Safeguarding Adults Review (SAR)

ADULT A

Overview Report

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Presented to North Lincolnshire Safeguarding Adults Board (NLSAB) on 27th May 2020

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1. INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW

1.1. Adult A was an 87-year-old gentleman who suffered from Alzheimer's disease[1]. Adult A also had prostate disease and type 2 diabetes. Adult A had been cared for at home by his family until June 2018 when he was admitted to a care home by his family due to a deterioration in his Alzheimer's presentation. His placement was self-funded. Adult A was taken to hospital twice in July following falls. On the second occasion, medical staff were concerned by multiple bruises and raised a safeguarding concern. The ensuing section 42 enquiry concluded that there were risks identified and action had been taken in relation to The Care Home. On the second admission Adult A was diagnosed with multiple secondaries from a cancer of an unknown primary source and died as a result of this seven weeks later.

2. METHODOLOGY AND SCOPE

2.1. The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR).

2.2. A referral for a SAR was sent to The North Lincolnshire Safeguarding Adult board (NLSAB) on 4 July 2019, following concerns raised about how the section 42 enquiry was conducted. The NLSAB Executive Group met on 9 July 2019 and agreed that the criteria for a Safeguarding Adults Review were met. Full Terms of Reference, rationale for the scope and methodology of the review etc. for this SAR can be found in Appendix 1.

2.3. This review takes into account interagency involvement covering the three months prior to the date that Adult A moved to The Care Home until the closure of the safeguarding enquiry. This is the period that covers identification of a number of contacts with agencies. Key background information will also form part of the review.

2.4. As dictated by the Care Act, the purpose of the SAR is not to hold organisations or persons to account for any shortcomings, that is for other processes. In order to promote learning, this SAR was carried out in an environment where practitioners were able to be open and reflective regarding their practice without fear of blame.

3. FAMILY ENGAGEMENT

3.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to publication. The purpose of this SAR is not to investigate the cause of the

[1] **Alzheimer's disease** is the most common type of dementia in the UK. Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. It can affect memory, thinking skills and other mental abilities.

bruising but to provide learning and recommendations regarding how agencies share information and work together to deliver safe and effective care and ensure that a safeguarding enquiry is robust and provides evidence-based conclusions and outcomes.

3.2. The author and Board Manager met with the family and their representative in order to hear their views so that they could be included in this SAR; their views and reflections have been included in this report where appropriate to the purposes of the review. The report was shared with the family at a later stage and they responded with helpful comments and suggestions that have been included the final version. Although the family of Adult A have expressed several concerns regarding agency involvement with him, they also had high praise and thanks for some professionals within the agencies concerned for how they undertook their roles and supported them as a family during this difficult time.

3.3. Throughout this report, where Adult A's daughter is mentioned, this was the daughter that was the main point of contact for professionals caring for Adult A and the main contact during this review process.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. Adult A had been married for over 60 years when he died; Adult A and his wife had two daughters. Adult A worked as a mining engineer and then in a management role for the National Coal Board. On retiring in his fifties, he spent much of his retirement in public service roles spending a period as local councillor and then mayor. Adult A enjoyed photography and other arts and crafts. He was well known within the community, living in an area where the majority of residents knew each other. Adult A was diagnosed with Alzheimer's disease following referral by the GP to the Memory Clinic of the Mental Health NHS Trust five years prior to the scoping period for this review. At this time Adult A understood his condition and how it may progress. He was actively involved in decisions about his care. Adult A enjoyed walking around the village and continued this up until his admission to the care home albeit that latterly he was accompanied by his wife. In order to prepare for the time when he may not have mental capacity to make decisions, he appointed his two daughters as attorneys with Lasting Power of Attorney[2] (LPA) regarding health and welfare and for property and financial affairs.

[2] **A lasting power of attorney** (LPA) is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help the person make decisions or to make decisions on the person's behalf. This gives the person more control over what happens to them if, they lack mental capacity'.

There are 2 types of LPA:

- health and welfare
- property and financial affairs

4.2. After diagnosis, Adult A remained under the care of the Mental Health NHS Trust Memory Clinic and his GP. He was cared for by his wife at home and attended a day centre once a week with an occasional additional day for 18 months prior to the period of this review.

4.3. Two years after Adult A's dementia diagnosis, he developed an enlarged prostate gland and was admitted to hospital. Treatment required an indwelling balloon urinary catheter to prevent the retention of urine within the bladder. His wife was taught to care for the catheter and managed this very well with no issues. The district nurses visited three-monthly to change the catheter as per usual process and procedures.

4.4. During the above admission, Adult A was referred to the hospital social work team for a care needs assessment. This resulted in advice and information related to Adult A's care needs and a carer's assessment for Adult A's wife. These assessments led to identification of support that Adult A's wife required with information being given regarding care homes that offered day care, carer break funding and sources of advice and support. It was during this time that confirmation from the Office of the Public Guardian[3] was received that Adult A's daughters had Lasting Power of Attorney as described above. A copy of this confirmation letter was saved on Adult A's file.

5. KEY PHASES

5.1. The following section will identify key phases in Adult A's story, key issues that are raised will be analysed in section 7 of this report. This section provides a succinct summary of the facts that lead to analysis.

Phase One – Month 1- Month 3 (Request for Care needs assessment to admission to Care Home)

5.2. In month one, as a result of family contact with the Memory Clinic, Adult A's daughter contacted the Social Work Access Team explaining that Adult A's needs were increasing and that her Mother was finding it increasingly difficult to manage Adult A's care needs. The existence of LPAs was established, and family understood that they would need to self-fund any care as Adult A had over the capital limit for funded care.

5.3. The assessment identified that Adult A had eligible care needs, that his daughter would consider increasing the number of care days at the day centre and also some respite care. It was agreed with the family that no formal support would be arranged at this time and that

[3] The **Office of the Public Guardian** (**OPG**) helps people in England and Wales to stay in control of decisions about their health and finance and make important decisions for others who cannot decide for themselves. **OPG** is an executive agency, sponsored by the Ministry of Justice.

Adult Social Care could facilitate an increase in support if required in the future.

5.4. In month two, there were further telephone calls from Adult A's daughter to the Memory Clinic regarding a continence assessment for Adult A. As the District Nurses were visiting regarding catheter care, it was agreed that they would be able to assess this. This was duly done, and assessment indicated that Adult A did not have control of his bowels but that there was no clinical reason for this that could improve with particular treatment. Adult A's family were buying continence products to manage this.

5.5. During district nurse contacts, assessments were carried out regarding nutrition and pressure area risk, no concerns in these areas were identified.

5.6. In month three Adult A's daughter made further contact with the Memory Clinic as her Father's needs were increasing and had deteriorated significantly over the previous two weeks; it was felt that her mother's health was being impacted by her caring role. This resulted in a GP appointment to rule out any physical health or other clinical reason for this deterioration. The Memory Clinic also requested that the GP reviewed Adult A's medication.

5.7. The Memory Clinic made a referral to adult social care for a further needs' assessment. The case worker from the access team made contact with Adult A's daughter. The case worker recorded that Adult A's daughter said that a further needs assessment was not required and as a result of family discussions, it had been agreed that they would be funding a respite placement for her Father. The family told the author that the plan at this point was not for respite care but was for full time care as they understood that Adult A's dementia would not improve. Adult A remined very capable of walking and eating and drinking by himself. It was Adult A's sleep and disorientation to day and night that were the main issues. Adult A's daughter stated that they would be going to look at a few care homes the next day. Adult A's daughter was reminded by the case worker to make contact if the family required further support.

5.8. The manager from the chosen Care Home assessed Adult A at home with his wife and one daughter present. The assistant manager was given copies of the Do Not Attempt Resuscitation form and LPA's. Adult A was admitted to The Care Home three days later, after the weekend.

Phase Two- The next four weeks (Admission to Care Home until Admission to Hospital)

5.9. The Care Home chosen by the family was a care home with a dementia unit. Adult A's needs and behaviours escalated on transition to full time care. Adult A started to display behaviours of pulling at his catheter resulting in it needing to be replaced three times in this phase. District Nursing staff visited regularly and replaced his catheter on three occasions when he

had pulled it out. Adult A was also found to have a discharge around the catheter site which was diagnosed as methicillin-resistant staphylococcus aureus (MRSA) for which a topical wash was prescribed. Adult A started to have regular falls. His sleep was causing concerns with him sometimes having very little, if any sleep. Adult A appeared agitated with reports of him striking himself.

5.10. 10 days after admission the ambulance service were called as Adult A had become sweaty and appeared to be in pain. Adult A was fully assessed by ambulance staff and identified he had raised blood sugars. There were no other clinical concerns. It was agreed that hospital treatment was not required but that the GP should be asked to review Adult A's type two dietary controlled diabetes. Further blood tests were carried out by the GP practice leading to Adult A being prescribed medication to reduce his blood sugar as diet alone was no longer able to control his diabetes.

5.11. During this time, The Care Home were also making contact with the GP for support with Adult A's sleep and concerns regarding him hitting himself. Care Home staff took Adult A to the GP surgery. The GP acknowledged that one of the reasons for admission to respite was because Adult A was not sleeping and that this had been difficult to manage at home. The GP also suggested making contact with the family to see if the hitting himself was how Adult A indicated pain. The GP practice undertook a thorough examination and could find no obvious source of pain, but paracetamol was prescribed. Care home staff did not discuss falls with staff at the GP practice. The GP suggested that care home staff contact the Memory Clinic for support with managing Adult A's agitation, which they did. The Memory Clinic asked that The Care Home keep behaviour charts for a week; they would then visit to review Adult A's care.

5.12. At the visit from the Memory Clinic, concerns regarding behaviour as above were noted and that the GP had seen him recently. The Memory Clinic asked The Care Home to try and encourage engagement in activities to foster stimulation and keep Adult A occupied. The Memory Clinic also referred Adult A to an occupational therapist for assessment of falls.

5.13. The majority of falls within The Care Home did not result in injuries that required treatment. Some of the falls were witnessed and some were not witnessed. Falls that resulted in injury were notified to the GP out of hours service, Unscheduled Care Team[4] or the ambulance service. Following one fall, the ambulance service attended, and a full clinical assessment was completed. The ambulance crew identified that Adult A was able to mobilise without pain and that there was an abrasion and a skin tear to the head. The ambulance service did not record any bruising visible at this visit. The ambulance staff arranged for the Unscheduled Care Team to visit to dress the wound. On visiting Adult A, the Unscheduled Care Team found

[4] Unscheduled Care Team (UCT) - A community based service which carries out unplanned care to patients to avert or manage a crisis. This is by providing a rapid response and initiating the necessary integrated approach and care to the person; within their home or community care setting; during a period of change.

a graze with no active bleeding, there was no open wound and therefore a dressing was not applied. No bruising is documented at this contact although given that the team were there to dress the head wound, no other examination took place.

5.14. Four days later, The Care Home contacted the GP concerned that Adult A was noted to be leaning when he walked. The Care Home reiterated the poor sleeping and stated that they felt that they were not getting help from anywhere. The Care Home informed the GP that there had been a fall five days previously. A full examination took place by the Advanced Care Practitioner (ACP) on the same day. This was the first time that the GP practice were aware that Adult A was falling. The ACP undertook a thorough examination that ruled out the possibility of a stroke and advised the home to monitor based on the history of two falls.

5.15. The next day Adult A fell, he was noted to have a skin tear to his inner arm and pain in his shoulder, arm, hip and leg. The ambulance service was contacted and on arrival found Adult A to be in a very agitated state. The ambulance crew did not find any spine or neck tenderness and that he had a full range of movement. The crew found a large tender mass on the posterior right flank and were of the opinion that this was painful on palpation. This was based on patient reaction as they also recorded that Adult A was unable to understand the pain score. Adult A was taken to hospital for assessment and treatment. Adult A's family were contacted to inform them of his hospital attendance.

5.16. Once in the emergency department Adult A underwent various tests and had scans. Nothing that was untoward was found other than the large haematoma[5] over the flank area. A body map was completed which showed the haematoma to the posterior flank, the body map for the front of the body was not completed. The carer from the care home informed the hospital that the front was intact. It is not recorded if staff fully examined Adult A or recorded any marks on his front or just accepted what the carer stated. Adult A was returned to The Care Home on agreement with the accompanying carer. Follow-up was requested from the GP regarding further investigation if pain and being unsettled continued. His blood clotting tests were normal. Adult A's blood tests and raised temperature indicated a possible urine infection. A urine sample was sent to the lab for testing. (The follow up with the GP was not undertaken as there was a second hospital attendance four days later that led to admission).

5.17. Two days later The Care Home noticed that Adult A had bruising to the penis, it was suggested in care home records that this was from pulling at the catheter.

5.18. The next day the visiting district nurse assessed Adult A regarding skin tears and examined Adult A further as care home staff were worried about bruising. The nurse found extreme bruising to the penis, scrotum, hips, ribs and legs. This was recorded by the nurse to be

[5] A haematoma is a collection of blood that has collected in the tissues outside of the blood vessels due to trauma. As the blood loses its clotting factors in these scenarios, it remains fluid and can track to other areas of the body

believed to be from the numerous falls and pulling out of the catheter. The nurse advised staff to call the GP over the worsening dementia and the need for one to one care that Adult A was now needing. The Memory Clinic also contacted The Care Home on the same day for an update. The Care Home informed the Memory Clinic that they had arranged a meeting with the family to identify how increasing needs could be managed.

5.19. Later that day the ACP visited and found things the same on assessment as the previous examination apart from the bruising. Blood tests were arranged as requested by the Memory Clinic.

5.20. The Care Home met with family later that day and discussed options to move Adult A to a Care home that could better meet his needs.

5.21. The next day Adult A fell again and appeared to have bumped his head and hurt his hip. The ambulance service was called. Adult A was examined and taken to hospital for further assessment and possible treatment. On arrival at the emergency department, Adult A was examined and found to have bruising that the doctor felt were more than would be usual for falls and some evidence of what was thought to be fingerprint bruising over the left arm.

5.22. Adult A underwent further tests that resulted in findings indicating cancer, although there was no primary focus of any malignancy, it was agreed with family that further tests were not in Adult A's best interests and the plan was for NHS Continuing Healthcare and NHS Funded Nursing Care [6] fast track discharge for end of life care. Albeit initially there was a working diagnosis of urine infection, this was later discounted as, urine test results from the laboratory, showed that Adult A's urine sample was free from infection on this admission. The working diagnosis may have been due to the fact that Adult A had raised infection markers in his blood, and he had an indwelling catheter. This is discussed in the next section.

5.23. As a result of the doctor's concern regarding bruising not being usual post falls bruising, the hospital raised a safeguarding concern to the local authority safeguarding team. To protect Adult A from any further harm and because The Care Home had already met with family regarding seeking an alternative placement, Adult A was admitted to hospital and discharged six weeks later to an alternative care home who could meet his needs.

Phase three – The safeguarding enquiry.

5.24. On the day that Adult A attended the emergency department at the hospital for the second time, the hospital social work team responded to a call from the emergency department

[6]The Continuing Healthcare Checklist and the Decision Support Tool form part of the National framework for NHS continuing healthcare and NHS funded nursing care https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

explaining that The Care Home had stated that they could not have Adult A back as they were not able to meet his needs. On a visit to see Adult A, a nurse informed the hospital social worker that a safeguarding alert had been raised with the Local Authority Safeguarding Adult Team due to the extensive bruising to Adult A, that photographs had been arranged and body maps completed. The social worker contacted a named nurse for safeguarding for the hospital who stated that some of the bruising could be explained but that the genital bruising was excessive and there was possible finger mark bruising.

5.25. The hospital social worker contacted the daughter of Adult A. Adult A's daughter stated that she was aware that Adult A was in hospital but not that he had been transferred to the Clinical Decisions Unit. Adult A's daughter explained that she was concerned that Adult A had deteriorated since he had gone to The Care Home. The Daughter also stated that there had been a meeting with The Care Home the day before due to the difficulty that they were finding in meeting his care needs. Adult A's daughter said that The Care Home had informed her of the bruising that had been attributed to falls and that she was happy for this to be investigated. The family report that they were not made aware as to the extent or the severity of the bruising.

5.26. The Safeguarding Team Case Worker and the Hospital Social Worker agreed to request that Adult A was not discharged prior to safeguarding investigation being completed as part of the initial protection plan. A copy of the safeguarding concern form was shared with Care Quality Commission (CQC)[7].

5.27. The Safeguarding Case worker and the Safeguarding Social Worker visited Adult A in hospital the next day. Adult A was not able to answer any questions regarding the bruising; he was settled and calm on the ward. The workers then visited The Care Home, the manager was not able to answer all of the questions that were asked regarding the bruising; copies of files and paperwork related to Adult A were taken from the home as it was found to be incomplete.

5.28. The Local Authority Safeguarding Adult Team Manager decided that there should be a strategy meeting as soon as possible; it was identified that the date would be two days later. The Local Authority Safeguarding Adult Team Manager instructed that the following agencies were invited:

- The Police
- District/Community Nursing Team,
- Hospital Safeguarding Team
- Local Authority Provider Development Team[8],
- Clinical Commissioning Group Safeguarding Team

[7] **CQC** is the independent regulator of health and social care in England. CQC make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.https://www.cqc.org.uk/about-us/our-purpose-role/who-we-are

[8] Local Authority Provider Development Team, work with care homes and other providers to support the effective and safe delivery of care

- Memory Clinic.

5.29. The Local Authority Safeguarding Adult Team Case worker contacted Adult A's daughter to explain about the strategy meeting. There was confirmation that Adult A would not be returning to The Care Home and that Adult A's daughter had an LPA as stated previously in this report.

5.30. Apologies for the strategy meeting were received from the hospital safeguarding team, district nurses, police and the Local Authority Provider Development team. The Police had stated in an email that although unable to attend the meeting, that this should be a joint investigation and that the case would be allocated to an investigating officer. The hospital safeguarding team sent an email containing information for the meeting; the provider development team liaised with the Adult Safeguarding Team and requested feedback after the meeting.

5.31. There was representation at the meeting from the Clinical Commissioning Group (CCG)[9] and the Memory Clinic. Information from the referral was discussed as well as the record keeping issues identified within the care home. Outcomes from that meeting related to gathering more information regarding Adult A's time within The Care Home and what issues and bruising was known at various times. The other recommendations were that the social worker would liaise with the hospital doctor to establish a professional opinion regarding the bruising being consistent with a fall and if there were any other concerns regarding The Care Home and that there would be liaison with CQC.

5.32. A little over three weeks after the first strategy meeting there was a second meeting. In addition to the Local Authority Safeguarding Adult Team, this meeting was attended by a nurse for safeguarding from the CCG, a safeguarding nurse from the Hospital NHS Trust, Team Manager from the social work locality team, and a district nurse. Neither the Memory Clinic nor police were invited to this meeting. The CQC Inspector was invited to the meeting but could not attend and was asked to be kept updated.

5.33. This meeting spent more time looking at the Care Home issues as a whole rather than specifically related to Adult A. The meeting did note that statements had still not been received by the hospital doctors in relation to information that had resulted in the initial referral regarding bruising to Adult A.

5.34. On the same day as this second strategy meeting, following the meeting, the police contacted the Local Authority Safeguarding Adult Team social worker. The social worker indicated that

[9] **Clinical Commissioning Groups** (CCGs) were created following the Health and Social Care Act in 2012 and replaced Primary Care Trusts on 1 April 2013. They are **clinically** led statutory NHS bodies responsible for the planning and **commissioning** of health care services for their local area

at that time the evidence appeared to be indicating that the bruising had been caused by falls and issues with the catheter. As a result of this the police made a decision not to proceed with any police investigation.

5.35. A week after Adult A was admitted, during a call with the social worker, Adult A's daughter said that she had visited Adult A whilst he was in hospital and as a result of the bruising that she saw, she had contacted the Police.

5.36. Throughout the next three months the safeguarding enquiry continued with the social worker and the case worker carrying out various conversations with other professionals in an attempt to understand the causes of bruising and to ascertain more about Adult A and how he had presented during his stay in The Care Home. This included requests for statements from the Emergency department doctors and copies of the photographs that had been taken. Work was also ongoing to ensure improvements were made to the record keeping in The Care Home as well as interviews with staff at The Care Home. There was ongoing email communication with the CQC inspector to keep them up to date with the ongoing enquiries and action plans with The Care Home.

5.37. Three months after the initial alert was raised there was a communication from the Local Authority Safeguarding Adult Team to The Care Home that the safeguarding enquiry was complete and that an outcomes meeting would be arranged. It is of note that Adult A had died four weeks previously; his death was expected, it was not referred to the coroner.

5.38. The safeguarding enquiry report showed that there was explanation regarding some of the bruising but that there were others that were inconclusive as to the cause. Information related to several issues identified in The Care Home regarding the following of policies and procedures, recording as well as a failure to apply for a Deprivation of Liberty Safeguards[10] (DoLs) authorisation.

5.39. The outcomes meeting happened two months later, in attendance were the family members and representatives, and the Local Authority Safeguarding Adult Team members. Family members had received a copy of the safeguarding enquiry report prior to the meeting.

5.40. The family raised significant concerns regarding several aspects of how the safeguarding enquiry had been undertaken and how the conclusion and outcomes had been reached. A further outcome meeting four months later, following an internal review of the safeguarding enquiry, did not provide the family with the answers that they were satisfied with. which led

[10] **Deprivation of Liberty Safeguards (DoLS) ensures** people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and, in the person's, best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS. https://www.scie.org.uk/mca/dols/at-a-glance?gclid=CjwKCAiAzanuBRAZEiwA5yf4unWSU4nO5BI8joDFbSxQ9JRI4WfZ-W4jkHU9xAQt8_PsXou8ZB10hhoCzcUQAvD_BwE

to a discussion with the Safeguarding Adult Board. As a result, the Safeguarding Adult Review was commissioned.

6. GOOD PRACTICE

6.1. It is important to note that many practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. This review has identified some good practice that is discussed throughout this report. Attendees at the workshops were asked to identify additional good practice from their own and other agencies involvement. It is important to highlight these as areas where learning can occur.

- The GP practice staff always responded a timely manner to requests for family and care home for advice, support and consultation
- The Care Home consulted and asked for support from various professionals.
- The social care needs assessments and carer's assessment, prior to admission to The Care Home were good.
- Care delivered to Adult A in hospital was of a good standard and the fast track for NHS continuing health care funding ensured a prompt transfer to a suitable nursing home for end of life care.

6.2. Many of the lessons learned by individual agencies, on preparation for this SAR and for other internal purposes, have been promptly addressed by organisations.

7. THEMATIC ANALYSIS

7.1. The analysis section takes a strengths-based approach identifying what went well and building a picture of areas where learning has occurred. It is important to remember in this case that the movement of Adult A to live in The Care Home, until the point where he was admitted to hospital with significant bruising was over a period of four weeks. The eventual diagnosis that Adult A had widespread cancer was not known during this period.

TRANSITION FROM HOME TO CARE HOME

7.2. The move to new surroundings and being cared for by 'strangers' can be daunting and frightening for a person in the advanced stages of dementia. Adult A had been cared for very successfully at home by his wife for four years following his diagnosis. The progression of Alzheimer's disease varies widely from person to person in life expectancy and severity[11]. For Adult A, he appeared to stay fairly stable for some period of time but during the period that this review is focussed on, there was a rapid decline in his memory and functioning that led to

[11] https://www.alzheimers.org.uk/about-dementia/types-dementia/alzheimers-disease-symptoms#content-start Accessed 05 November 2019

an increase of behaviours that were difficult to manage at home.

7.3. Adult A's family sought help and support from the Memory Clinic, Adult Social Care and the GP. The response from those services, was timely and supportive. Ultimately the family decided that the time was right for Adult A to move to a care home where he could receive specialist care. The proactive planning by the family meant that Adult A's daughters, using the LPA's in place, made these decisions in consultation with his wife in his best interests. This was all wholly appropriate in the circumstances. Adult A had savings over the capital limit for funding from Adult Social Care and the family understood this.

7.4. Adult Social Care offered support to the family and the family were aware that this was available to them. Having had a previous care needs assessment, the family declined a further assessment.

7.5. Much of the arrangements for choosing the home were handled by the family as was their right. There were no concerns by professionals that the family needed more support to do this. The family were all used to being together and the home chosen was in keeping with this as it was in close proximity and was one of those mentioned to the family by their GP. The family commented that this area was well known to Adult A and a family friend stated that he was likely to know some of the residents. The home chosen by the family offers specialist dementia care and had been rated 'Good' by CQC.

7.6. Once the family had chosen The Care Home, the manager (who had become the registered manager six days prior to this date) visited Adult A and the family at home to assess whether the home could meet his needs. As this was a family seeking a care home for their Father, there was no professional referral to the care home. The assessment was therefore undertaken by discussion with the family.

7.7. Due to record keeping issues that have been identified within The Care Home, this assessment paperwork is not complete and has gaps in information. It is not therefore known if the information was not gathered or was not recorded. This and other issues within The Care Home that arose as a result of this case were investigated under safeguarding procedures discussed later in this report.

7.8. This does leave the review in the position that much of the information regarding Adult A's life when he transferred to The Care Home is not clear. Many of the staff who were working within the care home at the time were not available to talk to or be involved in this review.

7.9. The family retrospectively told the author that, prior to admission to the Care Home, Adult A was able to walk around and had not fallen at home. He was able to feed and care for himself

with prompts from his wife.

7.10. The Care Home did not request information from the day care centre that Adult A had accessed. This would be usual and is a gap as the day centre knew Adult A well and had not had difficulties managing his care needs.

7.11. During this review process there was a discussion, within the practitioner workshops, regarding what might have provided a better and more acceptable approach to Adult A in this significant change in his home and care arrangements. It is not unusual for care needs to escalate rapidly in a person with dementia, and therefore the speed at which The Care Home was chosen, and that Adult A moved (approximately one week) was not thought to be a specific issue. There was, however, no transition period.

7.12. This was possibly because professionals had left the family to arrange the move with The Care Home. Professionals in both health and social care have reflected that they could have been more proactive in assertiveness regarding support for the family to understand the impact that a sudden move may have on Adult A, based on their experience and expertise of dementia.

7.13. It may have been that Adult A's deterioration over the previous few weeks could have been an indicator that his needs would significantly increase, particularly in a new environment and this should have been planned for.

7.14. Adult A had photographs and items from home that would make his room homely. This is advised and recommended by the Alzheimer's society and Age UK to help the transition to care home. A short life story[12] is also useful and was provided by family to the Care Home so that care staff can understand the person's background and include that in topics of conversation. This is also important in being able to understand the person behind the dementia so that they are not defined by their dementia which is only a tiny fraction of their life. It is not clear how much of this information was used in conversations and general care with Adult A. This life story was not mentioned in care home records.

7.15. A 'This is Me' booklet[13] from the Alzheimer's Society and endorsed by the Royal College of Nursing is also seen as best practice so that anyone caring for or visiting for a person with dementia can have specific information regarding the likes and dislikes of a person etc. This would have been useful on admission to hospital with documentation regarding Lasting

[12] https://www.dementiauk.org/for-professionals/free-resources/life-story-work/

[13] https://www.alzheimers.org.uk/sites/default/files/2019-03/Alzheimers-Society_NEW_This-is-me-booklet_190318.pdf

Powers of Attorney etc.

7.16. These documents, as well as observing Adult A in his new surroundings, would have helped the care home to develop person centred care plans in line with best practice. The care plans for Adult A were not well developed or recorded due to issues mentioned previously.

7.17. Other areas that professionals felt that should have been encouraged was a gradual transition with additional support at home to manage the transition period. A transition plan could have included day visits and overnight visits leading to a gradual move with Adult A moving permanently as he got used to his new surroundings.

7.18. The family were asked not to visit for the first four days. Adult A's wife visited every other day and phoned daily after that. Family members had been deterred from visiting for 14 days when Adult A had been diagnosed with MRSA. The Care Home state that this was miscommunication and that they were discouraged but that they could visit at their own risk as MRSA is contagious. This is not in line with NHS advice as the only contraindications to visiting a person with MRSA are for those with serious health problems, long-term skin conditions, such as eczema or open wounds.

7.19. In this short period of time Adult A's daughters stated that they had difficulty visiting due to business commitments and one of the daughters not living locally. It is of note that in these circumstances, Adult A may have benefitted from seeing family faces on a regular basis. Some care homes advise not to visit often in the settling period whilst a person becomes accustomed to their new surroundings as it can be distressing for the person. The author would argue that this should not be the case as a blanket rule, but on a case by case basis as a person-centred decision and should not be the norm.

7.20. It cannot be known if the transition had been more gradual along with use made of the Life Story and 'This is me booklet', that Adult A would have been calmer and more settled. Professionals felt that there was learning here regarding being more proactive in the preparation and transition advice, specifically where families are managing the transition themselves.

7.21. What is known is that Adult A's behaviour and agitation became significantly worse once he moved to The Care Home. The reason for this cannot be known. His behaviour had already been reported to have been deteriorating significantly over the preceding two weeks. The further rapid deterioration may have been due to the sudden change of environment, natural deterioration with dementia or for other unknown reasons.

Learning Point: Recent deterioration in a person with dementia may continue on moving to a care home, with an increase in deterioration on move to a care home that may or may not settle after a few weeks. Assessment should consider this.
Learning Point: The distress of a person with dementia moving to alternative full-time care may be minimised by a gradual transition process.
Learning Point: A person centred 'passport' and life story can support a person to be understood by carers and visiting professionals
Learning Point : Families may benefit from professionals proactively supporting them in managing care home choice and transition.

MANAGING FALLS, AND BEHAVIOURS IN DEMENTIA

7.22. Within two days of being in The Care Home Adult A had pulled his catheter out. This was something that he had not done before. The district nurses informed this review that they visited three times in the first nine days of Adult A's stay at the Care Home, to replace Adult A's catheter. The catheter was the only way to prevent Adult A retaining urine as he was not able to pass urine normally. There is no record of conversations between professionals as to consideration of this behaviour as an indication of distress or pain etc. Tugging at a balloon catheter to self-remove it is extremely painful and traumatic to the lower urinary tract. Requiring regular replacement of the catheter is also traumatic and can increase the risk of infection.

7.23. The family of Adult A expressed concern regarding Adult A developing MRSA within nine days of admission to the care home and argued that this might constitute neglect as Adult A did not have MRSA diagnosed when he was at home.

7.24. The review has considered this and the possible explanations. It is difficult to discern the level of support Adult A had within the care home in managing his hygiene and particularly catheter hygiene, due to the poor records that the home kept. That does not necessarily mean that Adult A was not supported with his hygiene, but that this was not recorded.

7.25. No visiting professional indicated any concerns with Adult A's hygiene presentation. When the district nurses noted the infection at the catheter site, swabs were taken, and treatment prescribed. This was in line with expected practice.

7.26. The NHS information service regarding MRSA suggests that 1 in 30 people carry MRSA on their skin, symptom free. This does not cause illness. If, however, a person is vulnerable or has a way in for the bacteria, as with having an indwelling urinary catheter, then infection symptoms may develop. It is a possibility that the increasing requirement to replace the catheter and the trauma from pulling at the catheter may have been a route for the MRSA

infection. It cannot be known if Adult A carried MRSA on his skin or the exact mode of infection, however the important factor was that it was diagnosed and treated promptly.

7.27. Further behaviours developed that concerned care home staff. Adult A started hitting himself; care home staff recorded this on several occasions. Adult A also had very poor sleep patterns that The Care Home were concerned about. From the records of other practitioners, it is clear that The Care Home contacted the Memory Clinic and GP in order to gain support for these issues. The GP requested that the care home staff ask the family if the hitting himself behaviour was how Adult A indicated pain. There is no record that this was undertaken, and the family reported that they did not know about the hitting.

7.28. Whilst all of this was taking place, Adult A started to have falls resulting in various injuries and bruising as described in section 5. These were reported and treated on occasions as previously described. Due to poor record keeping It is not clear if all Adult A's falls were recorded; the family were only informed of three falls.

7.29. There was a discussion within the review regarding whether it would have been appropriate to prescribe medication to calm Adult A during this settling phase. It was noted that Adult A was calmer in hospital as he was prescribed Lorazepam[14]. The prescribing of these types of medication in care homes is contraindicated since research raised concerns about the overuse of psychotropic drugs in care homes[15]. After this report there was The National Institute for Health and Care Excellence (NICE)[16] guidance and recommendations from the General Medical Council. Whilst these are still available new NICE Guidance has been introduced in June 2018, replacing old guidance, that covers wider management and prescribing for people with dementia[17].

7.30. These types of medication increase the risk of falls so are generally contraindicated for people with a falls risk. If the level of agitation and anxiety was suggestive of the need for medication for this in a care home, there would needed to have been a full risk assessment and prescribing would have needed to have been undertaken by a consultant. Full appraisal of this did not happen because of the short period of time that Adult A was in the Care Home. The memory team were, in accordance with current guidance, assessing behaviour management strategies that might have been appropriate. If these had not proven effective,

[14] **Lorazepam** is part of a group of medicines called benzodiazepines or anxiolytics. It is **used** for short-term treatment of severe and distressing anxiety and sleeping problems.

[15] Professor Sube Banerjee (2009) The use of antipsychotic medication for people with dementia: Time for action A report for the Minister of State for Care Services https://webarchive.nationalarchives.gov.uk/20130104165557/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108303

[16] **The National Institute for Health and Care Excellence (NICE)** provides national guidance and advice to improve health and social care. https://www.nice.org.uk/about

[17] **NICE guideline [NG97]** Dementia: assessment, management and support for people living with dementia and their carers https://www.nice.org.uk/guidance/ng97

then consultation with the Consultant Psychiatrist would have been likely to lead to a pathway for prescribing and monitoring being agreed. The Alzheimer's Society have produced useful guidance for these circumstances[18].

7.31. In hospital Adult A was mostly in receipt of one to one care and prescribing was undertaken by a consultant. Adult A was also subject to end of life care planning and therefore the prescribing of Lorazepam in those circumstances was appropriate.

7.32. All the visiting and supporting professionals managed each contact from the home as an isolated incident, made further referrals or required a period of further observation. There were several examples where visiting professionals asked care home staff to speak to other professionals rather than make that contact directly themselves. Whilst this was not wrong per se, it meant that those professionals in receipt of information were receiving it second hand. E.g. the district nurse could have spoken to the GP regarding the bruising rather than asking the care home to do that. The GP could have asked the family how Adult A indicated pain rather than asking the care home to do it.

7.33. There was no cohesive plan between professionals to address the escalating issues in a timely manner. Adult A was displaying behaviours of rapidly advancing dementia and distress associated with this (it was subsequently known that his cancer, that was undiagnosed at this point, was also possibly a contributing factor). It was clear that the true extent of the difficulties that the home staff were experiencing in managing this was not known to all involved until, in some cases, this review process.

7.34. It is important to reiterate that this was all happening in a four-week period with many presenting issues recognised as relating to settling into a new environment. The review spent some time considering what might have led to a faster response to support Adult A. One of the issues identified as a reason for this apparent parallel working was that in a case of this nature, professionals identified that there is no obvious key worker to coordinate care.

7.35. There were two main areas where this might have been addressed. For all people living in the community, where there is no other obvious care coordination role in place, the GP would normally be the main coordinator of care. In the case of Adult A, the GP should have been appraised of all concerns directly and as they arose so that the GP could have an overall view of the ongoing situation and coordinate a response. This would have needed to include all those involved, including those family members with LPA. There were several elements and concerns that the GP was not aware of until much later e.g. the number of falls.

[18] Alzheimer's Society July 2011. Optimising treatment and care for people with behavioural and psychological symptoms of dementia A best practice guide for health and social care professionals. https://www.alzheimers.org.uk/sites/default/files/2018-08/Optimising%20treatment%20and%20care%20-%20best%20practice%20guide.pdf?downloadID=609

7.36. The other route for coordination was via mental health services. As the Memory Clinic had the lead role in supporting Adult A and his family with dementia and have significant expertise, there were opportunities to have more involvement at the point where Adult A was going to be moving into The Care Home. Regular contact to and from The Care Home may have identified issues sooner. It is suggested that in many cases a person will settle into their new environment in a couple of days and that it was not anticipated that this would be required.

7.37. If the behavioural problems associated with dementia became difficult to manage in the care home, the Memory Clinic could have referred him on to the Care Home Liaison Team. This team are an intermediate care level team provide short term support in care homes to avoid hospital admission and to support care home staff.

7.38. The Care Home Liaison Team could have coordinated care and ensured that all members of the team that were caring for Adult A were aware of their involvement. The team would have liaised closely with family members who knew Adult A well and held LPAs.

7.39. If, as a result, it was felt that Adult A required longer term support then Adult A could have been referred to the Community Mental Health Team for older adults.

7.40. Person/s who are an appointed attorney must be consulted regarding issues over health and welfare. The person with LPA should be consulted on all care planning and health decisions where the donor (person who has appointed the LPA) does not have capacity to make those decisions. There is very little evidence that the daughters with LPA were regularly contacted by The Care Home or other professionals as often as they should have been. The role of a person with LPA must be exercised in a person's best interests; they are not usually allowed to delegate that role. The care home recorded that a daughter did state that they did not want to be contacted during the night. On meeting the author, the daughters did state that they did not want to be contacted during the night but would expect to be contacted the next morning.

7.41. The Mental Capacity Act Code of Practice states that social care and health professionals have a legal responsibility to consult with the person with LPA; the role of a person holding an LPA has legal requirements to exercise that LPA.

7.42. There were discussions within the workshops that an earlier assessment for NHS Continuing Healthcare and NHS Funded Nursing Care may have brought professionals together. This could have resulted in a case manager being appointed.

7.43. Information from the Memory Clinic indicates that Adult A's daughter had told them that the GP had requested that the Continuing Healthcare Checklist be completed. The GP

receptionist confirmed that the GP had requested the district nurses to undertake this. No other agency has any recording regarding this information. This was not done at this time as the request is not recorded in the district nursing records, appearing to be a communication error. If the process had been commenced, it would have still been in the early stages and it is unlikely that the checks and the assessment process would have proceeded far enough to have included a coordination role of any sort at this point.

7.44. Lack of coordination of care often leads to difficulties with communication. Learning from SARs nationally[19, 20] has identified similar themes regarding communication and coordinated assessments and care. These reports identify that work is often undertaken on 'multiple parallel lines' with no identified key worker/coordinating role and no multidisciplinary forum to bring all professionals together. In this case, there were possibilities to use a coordinated multidisciplinary approach as discussed above, but there was no key coordination role identified by any of the professionals involved.

Learning Point: Coordination of care, particularly for adults who have limited cognition and communication ability ensures early recognition of care delivery issues and concerns.
Learning Point: Use of existing roles to coordinate care and communication provide evidence of effective responses to issues and concerns.
Learning Point: Those who have LPA for health and welfare must be regularly consulted on all aspects of care decisions and concerns.

THE SAFEGUARDING SYSTEM

7.45. The Local Authority, in their Agency Review Report for this SAR, has recognised areas where practice fell below what would be expected in the safeguarding enquiry. In response, there is a comprehensive list of recommendations and actions are underway to address these. Whilst this review notes that, it is important to understand why the system did not work as it should have and the role of other agencies within a safeguarding (Section 42) Enquiry.

7.46. Section 42[21] of the Care Act 2014 became the legal statute under which adult safeguarding enquiries are undertaken. The Act identifies the circumstances whereby the local authority should exercise their statutory safeguarding duty. Chapter 14 of the Care and Support Statutory Guidance[22] defines how the Care Act 2014 section 42 should be implemented. Local

[19] Braye, S. & Preston-Shoot, M. (2017) **Learning from SARs: A report for the London Safeguarding Adults Board**
[20] Preston-Shoot, M. (2017) **What difference does legislation make? Adult safeguarding through the lens of serious case reviews and safeguarding adult reviews. A report for south west region safeguarding adults boards**

[21] http://www.legislation.gov.uk/ukpga/2014/23/section/42

[22] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Safeguarding Adults Boards build their individual procedures[23] around Chapter 14 Guidance.

7.47. As detailed in section 5, four days before the admission that resulted in the section 42 enquiry, Adult A was taken to the emergency department. As a result of this fall, he had significant bruising to his flank area. The following day bruising was noted to the penis and scrotum by care home staff. The day after that, a district nurse noted extreme bruising to the penis, scrotum, hips, ribs and legs. None of this severe bruising was recorded on dated body maps that would evidence when and what bruising was developing day by day; none of this bruising was deemed to be a safeguarding issue by professionals over those few days.

7.48. When this was questioned in the review, it was stated that it is not usual to use body maps in this way and that they are usually used when abuse is suspected. The author would suggest that the use of body maps for bruising to someone who is not able to communicate how and when bruising has occurred provides ongoing evidence of progression of bruising following falls and other accidents that may then lead to consideration of safeguarding concerns.

7.49. The medical input to this review gave a general explanation as to the nature of how the body deals with haematomas and bruising. It was explained that following initial bruising, the body dissipates the internal blood that has collected in a bruised area in order for the body to reabsorb it. This can mean that, following an incident that causes bruising, the bruising and haematomas can track downwards with gravity, particularly where a person is upright and mobile.

7.50. With the history of falls and agitation that Adult A had, this severe bruising pattern should have been noted, monitored and early medical opinion sought as to the likelihood that this bruising was accidental or that there may be other explanations. This did not happen, and assumptions were made that the bruising was due to Adult A puling at his catheter and from falls.

7.51. The review has identified that blood tests had been taken to rule out any clotting issues but also notes that the body's ageing process does lead to bruises being caused much more easily. This is due to a thinning of the skin and layer beneath the skin and more fragile blood vessels. Adult A was not on any drugs that would have been likely to increase the risk of bruising.

7.52. When Adult A arrived at hospital the second time, the absence of a full history and updated body maps from the Care Home meant that the significant bruising to the flank from the previous attendance along with any bruising that had happened since, was not understood by staff wo saw Adult A on the second attendance. Electronic records from previous

[23] http://www.northlincssab.co.uk/professionals/

attendances are available to the emergency department staff to review; there is no evidence that the records of the attendance four days previously were reviewed.

7.53. The initial notification and raising of an adult safeguarding concern by the Acute Hospital was timely and immediate action to protect was wholly appropriate. It was not known how the bruising had occurred, staff, including doctors, did not think that the explanation of falls fitted the pattern and spread of the bruising and therefore the decision not to discharge back to The Care Home was the right one.

7.54. The first element in raising a safeguarding adult concern is to apply a making safeguarding personal approach. The Making Safeguarding Personal (MSP) initiative began as far back as 2009 by the Local Government Association and Association of Directors of Adult Social Services[24] to ensure outcome focussed, person centred responses to adult safeguarding, rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process.

7.55. Following this it is clear that those with Lasting Power of Attorney for Health and Welfare, should have been spoken with to identify how Adult A's wishes and feelings and desired outcomes were to be established at the start of the S42 enquiry. Adult A's daughter was contacted on the day that the concern was raised and, on several occasions following this. It does not appear that the section 42 enquiry process was clearly explained or that Adult A's representative would be included as part of the enquiry and throughout the process. This meant that those with LPA for Adult A were not involved or aware of the process and progress of the enquiry e.g. they were not aware that the police had made the decision that there would be no ongoing role for them the enquiry.

7.56. The next stage of the process is to gather further information and make a decision as to whether the concern meets the criteria for a safeguarding enquiry. The "concern decision-making" stage refers to the actions taken by the lead agency, and the decision whether the concern meets the criteria for progression to a statutory Care Act s42 Enquiry, or whether other types of action, or provision of information & advice, are required to respond to the concern.

7.57. This decision is based on the principles highlighted in the Care Act as to what would cause a local authority to instigate a Section 42 enquiry i.e. The Local Authority statutory duty of enquiry applies where it has reasonable cause to suspect that an adult, aged 18 or over, in its area-

- has needs for care & support (whether or not the authority is meeting any of those needs),

[24] Lawson, J. Sue Lewis, S & Williams, C. (2014) Making Safeguarding Personal 2013/14 Summary of findings London, LGA

- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

7.58. Again, this element of the process commenced well by gathering some initial information establishing that the criteria were met. It is recognised in the Local Authority report for this review that, in fact, the decision could have been made with the details contained within the concern form. In essence, this did not delay the process as it remained within the required timescale of five days. The initial information gathering was from The Care Home and the hospital. There should have been information sought in this phase from the GP who had overall oversight of care and treatment for Adult A; the concerns were related to care and treatment.

7.59. In the case of allegations of physical abuse, which ostensibly is what this was, the Police must be contacted. This happened as required and, given the information shared, the police made the decision that they would open an investigation and allocate an investigating officer. At this point everything had commenced as expected.

7.60. There were two types of enquiry that were required under slightly different procedures. The first was related to the allegation that Adult A may have been physically abused and therefore an enquiry needed to be conducted around him and his wishes and feelings and need for protection as well as addressing any issues of identifying if there needed to be a criminal investigation in the case of any alleged abuse or neglect.

7.61. There also needed to be an enquiry in order to address the allegations that this abuse happened in a regulated provider setting. Each enquiry would need to involve largely the same professionals but be separate with clarity for any family members and professionals about which elements of the enquiries would be open to them and which would not.

7.62. In addressing concerns related to a regulated care provider, CQC are notified as are any other commissioners of placements for individuals within that setting. Enquiries should lead to discussion of other adults in residence and identify if any additional section 42 enquiries are required in respect of other residents. Throughout the remainder of the section 42 enquiry, there was little clarity between the two investigations and professionals were not always clear as to which element was being addressed. This created confusion and concerns that Adult A's family were being deliberately left out of enquiries.

7.63. There are separate NLSAB Procedures for managing enquiries into what may constitute organisational abuse. The Care and Support Statutory Guidance[IBID] provides clear guidance regarding how to proceed when abuse or concerns are raised about a provider setting such as a care home:

The employer should investigate unless there is compelling reason why it is inappropriate or unsafe to do this. For example, this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police.

An example of a conflict of interest where it is better for an external person to be appointed to investigate may be the case of a family-run business where institutional abuse is alleged, or where the manager or owner of the service is implicated. The circumstances where an external person would be required should be set out in the local multi-agency procedures. All those carrying out such enquiries should have received appropriate training.

7.64. In this case the Care Home management company did investigate but there were also enquiries made by the Local Authority Safeguarding Adult Team. The NLSAB procedures are not clear about when and who should investigate which circumstances. This is why there was little clarity as to who was undertaking which elements and how the provider (The Care Home) would be involved. Communication with the Care Home was limited. This needed to be much clearer in the planning phase so that there could be evidence of transparency and working in partnership with the Care Home as the Care and Support Guidance requires.

7.65. As detailed previously, the provider's own investigation uncovered significant issues relating to record keeping and following of policies and procedures. The organisational enquiry did establish several facts related to the documentation and recording within the Care Home as well as failure to apply for DoLs for relevant residents. An action plan was completed and monitored by the Safeguarding Adult Team and the Provider Development Team. Significant changes were made by the provider company related to the management and staffing of the Care Home. This was appropriately dealt with. It would be for the provider development team and CQC to continue the monitoring of the Care Home as per their identified roles.

7.66. There was also consideration and enquiries regarding the other adults within the home, with commissioners being notified where they were not local.

7.67. The CQC information provided for this review identified that the role of CQC in the safeguarding enquiry was to receive information and recognise any elements that would need noting for the next inspection. CQC were sent a copy of the minutes of both the strategy meetings following the second meeting. No action is recorded to indicate that inspectors were required to take any active role in the safeguarding enquiry.

7.68. CQC identified that information within emails to the Inspector was not transferred to the internal safeguarding record. This is not in line with organisational policy. CQC have a clear policy for the management of information received in emails by its staff. This was believed to be an individual issue and has been addressed internally by CQC through ongoing monitoring

and improvement work. It is of note that retrospective review of this information, once the SAR had been commissioned, identified that the information received would not have met the threshold for a focussed inspection which is only mandated if there is a potential breach of regulations; this proved not to be the case.

7.69. The remainder of this section will focus on Adult A and the enquiry related to the bruising that was raised as a concern.

7.70. Once the decision had been made that S42 criteria were met and that immediate protection has been afforded, the next stage is the planning phase. The purpose of the planning phase is to continue to gather more information and to plan the safeguarding enquiry. These plans should include who is going to be conducting various elements of the enquiry. Planning can happen through a series of conversations with relevant stakeholders and/or a meeting can be called.

7.71. In this case, in order to address the planning stage, a strategy meeting was arranged. This was in accordance with guidance. Of those invited, a notable gap is that of the GP, who at this stage was still unaware of the safeguarding concern and played no part in the safeguarding enquiry because there was no request to; no other agency spoke to the GP about the bruising. No one present at the meeting had met Adult A prior to his hospital admission and knew little about him. Family, including those with LPAs, were not invited to contribute as is required under Care Act Provision (see 7.54), and others who knew him had sent apologies. The Care Home were also excluded. The hospital safeguarding team had some email exchange ahead of the meeting. No other professional that sent apologies sent any written information to the meeting. The planning and setting of the parameters led to the social worker and case worker proceeding with the enquiry.

7.72. The absence of the police, in fact at this point did not impact on decisions as they had already discussed the case with the social worker and indicated that they would open an investigation and allocate an officer. The police have since addressed the issue of attendance at strategy meetings, thereby accepting that these meetings should always involve police.

7.73. The ongoing involvement and police investigation did not progress in a timely manner as there was a delay in allocating an investigating officer until 18 days later; the reason for this was not able to be identified by police in this review. There was no direct feedback from the social worker to the police after the meeting. The fact that this had been agreed as needing to be a joint investigation was not recorded in these minutes and the police did not commence an investigation. The minutes from this first meeting were sent after the second meeting and reflected that the social worker and the case worker from the adult safeguarding team would be investigating. This does not appear to have been challenged by the police.

7.74. Part of this enquiry should have been undertaken by a health organisation albeit still coordinated and overseen by the Local Authority Safeguarding Adult Team or lead. The needs of Adult A related to his health needs and it was health practitioners that knew him, had cared for him and had clinical knowledge and skills to investigate the health issues. This would be in line with the Care Act section 42 of 'causing others to make enquiries.' It was also evident that as part of the enquiry there needed to be a medical opinion sought on the bruising regarding likelihood of it being caused accidently or non-accidentally. This issue is picked up later.

7.75. The inviting to and circulating of minutes following meetings requires improvement. The GP should always be invited to a strategy meeting where the reasons for the allegation are linked to health and wellbeing. Professionals that have worked with and delivered care to the person should be invited rather than safeguarding leads alone. Reports containing relevant information and history should always be provided by those not able to attend as a record of involvement and any concerns. Information sharing in emails, means that vital information exchange is not always recorded in the right place. Teams should have generic email addresses or electronically shared folders so that the absence of a member of staff does not mean that emails or information are not are not seen/answered relating to safeguarding cases. Minutes need to be circulated soon after the meeting, particularly where there has been limited attendance from professionals. CQC should also be invited to any meeting that is related to a regulated service.

7.76. Following the initial good response, the Section 42 enquiry related to Adult A lost focus and drifted. There were statements provided by community nurses that had visited Adult A explaining their involvement and their responses as described in Section 5. The Local Authority Safeguarding Adult Team were attempting to get statements from the doctors in the hospital who had assessed Adult A along with the photographs of the bruising from The Hospital Trust. These were not received by the second strategy meeting. This had not been escalated but the safeguarding nurse who was representing the hospital stated that this would be addressed. These statements were never received, and it does not appear that the doctor/s who raised the original concerns, took any further part in the safeguarding enquiry. The only information received was a copy of the Accident and Emergency Records and a report from the doctor that saw Adult A on the previous attendance. Even staff within their own organisation were unable to elicit the required information. This has led to learning and recommendations for the Hospital Trust regarding the development of a medical role for safeguarding adults and the need to escalate concerns related to medical matters to the medical director, via the director of nursing if appropriate.

7.77. There were again notable absences from the second strategy meeting. CQC were invited but had sent apologies. The GP and police were not invited, neither were family representatives of Adult A. This again led to an incomplete view of Adult A's previous circumstances or his

wishes and feelings.

7.78. It is of note that the hospital took the photographs prior to the safeguarding enquiry being undertaken. These were taken by the medical imaging department in line with expected practice. They were taken as a best interest decision for Adult A as at that time there was no registered LPA copied into the records of Adult A. The hospital staff explained that they have difficulty obtaining prompt evidence from families that they have registered LPAs. The Office of the Public Guardian are aware of these issues. The Named Doctor for Safeguarding stated that there is a computerised system being developed; there is no resolution at this point. Use of the 'This is Me' passport having space for details of the registered LPA would be helpful, but families would still need to provide evidence of the original documents.

7.79. It is not clear how the photographs were going to be used in the safeguarding enquiry. The photographs were not seen by the police; they were not sent to the social worker until after the second strategy meeting. There should be clear guidance regarding the use of photographic evidence in a safeguarding enquiry, particularly when the investigation could be of a criminal nature.

7.80. There were extensive enquiries undertaken in an attempt to establish the facts. As stated above, ongoing enquiries that were being made appeared mostly to relate to the organisational investigation into The Care Home. However, establishing facts regarding the bruising to Adult A did not happen.

7.81. By the second strategy meeting even though there was still no definitive medical opinion regarding the bruising to Adult A, there was a significant discussion with the now appointed investigating officer in the police later on the same day as the meeting. This was a lengthy conversation where the social worker indicated that there did appear to be explanations for some of the bruising, that The Care Home was experiencing considerable difficulties in caring for Adult A and that the paperwork in The Care Home was poor. This led to the police deciding that there was no further role for them in this enquiry.

7.82. In terms of ongoing risk to Adult A, this was addressed by not sending him back to The Care Home. His care needs were going to be met in an alternative home under NHS Continuing Healthcare Funding.

7.83. The conclusion of the safeguarding enquiry had not sufficiently established the facts related to the bruising to Adult A. It may not have been possible to have a definitive answer given the history that was known, the lack of recording and body maps and that Adult A was unable to communicate what had happened to him. It is, however, clear that these facts should have been based on professional medical opinion and that the medical opinion should have been discussed with the police. As it was, assumption was made on history and social work

interpretation of hospital records, emails/verbal communication from nurses in the hospital safeguarding team.

7.84. During the supplementary enquiry following concerns raised by the family, the opinion on the bruising came from a safeguarding nurse reviewing photographs and medical records. It is not clear from the report from the Hospital Trust why medical staff did not provide specific information for the Section 42 enquiry and why a safeguarding lead nurse appeared to have a conversation with a social work manager that led to final conclusions and outcomes of a section 42 enquiry. Further discussions during the review process identified that the purpose of the conversation referred to was not clear to the safeguarding lead nurse who did not understand that this conversation would lead to conclusions being drawn for the supplementary s42 enquiry which would explain why a nurse had this discussion. This raises a significant safeguarding system issue.

7.85. If this had been a child protection enquiry under Section 47 Children Act (1989) the indication of allegation of non-accidental bruising would have been examined and resulted in a request for a child protection medical, the findings of which would be shared with the social worker and the police. This would lead to joint decision making.

7.86. No such service is available for adults who present with unexplained bruising either nationally or locally. This means that doctors may well be concerned regarding patterns of bruising, but without a forensic medical training and/or background, would be unlikely be able to give the definitive forensic medical opinion that this case required and is a gap in the system to safeguard adults. It is of note that the Adult Safeguarding: Roles and Competencies for Health Care Staff[25], discusses the need for knowledge and skills in this area for appropriate staff but does not go as far as to suggest who this might me and how the provision will be funded. It appears that there are considerations for the Board locally to work with Health Partners to a resolution of this.

7.87. As a result of this case, work has begun by the named GP for safeguarding in partnership with NHS England[26] to address this gap.

7.88. In this case police and social care staff were reliant on medical staff providing expertise but the hospital medical staff showed a reluctance to be engaged, possibly due to a feeling that they were not trained in this area. This review has been unable to find out whether this was the case; the GP was not consulted at all in the section 42 enquiry.

[25] **Adult Safeguarding: Roles and Competencies for Health Care Staff** First edition: August 2018 Intercollegiate Document. London Royal College of Nursing https://www.rcn.org.uk/professional-development/publications/pub-007069

[26] **NHS England leads** the National Health Service (NHS) in England. Local health systems are supported by seven integrated regional teams who play a major leadership role in the geographies they manage. They make decisions about how best to support and assure performance in their region, as well as supporting system transformation and the development of sustainability and transformation partnerships and integrated care systems (ICS).

7.89. There are considerable issues in identifying causes of bruising in the elderly, particularly where they are not able to indicate how bruising has happened. Research into patterns of bruising in relation to elder abuse[27] identify that there is little research into patterns of accidental bruising that older adults suffer from, making it difficult to identify those bruises that are more likely to be non-accidental.

7.90. Two further studies have attempted to identify the pattern and location of bruising in elders who have been physically abused. They concluded that bruising to the lateral anterior arm (front and outer aspect), head and neck and posterior torso were more likely to be non-accidental. It is important to note, however, that each case must be reviewed based on the history and characteristics. The research was based on adults who were living at home and had been abused by a family member including domestic abuse. It is important therefore, that although attempts have been made to distinguish accidental and non-accidental bruising in older adults, it is a highly complex area.

7.91. It follows from this that medical expertise related to bruising in the elderly would be required to assess history, current physical and mental health along with medication in an effort to identify causes of bruising to indicate if it is likely that abuse has occurred. The author suggests that this is not a role for any professional other than those with a forensic medical training and background, although other medical professionals could give a view based on their experience and area of expertise.

7.92. Procedures elsewhere in the country identify that if forensic evidence needs to be collected regarding physical injuries, then police would normally arrange for a Forensic Medical Examiner to be involved. Police in this locality have stated that this is something that they would not undertake but agree that the police should have remained involved and sought to identify, along with partner agencies, a forensic medical opinion regarding the bruising.

7.93. It is also of note that, as Adult A's death was expected, it was not referred to the coroner therefore any information related to possible accidental or non-accidental injuries were not investigated post death. This is in line with requirements as cases where death is expected are not referred to the coroner. Cases where abuse or neglect are attributed to the cause of death are required to be referred the coroner. This case, however, has raised issues where there is an open Section 42 Enquiry, but death occurs from other causes. The local coroner has indicated that they would be open to making this a requirement. CQC have also indicated that clarification in their guidance on the notifications of death would be useful and work is underway to address this. This therefore leads to learning and recommendations.

[27] Mosqueda, L. Burnight, K. & Liao, S. (2006) Bruising in the Geriatric Population (Unpublished) From the University of California, Irvine College of Medicine, Program in Geriatrics Orange, California.

7.94. Conclusion of the safeguarding enquiry also contained information that Adult A had a urinary tract infection on second admission to hospital that could have been contributing to the falls. This was recorded as a result of a conversation between the social worker and the safeguarding lead nurse at the same time that the reasons for the bruising were discussed (see 7.80). Following the result of laboratory testing, the GP confirmed that the urine had been clear on this admission. It is believed that the working diagnosis was urine infection. The Accident and Emergency Records did not show the updated results as this would have come later. This is further evidence of the danger of not having full multi agency discussions and access to all information when making decisions as to cause and effect. The family were led to believe that the falls were caused by an undiagnosed urinary tract infection. The family were concerned that this indicated a lack of care in diagnosing a urinary tract infection. This review has evidence that this information was incorrect.

7.95. In an attempt to understand why so many of the safeguarding system elements failed to arrive at safe and robust outcomes for Adult A and the other adults resident at The Care Home, there are several factors.

7.96. In order to apply good safeguarding processes, the starting point is the policies and procedures. The author would suggest that the multi-agency procedures are difficult to navigate, provide limited flow charts of each stage of the process and do not provide specific guidance regarding making enquiries into physical abuse. Issues also include non-congruence in terminology between the Local Authority internal procedures and the multi-agency procedures.

7.97. Finding the correct procedures is not easy. The Local Authority Safeguarding pages link to the old procedures, although here is a link to the Safeguarding Adult Board Website.

7.98. Effective leadership is required to guide and mange staff through the process, providing expertise and advice to staff. This review has recognised a gap in medical leadership for safeguarding adults in the Hospital Trust and has made recommendations to address this internally.

7.99. Effective leadership leads to effective challenge when processes are not in line with requirements. Safeguarding is a multi-agency responsibility albeit that the local authority takes the lead role. The lack of attendance at the strategy meetings, minutes not being received etc. was not escalated and challenged by any of the professionals.

7.100. The requirement for medical representation at these meetings, or at the very least robust and timely reports based on the requirements of the section 42 enquiry was an absolute ‘must have’. The decisions not to proceed with police investigation should only have been made following a discussion based on medical input to the enquiry. It was medical staff that

raised the concern, but no doctor provided any further effective, first-hand relevant input.

7.101. Effective professional challenge should be embedded as part of any system in order that the system remains effective and robust. Reports referenced previously [9,10] highlight the need for effective collaboration and multi-agency working in safeguarding adults' processes.

7.102. Following on from robust procedures is ensuring that staff are competent in Adult Safeguarding work related to their role. The author has been unable to find as many documents and advice relevant to training on the board website as would be expected.

7.103. The subgroup of the board with the remit for assurance regarding partner agency training, has recognised that further work is required to enable the SAB to be assured that all staff are competent and appropriately trained in adult safeguarding work. This includes working with the Children's Multi-Agency Resilience Safeguarding (CMARS) to circulate a joint Safeguarding Adults & Children's Training Needs Analysis to be completed by all partner agencies. This will then be collated and reviewed by the subgroup to identify any gaps or learning opportunities.

Learning Point: Making enquiries regarding physical injuries requires specialist guidance and input.
Learning Point: Collaboration between Local Safeguarding Adult Boards to produce joint multiagency procedures may be helpful to organisations who cover several areas.
Learning Point: Body maps provide evidence of bruises from falls and other accidents. This is particularly helpful in a person who is not able to communicate.
Learning Point: Making Safeguarding Personal provides clarity on person centred safeguarding processes that include the person and their representatives throughout safeguarding processes.
Learning Point: Those with LPA for Health and Welfare must always be consulted and included in health and welfare decisions.
Learning Point: Clarity regarding outcomes for different procedures being followed avoids confusion and helps maintain focus.
Learning Point: 'Causing others to make enquiries' when more appropriate ensures effective use of expertise.
Learning Point: Single Agency procedures are more effective when congruent with multi agency procedures.
Learning Point: Multi agency safeguarding procedures need to be easy to access, navigate and follow.
Learning Point: Professional challenge and escalation plays a key role in safeguarding procedures and practice to ensure effective and robust section 42 enquiries.

8. CONCLUSION: MULTI AGENCY WORKING AND COMMUNICATION

8.1. It can be identified in drawing together conclusions in this case, that learning relates to the use of systems to support multi agency working. These may have provided a more cohesive approach to safeguarding Adult A that incorporated his wishes and feelings.

8.2. Adult A had been cared for at home with his progressive dementia and an indwelling catheter for several years. As his condition deteriorated, family turned to alternative care provision due to the impact of his escalating care needs on his wife.

8.3. They chose a care home that was able to provide services for people with dementia in an environment developed in line with the needs of people with dementia.

8.4. As Adult A had a social care assessment a few months previously and the family were going to be funding the placement themselves, they managed this decision and move without the support of professionals. There was ostensibly nothing wrong with this and many families undertake this for their family members.

8.5. On reflection, professionals felt that they could have been more assertive in offering advice and support and discussion regarding how Adult A may be affected by the move to a care home. Professionals have considered that there should be more support to manage a gradual transition in some cases rather than a sudden change in surroundings.

8.6. Once Adult A had moved, his needs escalated, and The Care Home were finding it very difficult to manage his day to day care. Professionals reflected that the lack of a key worker to coordinate care meant that no one professional had an overall view of this sudden escalation. It was largely put down to him needing a settling in period.

8.7. Family members who had LPA were not consulted as regularly as they should have been and there was no clarity sought about how they wanted to be involved. Escalating concerns eventually led to Adult A's family meeting with care home on the day before he was admitted to hospital and it was agreed that they would seek an alternative home for him.

8.8. When Adult A was admitted to hospital following a fall with significant bruising a safeguarding concern was raised. This was good and timely practice. This review found multi organisational and systemic failures in the multi-agency responses to the safeguarding enquiry. Reasons were multi-facetted. There was a lack of effective leadership, challenge, escalation, and procedures that were difficult to find and navigate. At the time of this review, there was no escalation process in place. There was no specific guidance regarding the investigation of possible physical abuse and no commissioned service or agreements regarding how medical opinion would be obtained in a case of this nature.

8.9. All of the above led to Adult A being in a home that could not cater for his escalating needs that were not addressed in a timely manner and an inadequate safeguarding response that left a family confused and upset about what had happened to their father.

9. RECOMMENDATIONS

9.1. The findings identified above have been included in learning points throughout this report and lead to recommendations for improvement.

9.2. Where agencies have made their own recommendations in their Agency Review Reports, and other investigations, NLSAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

9.3. It is of note that the Safeguarding Adults Board Policy and procedures are under constant review and have been updated since the timeframe of this review. As a result of this case, rapid action has been taken to review and update the procedures based on early findings from this review. Further changes to the procedures should be expedited to ensure all safeguarding process issues identified in this review are incorporated.

9.4. The following multi agency recommendations are made to the NLSAB as a result of the learning in this case:

Transition from Home to Care

1. NLSAB should identify how to ensure that all carers, including via support groups have access to packages of information related to choosing a care home.

2. NLSAB should produce briefing related to the learning from this Safeguarding Adults Review to be shared amongst partners and residential settings related to the following:
    a. Pre-admission assessment must consider likelihood that previously identified rapid deterioration of dementia may continue on admission to a care home.
    b. Consideration should always be given to a gradual transition to a care home for people with advancing dementia.
    c. Use should be made of person-centred passport (This is Me) and life story on admission to a care home.
    d. Where care is self-funded, professionals should seek to proactively support families in managing care home choice and transition.
    e. Providing accurate information on visiting a person who has an MRSA infection.
    f. Ensuring that all staff who provide care are aware of the need to regularly consult and involve with those that hold LPA for health and welfare. This should include

the need to record such involvement.

Managing falls and other behaviours in dementia

3. NLSAB should seek assurance from health and social care providers regarding the frameworks in place for ensuring key working in a case where a person with dementia is admitted to a care home. This should include the role of the GP, mental health services and early instigation of NHS continuing healthcare checklist.

4. NLSAB should seek assurance from NHS and Social Care providers that there is robust use made of those with LPA in care planning and decision making. Assessment and care planning proformas must have specific prompts for this.

5. NLSAB must ask the CQC, as well as all agencies involved in quality assurance, to ensure that policies and procedures related to falls and accidents require the use of body maps in all cases where bruising is discovered, and the person is not able to provide clarity on how and when the bruising occurred.

The safeguarding system

6. NLSAB should carry out a multi-agency audit of current safeguarding s42 enquiries to provide a baseline audit regarding the issues found in this case and seek to ensure that current concerns are addressed immediately. A follow up audit should be carried out in one year.

7. NLSAB should ask all local agencies to review their internal safeguarding policies and procedures, ensuring that the Multi Agency Procedures are referred to and that terminology and processes are congruent with multi agency procedures.

8. In the current review of Policies and Procedures and Guidance, NLSAB must consider the effectiveness of guidance related to:

    a. Involvement of families in all safeguarding enquiries (unless the family is considered to pose a risk).
    b. Clarity regarding advocacy for the person i.e. either the person with LPA, or where there is no available LPA or other appropriate family or friend advocate, that an independent advocate is appointed.
    c. Clear procedures for 'causing others to make enquires'
    d. Ensuring that all partner websites have links to the right policies
    e. Professional challenge and escalation

f. Guidance regarding gathering forensic evidence and investigation of physical injuries

9.

a. NLSAB should request updates from NHSE and the Named Doctor for Safeguarding, regarding the work being developed on coordination of assessment and documentation of injuries in adults at risk of harm.
b. This SAR should be shared with the NHS England Quality Surveillance Group[28] for Yorkshire and the Humber to ensure that learning is shared.

10. NLSAB, should write to the chief coroner and CQC (to include in their death notification guidance), quoting this case to seek consideration of adding the requirement to inform the coroner where a person may have died from unrelated causes but where there is an open section 42 enquiry regarding allegations of abuse and neglect.

11. NLSAB should continue with exploring collaborative work with other SABs in the region to work towards regional Multi Agency Policies and Procedures.

12. NLSAB must produce a learning briefing related to all learning points from this SAR for circulation to all partner agencies.

[28] **Quality Surveillance Groups (QSGs)** bring together different parts of the health and care system, to share intelligence about risks to quality. It is a platform for sharing learning from various sources, regionally and nationally.

Appendix One Terms of Reference (REDACTED)

Safeguarding Adults Review
Case 01/2019
Adult A
Terms of Reference and Scope

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

Adult A was an 87-year-old gentleman who suffered from dementia. Adult A had been cared for at home by his family until June 2018 when he was admitted to a care home by his family. His placement was self-funded. Adult A was taken to hospital following falls. Medical staff were concerned by multiple bruises and raised a safeguarding concern. The ensuing section 42 enquiry concluded that there were risks identified and action taken in relation to the home. Adult A later died of an unrelated illness seven weeks later.

3. Decision to hold a Safeguarding Adults Review

A referral for a SAR was sent to The North Lincolnshire Safeguarding Adult board (NLSAB) on 4 July 2019, following concerns raised about how the section 42 enquiry was conducted. The NLSAB Executive Group met on 9 July 2019 and agreed that the criteria for a Safeguarding Adults Review were met based on the following:

Criteria 1 (met) – Adult A was an adult who had both care and support needs.

Criteria 2 (met) – There is a concern in relation to how partner organisations worked together to complete the S42 Enquiry after the safeguarding referral had been raised.

Criteria 3 (not met) – Members acknowledged that although Adult A had died there was no indication that this was as a result of abuse or neglect. Adult A's cause of death had a clinical diagnosis, un-related to the safeguarding concerns.

There were, however, concerns in relation to how the S42 Enquiry was undertaken:

- Concerns that agencies could have worked more effectively together to conduct the enquiry
- Concerns that the possibility of neglect was not fully explored or considered
- Concerns that issues in relation to clinical care delivery was not fully explored, or sufficiently understood

Members agreed that as a result of the above points the original outcome and conclusion of the S42 Enquiry were also brought into question.

Criteria 4 – Not relevant as Adult A has died

Criteria 5 (met) – The North Lincolnshire SAB Executive Group are free to arrange a SAR in any other situation involving an adult in its area with needs for care and support.

The NLSAB Executive Group and made a recommendation to the NLSAB Independent Chair. The Independent Chair endorsed this decision. It is of note that it was the issue of concerns around the section 42 enquiry where the criteria are met for a SAR and not the death in the Nursing Home.

4. Scope

The review will cover the period from when a referral for a care needs assessment was received into Adult Social Care and the end of the S42 enquiry. This is the period that covers identification of considerable numbers of contacts with agencies. Key background information will also form part of the review that will inform the more contemporary elements of Adult A's care.

5. Method

In determining the methodology to be used for this Safeguarding Adults Review the NLSAB considered the Care Act 2014 Statutory Guidance which states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

NLSAB chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a Learning and Reflection Workshop to review all of the material and identify key themes and learning. A further workshop will take place to review the first draft of the overview report and formulate recommendations.

6. Key Lines of Enquiry to be addressed

As well as broader analysis provided within the Agency Review Reports the following case specific key lines of enquiry will be addressed.

6.1. Assessment

What assessment did your agency undertake of Adult A's holistic needs, inclusive of physical and mental health? How did this inform care or other planning and interventions? Please provide analysis of assessment policies and frameworks that were in use, identify good practice and any gaps in policy and/or practice. Please identify and analyse any differences identified due to the self-funding status of Adult A.

6.2. Clinical Care and Management

What did your agency understand of the clinical diagnoses of Adult A and his care needs as a result?
Please identify how well clinical diagnoses was communicated and informed care given as a result.

6.3. Falls

What did your agency know of any falls that Adult A experienced?
What falls prevention strategies and care planning were undertaken as a result of knowledge of any falls?
What was your agency's expected practice in relation to any falls experienced?
What training do staff have on application of falls management?
Were appropriate referrals made to, and information shared with, other agencies and services when required?
Where referrals were made, please analyse timeliness and quality of referrals and responses received. If necessary, where referrals were not made, please provide a reason.

Please comment on how well agencies worked together on falls management to improve outcomes for Adult A.

6.4. **Safeguarding and Risk Management**

What was your agency's involvement in the safeguarding concern being reported and meetings in July and August 2018?
What information did your agency share for the S42 Enquiry?
Please comment on the decision making and communication that ensued from the information that was shared. Please analyse and comment on application and compliance with the NLSAB Multi-Agency Safeguarding Adults Policy & Procedures.

6.5. Multi Agency Working

What did your agency understand of the other agencies involved during the whole period that this review covers? What evidence is there regarding multi agency coordination and sharing of risks, assessments and plans? Discuss this in terms of what would be expected for multi-agency working against best practice.

6.6. Family Involvement

How were the wishes and feelings of Adult A demonstrated in the care given? Please comment using examples.
How did your agency engage with Adult A's family?
How were they included in plans, assessments and investigations? Were there any issues of consent and confidentiality?

6.7. Documentation

Please identify if documentation was in line with agency and regulatory requirements. If it was not, please analyse why this might be.

6.8. Good Practice

Please identify examples of good practice from your agency and others.

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this Safeguarding Adults Review is **Karen Rees.**

8. Organisations to be involved with the review:

- The Hospital NHS Foundation Trust
    - Community Nursing Teams

- Acute Hospital Care
- CCG for GP
- The Mental Health NHS Foundation Trust
- Local Authority Adult Social Care
- Ambulance Service
- Police
- CQC
- Management Company for The Care Home

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to finalisation of the report. The Independent Chair of NLSAB met with Adult A's family prior to the commencement of the review. The Independent Reviewer will make arrangements to meet with the family.

10. Project Plan dates:

		Date
1.	Scoping Meeting	11/09/2019
2.	Terms of Reference updated	As above
3.	Agency Authors' Briefing	As above
4.	Agency Review Reports submitted	17/10/2019
5.	Review of Reports by Independent Author	17-23/10/2019
6.	Distribution of Reports to all Learning & Reflection Workshop attendees	23/10/2019
7.	Learning and Reflection Workshop (Full Day)	30/10/2019
8.	First Draft Overview Report to all attendees	03/12/2019
9.	Learning and Reflection Review Workshop	12/12/2019
10.	V2 Overview report circulated to workshop attendees	02/01/2020
11.	Comments on V2	15/01/2020
12	V3 to SAR Subgroup	24/01/2020
13	SAR Sub-Group to agree workable achievable recommendations and agree report prior to presentation at Board.	20/02/2020
14	Presentation to NLSAB Meeting	27 MAY 2020