the Safeguarding Adults Procedures, with an emphasis on personalisation.

8.8 Recommendation 8 - Cross-borough communication on Safeguarding Adults Enquiries, care management reviews & contract monitoring: To provide assurance of a clear communication Strategy between Health and Social Care agencies in Brent and Harrow.

8.8.1 To develop a Brent and Harrow Safeguarding Adults communication protocol, in line with the ADASS inter-agency protocol; outlining expected practice in terms of timely and effective information sharing and working together; relating to reviews, multi-agency risk management meetings and safeguarding enquiries. This should incorporate key contacts in both boroughs.

8.8.2 To provide cross-borough assurance of a common understanding and cohesion on safeguarding adults enquiries.