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Safeguarding Adult Review

Mrs D

Royal Greenwich Safeguarding Adults Board

June 2020

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1. Introduction

1.1 This report was commissioned by the Royal Greenwich Safeguarding Adults Board (GSAB) following the death of Mrs D on the 20th December 2017.

1.2 Mrs D had been brought to the emergency department of Acute Hospital 1 on the 18th December 2017.

1.3 She had a grade[1] (category) four pressure ulcer[2] on her sacrum[3] and her heels were necrotic, that is the flesh had died and formed a hard black shell.

1.4 She had developed sepsis that is an overwhelming infection which led to multi organ failure and her death. On arrival at hospital Mrs D was unkempt and appeared to have neglected her personal care.

1.5 The hospital had raised a safeguarding concern via the adult safeguarding team as such ulcers are potentially preventable.

2. Family Background

2.1 Much of this detail has been obtained from correspondence to Mrs D's GP from a variety of clinical services.

2.2 Records reveal little of Mrs D's behaviour and personality prior to 2003.

2.3 She lived with her husband, daughter and granddaughter in an owner occupied house.

2.4 She had a son who had lived with the family but who by the time of her death no longer did so.

2.5 She worked as a care assistant for the local authority social services department but appears to have become unwell in 2003 and was unable to work.

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[1] As part of the Stop the Pressure programme, new guidance on pressure ulcer definition and measurement in England has been issued by NHS Improvement after a consensus-seeking exercise involving a large range of stakeholders. The guidance was rolled out nationally from April 2019. Instead of Grade pressure ulcers are now referred to by category.

[2] This is a wound where there is full thickness loss of tissue that is through all skin layers and possibly exposing bone and tendons.

[3] The sacrum is the large triangular bone at the base of the spine, it joins the spinal bones to the pelvis

2.6 In May 2003, an incident occurred which led the police to attend the house, this resulted in concerns being raised about the state of the accommodation. At this time Mrs D's granddaughter was ten years old. Social services were alerted to an environment which was very dirty, cluttered and where the living conditions were insanitary. A follow up visit in June 2003 showed sufficient improvements in the state of the accommodation and no further action resulted.

2.7 The reports in all records emphasise the affection between family members.

3. Background to events prior to 2016

3.1 None of the records we have seen offer an objective picture of Mrs D pre-morbid personality or abilities.

3.2 In September 2003, Mrs D began to complain of headaches which were disturbing her vision. The headaches were debilitating and in November 2003 she was referred to a neurologist at Acute Hospital 1, which housed a regional neuro surgical centre. The cause of the headaches was not immediately clear, but following a CT scan in January 2004 a tumour was diagnosed.

3.3 The tumour was a ganglioneurocytoma. These are rare tumours and are often not discovered until they are large and because of their situation in the brain total removal is difficult. The tumour was not malignant. Such tumours and surgery for their removal, can lead to personality and behavioural changes. Initial surgery took place in early 2004 at the regional neurosurgical unit.

3.4 Further surgical revision took place in September 2004 at the same unit.

3.5 In November 2004 Mrs D spent three weeks in a specialist intensive inpatient neuro-rehabilitation unit for patients recovering from a severe neurological event. She required assistance with all activities of daily living (ADL). She had difficulty retaining information and managing household tasks. The discharge report noted "Mrs D will require constant supervision on discharge. The concept of 24 hour care had been explained to Mrs D and her family and they have declined assistance with this from social services at this time".

3.6 They also declined occupational therapy.

3.7 In December 2014 a solicitor acting for the family gave notice of their involvement and concerns of negligence and delays in treatment. The records do not offer any greater clarity around the outcome of the case.

3.8 In December 2014 Mrs D applied for a Freedom pass and in the application, which was supported by her GP, her limited mobility is noted as being unable to walk more than fifty metres.

3.9 As part of the follow up after surgery Mrs D was seen by neuro surgery, rehabilitation services, psychology and neuropsychiatric services.

3.10 Her family reported that she was now aggressive, physically lashing out at them and that she was much changed since the surgery.

3.11 In June 2005 there was a joint examination of Mrs D by these services.

3.12 Mrs D denied any changes in her behaviour and ascribed her anger to being unable to work and having to spend a great deal of time at home with her husband. They found no evidence of a functional mental illness but set out a plan to try to deal with some of the presenting issues and to support Mrs D including contact with adult social care.

3.13 A consultant psychologist from a specialised Brain Injury Unit at Mental Health Trust 1 saw Mr and Mrs D in July 2005. It was not possible to interview them together as there were significant difficulties in their personal interactions. He saw them individually.

3.14 Mr D reported that Mrs D had been verbally and physically aggressive to her daughter and granddaughter.

3.15 Mrs D accepted that she was irritable and angry at times. She attributed this to being unable to work and as her husband had been made redundant, she was worried about money and being unable to afford repairs which were needed to their house.

3.16 She felt frustrated as her husband was “sitting around doing nothing”.

3.17 She was resistant to any suggestion that the tumour and his treatment might have affected her abilities and behaviour. She believed she had returned to her normal level of functionality . As he felt this was true lack of insight, the

consultant psychologist concluded that it was unlikely that a therapeutic intervention was possible.

3.18 A follow up appointment with the consultant psychologist led to the same conclusion. Mrs D was referred to a "welfare worker" but it being unclear what the outcome was.

3.19 A further clinic appointment on 1st September 2005, notes the following "I have contact [*sic*] the physical disabilities team again today who have assured me that they will discuss and allocate Mrs D on 31st August 2005"

3.20 No detail of this contact or resulting assessment has been seen. The local authority IMR did not identify this information[4].

3.21 Mrs D was seen again by a consultant psychiatrist from Mental Health Trust 1 on 7th November 2005. As well as noting the challenging family dynamic he commenced olanzapine, an anti-psychotic drug, as Mrs D was exhibiting paranoid ideas. He also suggested approaching a named brain injury association for help.

3.22 Review in clinic with the psychiatrist on the 12th January 2006 noted that Mr D initially reported that olanzapine had made her irritable Later discussion suggested she was calmer and that she had been seen by the named brain injury association. He wrote to the association but had received no response when he saw Mrs D in June 2006.

3.23 Her GP had reduced the dose of olanzapine to 5mg and there was little change in her presentation. A trial of beta blockers was suggested.

3.24 Consideration was to be made of an inpatient admission to a specialist behavioural unit. This required funding from the local commissioner, the funding was not agreed. We do not know why the funding was not agreed and there is no letter in the GP records to explain the decision.

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[4] This information was found in a discharge letter to the GP from the psychiatrist. The reason for the refusal is not detailed. The local commissioner would have been the Primary Care Trust. These bodies were disestablished in 2013.

3.25 She was seen again in July 2006 and appeared more irritable and reported that the beta blockers had caused itching. The same consultant psychiatrist noted “I feel we may be running out of therapeutic options”.

3.26 He suggested a trial of sulpiride, a different anti-psychotic. He also noted that he would write “to social services as it is very unclear to me what, if any, help she is getting from that end”.

3.27 He saw Mrs D again in September and noted a letter which had been sent to Mrs D by a social worker from a Local Authority adult services.

3.28 His response letter to the social worker noted that funding for the named brain injury association has been turned down.

3.29 He wrote “It may not be realistic to insist that Mrs D allow a care manager to assess her at home. It is the nature of her difficulties that she is argumentative and unreasonable and so may not co-operate with a domiciliary assessment. It would be clearly absurd if that meant that services were then denied to her”. He goes on to say that he hopes they will be able to assess her.

3.30 Mrs D was seen by the same psychiatrist in March 2007. Mr D stated that Mrs D was more irritable since taking the sulpiride, he felt she appeared less persecuted but as Mrs D also felt it had not helped he suggested a trial of trazadone, which is an anti-depressant. He also added a post script to the letter thanking the same social worker for finding a place for Mrs D at the Greenwich disability resource centre, he suggested a community OT assessment and help with benefits. He planned to see her again in May 2007.

3.31 Mrs D was seen in the neuropsychiatric clinic in June 2007. The trazadone appeared to have helped a little. He noted that recent neuropsychology confirmed cognitive deterioration and her existing problems persisted.

3.32 He noted in the letter to the GP “I am still concerned that although medicine has little to offer the couple in terms of improving Mrs D’s function, they may be entitled to more practical or financial help than they are currently receiving.” He noted that Mrs D was no longer attending the resource centre as there were “disabled” people there.

3.33 He went on to say to the GP that he thought it would be helpful if she could have advice from social services or a benefits adviser and he copied the letter to social services[5].

3.34 Mrs D applied for a "blue badge" in February 2008, the application which was signed by her GP notes that she can walk less than fifty metres. The blue badge was granted.

3.35 Mrs D was seen by the neuropsychiatrist on 13th March 2008, little had changed except that Mrs D had decided to stop the trazadone as her husband complained that she stayed in bed until the afternoon and had given up doing housework and shopping.

3.36 Mrs D's next appointment was on the 12th June 2008.

3.37 Following this appointment the psychiatrist wrote again to the social worker with whom he had previous communication, the letter dated 23rd June, noted that he was unsure what therapeutic support was being offered to Mrs D and her family. He asked for "Your team's reassessment of the situation and if necessary any liaison with named brain injury association "

3.38 The Local authority IMR notes the following: "In August 2008 a referral was made to Local authority adult services by the neuropsychiatrist from the regional neurosurgical unit hospital requesting an assessment for support with 'social activity'. A letter was sent on the 1st September 2008 by a social worker in the Physical Disability Team, offering an assessment on Wednesday 17th September 2008 and to confirm a convenient time. Case notes indicate that Mrs D was expected to attend an Overview Assessment on the 17th of September but the time was changed from 1pm to 1.30pm on the day of the appointment. Despite there being an Overview Assessment document on Framework-I, this is empty."

[5] The IMR from social services contained information from 2003 until 2018. The information 2003-2004 came from children's services, the adult service contact began in 2008. However, evidence of earlier contact with adult services is found in the discharge letters from the psychiatrist to the GP. The psychiatrist noted that he had referred to social services.

3.39 Mrs D did not attend her appointment with the neuropsychiatrist in October 2008. She attended no further appointments for any follow up post-surgery and was therefore discharged in 2009.

3.40 Between 2009 and 2013, there is little contact with the GP service and there are no outpatient records.

3.41 Mrs D did not change GP practice and the records were already in electronic format at this time. It must be assumed, in the absence of any information from the GP practice that the records are complete.

3.42 Mrs D declined breast and cervical screening, she did not reply to invitations to attend for smoking cessation and she did not return her bowel screening kit. Mrs D regularly ignored or declined all types of screening. There is nothing in the GP records to suggest that there was any intervention by the practice to discuss her lack of engagement.

3.43 The practice last reviewed her medication on the 4th January 2011. As they were not prescribing multiple medications for her and she had no recorded diagnoses of a chronic health condition and was not over 75 years old, there would have been no mandated reason for them to do so.

3.44 Mrs D saw a nurse in an emergency department [Acute Hospital 2] for removal of a foreign body from her ear in January 2013.

3.45 Later that month she was seen in the oral medicine department at Acute Hospital 3, where she had been referred by a community dentist.

3.46 The dental attendance required routine hospital follow up in two weeks. There is nothing to suggest that this occurred.

3.47 In the discharge letter to the GP, there is an observation in the additional notes "She is no longer under follow up from neurosurgery at [Acute Hospital 1] because she refuses to go. She also advised me that she does not see her GP as she does not like going to see doctor"

3.48 The only time Mrs D was seen in the surgery after 2008 was on 7th February 2014, Mrs D wanted a letter to confirm that she had been treated for a brain tumour at the regional neurosurgical unit.

3.49 In 2015 she was invited to have a flu vaccination but did not respond.

3.50 In summary, prior to surgery in 2003, the living conditions at Mrs D's house were noted to be cluttered, insanitary and dirty. From at least 2005 Mrs D articulated concerns about the need to carry out and pay for repairs to the house.

3.51 After surgery in 2004, Mrs D became more frustrated and aggressive, from time to time lashing out at family members. She was seen and assessed by a number of clinical services and trials of anti-psychotic drugs and anti-depressants made little difference.

3.52 Mrs D had little insight into her behaviour and the responses of her husband and family to her changed behaviour appear to have exacerbated the problem at times.

3.53 There is evidence that social services were contacted at various points but there is no assessment seen in the records. In particular there is nothing to suggest that either healthcare or social services visited Mrs D at home and formed a view on any challenges which she might face in that environment.

3.54 Mrs D had no support package from social services. There are examples of Mrs D and her family refusing services such as Occupational Therapy from 2005 onwards.

3.55 Mrs D's limited mobility was acknowledged from 2004 onwards when she applied for a freedom pass and later for a blue badge.

4. Narrative of events September 2016-December 2017

4.1 On 27th September 2016, Mrs D's granddaughter telephoned the GP surgery as Mrs D was confused, talking to herself and seeing people who were not there. GP 1 advised the receptionist to tell the family to take Mrs D to hospital.

4.2 On the 28th September 2016 at 20.48 an ambulance was called by Mrs D's family to take her to hospital, she was reported to be violent and hallucinating, the ambulance service informed the police. At 20.57 the ambulance was cancelled as the family intended to take Mrs D to hospital themselves. At 21.01 this situation was confirmed with Mrs D's granddaughter and the ambulance and police were both stood down.

4.3 On the following day, 29th September Mrs D was taken to the A&E department at acute hospital 1. A doctor from acute hospital spoke to a GP from the

registered practice to gain information about Mrs D's previous medical history. The information provided did not include the detailed input from the services at Mental Health Trust 1.

4.4 She had a CT scan which showed no new abnormalities.

4.5 The decision was made to detain Mrs D under section 2 of the Mental Health Act (1983), as due to illness she was unable co-operate with care on an informal basis, this can last for up to twenty eight days.

4.6 On 30th September Mrs D was admitted to an inpatient ward designated for older people with functional mental health problems which is run by Mental Health Trust 2.

4.7 Whilst on the ward Mrs D had two falls. She was incontinent of urine at times and was reluctant to accept help with activities of daily living.

4.8 The GP practice faxed details of Mrs D's previous medical history to the ward at Mental Health Trust 2.

4.9 This consisted of the journal entries from the electronic patient records and the most recent letters including the last neurosurgical follow up in November 2009. It did not include the earlier correspondence with the neuropsychiatrist.

4.10 Mrs D was prescribed olanzapine once more and this reduced her paranoid fears.

4.11 A specialist doctor who undertook a neurological assessment on the 19th October acknowledged that she had previous psychiatric problems. This identified no new or emerging neurological problems.

4.12 Mrs D was seen by a Physiotherapist and an Occupational therapist.

4.13 On the 25th October the specialist doctor saw Mrs D, and the section 2 order was rescinded by a specialist doctor. Mrs D was not happy to be an in-patient and did not engage with others on the ward.

4.14 Her psychiatric condition had improved since admission, the psychiatrist concluded that Mrs D lacked the capacity to consider where she should be accommodated for the purpose of being provided with care and treatment.

4.15 A Deprivation of Liberty safeguards assessment was requested on the 27th October and this was completed on the 7th November.

4.16 The assessor noted of Mrs D: “She needs care intervention with personal care and personal hygiene. She often refuses such assistance and when she is soiled then staff are more persuasive in requesting her consent to their care intervention.”

4.17 The assessor spoke to Mrs D’s granddaughter who confirmed that she provided personal care and assisted her grandmother with hygiene needs.

4.18 The DOLs assessment noted that. Mrs D wanted to go home and her family wished her to return there. The assessment recorded the specific advice given to Mrs D’s granddaughter around her responsibilities and the legal steps which needed to be followed if Mrs D “continues to object, either verbally or by her behaviour, to the current place of residence” in additions she agreed to “ bring an application to Court if, following the ward round on 3/11/16, [if] the ward decide to extend the inpatient admission”

4.19 On the 3rd November as part of the discharge planning process it was identified that a home visit from an OT was required. The family agreed to this.

4.20 On 7th November the OT telephoned to arrange the home visit, they were told by Mrs D’s granddaughter that her grandfather would not allow anyone into the house.

4.21 Mrs D went on home leave on the 8th November, after a meeting with Mrs D’s granddaughter, there was agreement for the intensive home treatment team (IHTT) to attend and provide support.

4.22 The IHTT attended and observed the following: “Family present. [Mrs D] happy to be at home, granddaughter managing medication home environment neglected and chaotic, 8 cats.”

4.23 On the 13th November Mrs D’s granddaughter rang to cancel the visit, saying she was taking Mrs D out and she had no concerns.

4.24 A doctor attended at the home visit on the 14th November and a more detailed plan for discharge was made including the following note: “Please could CCO [Care Co-Ordinator] visit. Her home raises some concerns re their living standards - could they benefit from additional support? Should also have smoke alarms”

4.25 The discharge was agreed with the family on 17th November.

4.26 At a home visit on the 18th November a member of the IHTT notes that Mrs D had seen the GP about a swollen ankle. There is no entry in the GP record to

support this. There is also a reference to discussion with Mrs D's granddaughter about the clutter in the house and the need for fire alarms.

4.27 A ward discharge notification was sent to the GP on 22nd November which summarised the treatment and noted that Mrs D's home was "run down and clutter [*sic*], furniture unclean and in poor repair."

4.28 The diagnosis was noted as "Organic delusional (schizophrenia-like) disorder"

4.29 It was noted that the Care Programme Approach[6] at discharge was a new "CPA".

4.30 The prescription for olanzapine was added to Mrs D's regular prescription template at the GP surgery.

4.31 The discharge letter noted Mrs D's granddaughter as her carer. The GP practice did not add her to their carer's register. Mrs D's GP records noted Mrs D's daughter as her carer.

4.32 Further visits from the IHTT took place on the 21st and 24th November. The family reported that they would not fit fire alarms as Mrs D thought they might go off unnecessarily.

4.33 On the 28th November the IHTT carried out a joint visit with the care co-ordinator for the community mental health team. Mrs D was discharged from the IHTT. The visit entry records noted a referral to the London Fire Brigade for a safety check.

4.34 No safety check took place. The Fire Service reported that they never received a referral.

4.35 A copy of the discharge from the IHTT was sent to the GP on 29th November, this was not scanned onto the electronic record until 19th January 2017. The care plan was essentially as described on the 22nd November.

4.36 In addition it requested that the GP consider alternative referral for neurology, she does not wish to be seen at the regional neurosurgical unit. The requirement for follow up is unclear. Mrs D had no new neurological symptoms and had been assessed. The GP did not make a referral.

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[6] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

4.37 The discharge letter did not refer to the home environment in the key risk assessment. It referred to “likely to self-neglect without the support of family”

4.38 The care co-ordinator visited on the 6th and 19th December. There were no comments about the home environment.

4.39 There was contact by telephone on 28th December to check how Christmas went. No problems had been experienced.

4.40 The Mental Health Trust’s timeline notes a clinic attendance on 10th January, no detail of this is seen in the GP records.

4.41 On the 11th January Mrs D was seen in the A&E department at acute hospital 1, she had a chesty cough and was noted to be agitated. A chest x-ray suggested an infection and antibiotics were prescribed.

4.42 Her social history notes “Granddaughter main carer, independent but has care worker”

4.43 She was discharged home and the follow up included a request for a repeat chest x-ray in six weeks and consideration of an echocardiogram as the chest examination had revealed heart sounds suggestive of a cardiac murmur.

4.44 The letter was scanned included in the GP record, but no referrals were made.

4.45 On the 20th January 2017, a CPA meeting took place. Mrs D, her daughter and granddaughter were all present. The meeting includes both a view from the carer (granddaughter) and Mrs D. Everything appeared to be working well and Mrs D was discharged from care co-ordination. Care co-ordination had been in place for two months.

4.46 This was now changed to three monthly attendances at a Psychiatrist clinic in outpatients at Mental Health Trust 2.

4.47 There is nothing to suggest that the issues relating to Mrs D’s home circumstances had been revisited or addressed.

4.48 A plan for a placement at a day care centre was agreed, but the family refused this after they were contacted on 7th February.

4.49 Appointments with the mental health service scheduled for 11th April and 16th May were cancelled, the stated reason was that the client cancelled because they were unwell.

4.50 An appointment on 6th June is noted as “Cancelled by carer” and a further appointment on 8th June was not attended (DNA).

4.51 Mrs D was seen in clinic on 15th June, no reference is made to the cancelled appointments. Mrs D was reported to be interacting once more with auditory hallucinations and had fallen a few times.

4.52 The care plan was to continue with the antipsychotic at the same dose. The GP was asked if they thought it was appropriate for her to be referred to falls clinic. It is not entirely clear if that was a request for the GPs opinion on a referral or a request for the GP to refer her. No referral was made to falls clinic.

4.53 The letter was copied to Mrs D and a standard footer with contact details can be seen at the end of the letter. This signposts patients and families in the event of an emergency.

4.54 Mrs D was seen by no other health or social services until 28th September when she was again seen in CMHT OPD clinic. Her mental state was much the same as previously. However as Mrs D was now sleeping for very long periods, her medication was changed to Risperidone which is a less sedating anti-psychotic drug. On all occasions when she was seen in the OPD, Mrs D was mobile and was not perceived as physically frail by the healthcare professionals who saw her.

4.55 The letter concludes “Her family know that they can call us between appointments if the need arises”

4.56 On the 6th November Mrs D’s granddaughter rang the CMHT to say that since the change of drug, Mrs D was significantly worse. After discussion it was decided to revert to Olanzapine and a member of the team delivered the prescription to the family. Her outpatient appointment was brought forward to the 14th November, the note on the system states cancelled by client due to illness, reinstated appointments for the 28th November, 30th November and 19th December were all cancelled by the carer. There was no obvious follow up to establish what the problem was after the 6th November.

4.57 On the 18th December, Mrs D was unwell. Her family decided to try to take her to hospital by taxi. They had difficulty in moving her and eventually called an ambulance. At 16.43 an ambulance arrived. Paramedics found Mrs D outside her house, against the door. The family told them that they had been trying to take her to hospital by taxi when her legs buckled.

4.58 They examined Mrs D, who had a reduced level of consciousness and was very cold. Her temperature was recorded at 27.7 degrees Celsius. Her clothes were soiled and cut off by ambulance staff and she was wrapped in foil blankets.

4.59 After arriving at A&E at acute hospital at 18.44. Mrs D was diagnosed with sepsis and hypothermia.

4.60 Her granddaughter reported a four day history of confusion and a reduced oral intake. She told staff that she had noticed a sore on her grandmother's buttock that morning and that her grandmother would not let her assist with washing.

4.61 The pressure ulcers required surgical debridement in theatre. After this Mrs D was transferred to ITU where she was mechanically ventilated. She was extremely unwell and it was difficult to maintain an effective level of blood pressure and to correct the acidic level of her blood despite maximum drug therapy. The consultant in charge of her case believed the situation to be futile and after discussion with the family agreed to put a do not attempt cardio pulmonary resuscitation order in place. Organ support was stopped and Mrs D passed away peacefully at 15.30 on 20th December 2017.

4.62 A safeguarding adult concern was raised on the 18th December. The concerns were the nature of Mrs D's pressure ulcers, her hypothermia, delays in seeking medical assistance and her living conditions.

4.63 On 27th August 2018 it was decided that this case met the criteria for a safeguarding adults review.

5. Summary Overall analysis

5.1 Mrs D's engagement with healthcare services in relation to her brain tumour and the effects that this had upon her began in 2003. The effects of this condition were life altering and it is unclear if this was ever fully accepted by her or her family.

5.2 Part of the challenge was that she expected and appeared to believe that she was functioning as she had before she developed the tumour. We do not know if this exacerbated an existing mistrust and dislike of healthcare and other support services but this certainly was apparent by 2008.

5.3 Mrs D's attitude appeared to dominate her family's engagement with health and care services.

5.4 Considerable efforts were made through mental health services to try to engage and find support and assistance for Mrs D and her family prior to 2008.

5.5 There was a gap between 2009 and 2016 where Mrs D had little to no contact with health services of any kind.

5.6 When reconnection came to mental health services in 2016, it was through a different mental health service provider. They did not have access to the previous records. It is debatable how directly relevant these would have been eight years later but they would have provided a potential insight into a recurrent pattern of behaviour.

5.7 Mrs D and her family were always reluctant to allow anyone into their home.

5.8 Issues relating to the state of the home were long standing and whilst there was an improvement in 2004, Mrs D expressed concern about the need to pay for repairs to the house. As no domiciliary services or home visits were recorded there are no contemporaneous descriptions of the environment until 2016. In 2016, the property is described as chaotic.

5.9 There is a lack of any GP focus in the care provided, this is mainly because Mrs D did not attend the practice and actively resisted medical input except in emergency situations.

5.10 There is an absence of any engagement with adult social care and the one assessment appointment which was arranged in 2008 never took place.

5.11 Mrs D's case never appears to have reached a threshold in any organisation which triggered concern for her well-being.

5.12 None of the professionals who met Mrs D, in any setting recorded any safeguarding concerns.

6. Themed Analysis

Engagement and withdrawal

6.1 A review such as this enables us to see patterns and trends which are not necessarily apparent at the time that events take place. When we look back at over a long period it is possible to interpret events and information very

differently from the people who were there at the time, who of course could not know or even predict the outcomes. There is a considerable tendency towards hindsight bias when events are seen in this way.

6.2 There is a clear pattern from 2004 onwards which is even more marked from 2008 of Mrs D and her family, agreeing to plans and then withdrawing from them.

6.3 There are multiple occasions when Mrs D and her family agree to an approach, such as a home OT assessment, attending a day placement, only to withdraw consent at a later point. The neuropsychiatrist who saw her in 2006 recognised that "It is the nature of her difficulties that she is argumentative and unreasonable and so may not co-operate with a domiciliary assessment".

6.4 Mrs D's carer told us that her Grandmother could be very difficult; she hit them and refused to co-operate. Some of this behaviour predated Mrs D's tumour surgery.

6.5 Violence from Mrs D towards her family is noted throughout records, from 2004 onwards, what is less clear is what action was taken as a result of these disclosures.

6.6 The Mental Health Trust 1 medical records also show a picture of a family who struggled to avoid arguing with Mrs D.

6.7 Respite in the form of attendance at a day centre was not forthcoming as Mrs D had refused to attend.

6.8 We do not know why the overview assessment planned by adult services in September 2008 did not take place. The IMR from adult services noted that the time for the assessment had been changed at the request of the Practice Senior, Physical disabilities and Sensory Service team. There was a telephone conversation with Mrs D's husband, the IMR continues: " There is no record of this 'Overview Assessment'. Whilst there is an episode dated 17/09/2008 it is blank. There is no reference in the case notes whether the assessment took place or not."

6.9 By 2008, it was apparent that there were no therapeutic options which were going to lead to an improvement in Mrs D's behaviour.

6.10 As her behaviour was in part the result of a functional problem, it was unlikely to change. Mrs D saw herself as well and she seems to have believed that she was functioning normally.

6.11 We can be clear that from 2009 until 2016, Mrs D was not in contact with either health or social care services, her family did not approach any services for support.

6.12 Mrs D's granddaughter told us they did not know who to speak to, to get help.

6.13 During the brief period of two months in 2016/7, when Mrs D was subject to CPA, a care plan was established and contact details for support were shared with the family. These are reiterated on letters following clinic appointments with the CMHT. These letters were copied to Mrs D's family and did provide information on who to contact.

Letting anyone in to the house and the state of the property

6.14 Mrs D's home was known to be in a poor state of repair, unclean and potentially hazardous from 2003. Although the incident which led to the original contact was resolved and there was some improvement, this does not appear to have been sustained. In November 2016, the IHTT noted that Mrs D's home was chaotic and cluttered with many cats living there. This was not a value judgement but a clear concern. There is a further comment in late November suggesting some improvement. However, deterioration led to a point that the mess in the house was noted in January 2018 by a police officer as the worst they have ever seen.

6.15 The team who visited Mrs D at home in December 2016, did not observe such a level of mess, however the team do recall that they had limited access to the home and did not see Mrs D's bedroom or the bathroom.

6.16 The house was routinely cluttered and messy, unclean and in poor repair and shared with a large number of cats. This became worse after the withdrawal of the domiciliary visits undertaken by the mental health team.

6.17 There is no recorded consideration that there was any recognition of issues relating to hoarding and self-neglect. Hoarding is often perceived to be an issue where individuals live alone. It is possible that Mrs D's family were seen

as a protective factor without further consideration of what was going on there and the effect of the accommodation on them.

6.18 Both Mr and Mrs D were reluctant to allow entry to their home, and there are references to their daughter and granddaughter apologizing for the state of the house.

6.19 Mrs D's granddaughter told us that her grandparents prevented her from getting help, and that the house became too much for everyone living there.

6.20 The concerns about the house when they are escalated by the IHTT appear to be limited to the need for smoke alarms. Fire and the ability to evacuate were certainly an issue, but by no means the only concern.

6.21 We have established that the fire brigade did not have any contact with the family prior to Mrs D's death. There is no clear follow up by the CMHT to the referral and no revisit of the concerns.

6.22 A further decline in the living conditions in the house appears to have taken place in 2017, and this exacerbated the reluctance of the family to allow anyone into the house.

Who were the carers?

6.23 From 2008, when she was sixteen, Mrs D's granddaughter told us that she was the main carer for her grandmother. She was also the carer for her mother who had mental health problems and that she supported her uncle who also had a mental health diagnosis. None of the records which we have seen identified the full extent of her caring responsibilities.

6.24 Mrs D's granddaughter accompanied her mother to her healthcare appointments at hospital and the GP surgery.

6.25 The GP clinical record had a coded entry noting Mrs D's daughter as her mother's carer but a free text entry in the medical records had amended this, to show that it was her granddaughter but no change had been made to the practice carers register.

6.26 The Mental Health Trust 2 discharge letters note Mrs D's granddaughter as the carer. The GP records were not updated in response to this information.

6.27 None of Mrs D's family were offered a carer's assessment by adult services or by Mental Health Trust 2.

6.28 All of the clinic appointment records, from both Mental Health Trust 1 and Mental Health Trust 2, note that Mrs D's family are keen to care for her. None of the records include any discussion of any particular techniques or skills that might be needed to manage her physical care.

6.29 There is nothing to suggest that Mrs D's family sought any advice or support with her physical care. Mrs D's granddaughter told us that she had told someone that her grandmother was incontinent; we have not been able to identify who this may have been or what service they came from.

6.30 Mrs D's granddaughter told us that she was never given specific advice around managing her grandmother's personal hygiene or the possibilities of pressure ulcers[7] developing or what to do about them. When Mrs D was last seen and assessed as an in-patient by mental health trust 2 she was perceived to be mobile. Any reduction in her mobility was likely to increase her risk of developing pressure ulcers. The provision of simple advice with regard to providing personal care and highlighting the risks of immobility would have been appropriate as part of future planning to help Mrs D's granddaughter tackle the very challenging task of providing intimate care to a close relative.

6.31 Mrs D's granddaughter was struggling to provide care. There was no package of care in this case, for the reasons identified in this report.

[7] "Pressure ulcers may occur as a result of neglect. Neglect may involve the deliberate withholding OR unintentional failure of a paid, or unpaid, carer to provide appropriate and adequate care and support. Neglect and acts of omission include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating. In some instances this is highly likely to result in, significant preventable skin damage. Where unintentional neglect may be due to an unpaid carer struggling to provide care an appropriate response would be to revise the package of care and ensure that the carer has the support and equipment to care safely.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756243/safeguarding-adults-protocol-pressure-ulcers.pdf

Baseline assessment and ongoing review of mobility and physical health

6.32 In line with NICE clinical guidelines such as CG 178, Mental Health Trust 2 has a "Promoting the Physical Health and Wellbeing of service users with Mental Health and Learning Disabilities" policy. This policy has been reviewed since Mrs D's admission.

6.33 The present policy sets out expectations around vital sign observations and physical assessment care of patients with mental health problems.

6.34 Mrs. D did not have a formal diagnosis of schizophrenia, her actual diagnosis of "Organic delusional (schizophrenia-like) disorder", however the requirements of this policy would now be followed.

6.35 Within the present Mental Health Trust 2 policy quality standard IP4, requires that "Older people Mental health Inpatient areas [sic] will have a Waterlow score for all patients to assess risk of pressure ulcers" in 2016 this was not the case.

6.36 A Waterlow score is a structured and objective system to assess the likelihood of pressure ulcer development in a patient. Any such assessment even if completed at an earlier point offers a baseline for future reflection.

6.37 Although Mrs D was incontinent at times, her usual level of continence was not assessed to develop an ongoing plan. It appears that it was seen as a symptom of an acute psychotic episode rather than as an ongoing issue affecting a patient in decline.

6.38 Although the inpatient episode was a year prior to her death, and she was generally mobile at the time, the assessment of the likelihood of the development of a pressure ulcer would have provided a baseline and potentially a prompt for review. There is some debate on the value of considering historic assessments and we note the change of the Mental Health Trust's policy.

6.39 On discharge from hospital and from the IHTT, we have been unable to identify if there was any consideration that an assessment by a district nurse might have been a useful adjunct to Mrs D's mental health care plan. The GP told us that their approach to such assessments is to refer the patient if the family request this or if they do a home visit and identify a need. There was no request and no home visit in this case.

6.40 Similarly the coding , or lack of coding of Mrs D's mental health diagnosis meant that she was not on the GP mental health register and was not followed up routinely. If she had been on the practice mental health register it is likely that more proactive contact would have resulted from the practice as the quality and outcomes framework (qof) has an indicator which prompts practices to ensure that care plans are documented in the clinical records.

6.41 The GP practice usually routinely problem code patients in receipt of Care Programme Approach, this did not occur in this case.

6.42 Mrs D had a blue badge and the practice had recorded that she was unable to walk more than fifty meters as long ago as 2004. No formal check on her mobility appears to have been made after this date whether or not she was effectively housebound.

6.43 She attended the GP surgery very seldom. She was not in receipt of a regular prescription for a number of repeat medications this would have provided an additional request from the practice to review her.

6.44 From her admission to hospital in September 2016, Mrs D needed help to maintain her personal hygiene, however she was resistant to accepting help. It is unlikely that this situation would get better over time. There was no assessment of her personal care needs after discharge, in part because Mrs D rejected offers of assessment.

6.45 Staff had to be firm in ensuring that she accepted help when she was soiled. They were able to do this by acting in her best interests during her detention under the mental health act and subsequent Deprivation of Liberty Safeguard.

6.46 Part of the identified learning from this review is that, physical health needs should be embedded into practice by being part of everyday discussions and management rather than simply seen and noted as a risk. This is already a requirement of NICE Guideline CG 178. We acknowledge that it is not always possible to achieve total compliance with all aspects of the guideline in every clinical encounter but the annual physical health check should provide an opportunity to translate the guidance into practice.

Multi-disciplinary working - Linking information together

6.47 Mrs D declined care from anyone except her family. Whilst there was every reason to accept their desire to care for her, there was little examination of the scale of the task which they faced and the challenges they might meet. Their isolation and refusal to engage with services was known.

6.48 Mrs D was an inpatient for over a month in 2016 before being discharged and supported by the IHTT. She had one CPA review and was then discharged. This is a very short period of CPA in view of the duration of her symptoms.

6.49 When she was an inpatient the GP provided the immediate medical history but the detailed work which had been undertaken by Mental Health Trust 1, was not a part of the information shared.

6.50 Although it had been undertaken eight years earlier it contained useful information around Mrs D's baseline condition and insight into the engagement of her family and the state of her home. It is possible that had Mental Health Trust 2 had access to these records, a different approach might have been taken.

6.51 When Mrs D or her carer cancelled clinic attendance in April and May 2017, there was no follow up enquiry to establish if there was a problem. In November 2017 a series of appointments were cancelled and again no action was taken such as a call to check the nature of her illness.

6.52 The second series of cancellations is more significant. They came after the family had raised a concern about Mrs D's behaviour which led to a member of Mental Health Trust 2 staff delivering a prescription. We have found nothing to suggest that this prompted internal discussion or contact with other services. Even without the benefit of hindsight, this situation should have roused curiosity and further investigation of what was going on.

6.53 Mental Health Trust 2 staff were not dubious of family assurances although they had refused professional input and had cancelled appointments. A greater degree of clinical curiosity might have uncovered the difficulties that created a mounting dependence of her family on the granddaughter.

6.54 The GP was not engaged in any follow up of Mrs D and was unaware of any concerns, the GP practice had no effective relationship with Mrs D as she did not attend the practice and did not respond to screening invitations.

6.55 Adult services were also essentially unaware of any problems during the period September 2016- December 2017.

7 Conclusions

7.1 The review has considered whether or not policy and procedures were properly followed addressing the six principles of safeguarding during the period September 2016 to December 2017. Mrs D was empowered to make her own decisions. We have found any no evidence to suggest that she was coerced or unduly influenced in making the decisions that she did.

7.2 Whilst no major red flags were missed in this case, the overall challenges inherent in dealing with an individual and her family with long standing mental health and behavioural problems accumulated and a delay in accessing help when she became acutely unwell in December 2017 contributed towards a poor outcome.

7.3 There were gaps in the support provided to Mrs D, some of these such as involvement with the general practice might possibly have offered protection to her, however given the extreme ambivalence expressed by Mrs D and her family to engaging with services, especially domiciliary services, we cannot be certain that any further interventions would have resulted in a different outcome.

7.4 The most significant gaps in safeguarding support relate to Mrs D's granddaughter who was a child when she was first the main but informal carer to her Grandmother. It is however, unclear if her role was apparent to all of the services with whom she had contact.

7.5 There were missed opportunities to provide information to her family which might have enabled them to look after her more effectively. Equally her family did not seek advice from any services to gain support which was open to them.

7.6 This has to be set against what was known, which was that Mrs D made her views clear and her ability to do this was respected by her family. They had sought help when she became unwell in September 2016.

7.7 All reports concur that her family wished to care for her and that she wished them to care for her. Moreover although she and her family declined home based services there was nothing to suggest additional vulnerability or safeguarding issues to those who did see her, when she did attend outpatient appointments.

7.8 The last time that professionals were allowed into Mrs D's home was in December 2016 and their ability to assess the home environment was severely limited. They saw only a small part of the home. What they did see was a house which was cluttered, untidy and chaotic. Beyond for the need to consider smoke alarms it did not raise sufficient further concerns in those who were present. They formed a view that the house was inhabitable and that the family mitigated the risk of the environment. There is nothing to suggest that the clutter and chaos led the team to consider if hoarding was an issue for the entire family. We may now conclude in light of the further decline of the property that it was, but this may not have been apparent at the time and the guidance on hoarding concentrates on this being an issue for one individual in their home rather than an issue for a whole family living together.

7.9 There was acceptance without caution on the part of professionals that it was patient and family choice to decline services, It was taken at face value. Mrs D and her family's attitudes to health and adult care services were never explored and whilst it may not have amounted to a need to raise a safeguarding alert further exploration of why services or assessments were accepted and then rejected would have been appropriate to ensure that Mrs D and her family were making an informed decision and understood the possible consequences.

7.10 There is little to no recorded exploration of the family's capability or capacity to care for the demanding and difficult patient after 2008; it is accepted that they wish to look after her. There is no evidence of direct support for her carers, and no evidence that they sought any support. It is an assumption that they have the capacity and ability to care for her.

7.11 When Mrs D cancelled a series of appointments and was reported as unwell, further appointments were offered and action was taken to support the family's request for medication. There was no recorded reflection on what impact a further deterioration of her mental health might have had on her physical abilities and the effect that any decline might have. The subsequent cancellation of appointments did not prompt any action other than rebooking. Had Mrs D and her family simply not attended the appointments, this would have prompted greater scrutiny.

7.12 The GP practice might have had a role in signposting services and input into Mrs D's care on an ongoing basis. Their approach was reactive. Mrs D was on no specific disease or condition register at the practice which might have offered a prompt to review. Whilst they report they would have been happy to refer Mrs D to Mental Health Trust 2's district nurses[8] for continence assessment, they were unaware that this was a problem. They had no current view of her physical health as she had not been seen at the practice in several years. The prompts to attend the surgery which had been issued in the past such as influenza vaccine and disease screening had been rejected and had not always been offered again.

7.13 Mrs D's family never approached the general practice for support or to discuss concerns relating to her. Neither did they call the psychiatric outpatients department for advice on anything except medication.

7.14 The family delayed seeking help for Mrs D when she became more unwell on around the 15th December.

7.15 When Mrs D became more unwell and was more reliant on care from her family they continued to abide by her wishes and had no plan to prompt them to override her refusal to accept help until she became very ill.

7.16 The reviewers are asked to consider if Mrs D's death was predictable and or preventable. Earlier healthcare involvement and transfer to hospital when she became acutely unwell might have led to more effective interventions. With high quality skin care, pressure ulcers can be detected and treated at a much earlier

[8] The trust also runs community nursing services for the area

stage than category 4/5. This does not however allow us to conclude that her death was either predictable or preventable.

8 Recommendations

8.1 The Local authority guidance on Hoarding should be reviewed to consider if in some cases this may be a family wide issue.

8.2 There is a need to disseminate simple guidance for families looking after a relative on what to do if they become unwell and lack insight into their needs. Examples include: https://www.nhs.uk/conditions/social-care-and-support-guide/practical-tips-if-you-care-for-someone/how-to-help-someone-you-care-for-keep-clean

https://www.alzheimers.org.uk/get-support/daily-living/washing-and-bathing such dissemination can be delivered by health and social care services. This is a recommendation for all health and social care organisations.

8.3 All health care services should promote the use of carer's assessments and keep records where these are refused including prompts to reoffer these. As part of the assessment, a record should be made which identifies how many people a carer is looking after.

8.4 Following on from the identified learning at point 6.46 of this report; As part of their existing systems to audit compliance with NICE Guidance, mental health trusts and GP practices should pay particular attention to the requirements of guidance on the requirement for annual physical health checks . For NHS organisations they should consider capturing this within their quality accounts and for GP practices the information could form part of the evidence for their assessment of "Effectiveness" for CQC review as well as reporting for the quality and outcomes framework.

8.5 All services should consider their oversight of patient and carer cancelled appointments. Whilst it would be impractical and inappropriate to review every individual appointment, it should be possible to flag multiple cancellations and for this to lead to review when a threshold is reached. Such an approach might prompt further scrutiny and increased clinical curiosity.

8.6 Consideration should be given to developing specific guidance for health and social care professionals in cases such as this where there is apparent engagement from a family but where there may be disguised compliance – this could also include advice on the issues of lack of access to a home, or repeated cancellation of appointments.

9 Methodology and details of approach

Nina Murphy Associates LLP were commissioned to undertake authorship of the report. Following an initial meeting of the SAR panel we identified the organisations from who chronologies and reviews were required. A multi professional clinical and quality assurance team considered the information and Sheeylar Macey was the lead reviewer and main report author.

We merged the chronologies into a single timeline, which enabled us to cross referenced and triangulate sources.

The following agencies were asked for chronologies:

Mental Health Trust Ambulance Service

Local authority Adult services

Hospital NHS Trust

Police

- Mrs D's GP practice
- Mental Health Trust 2

The case had been subject to root cause analysis by Mental Health Trust 2 and we therefore reviewed this along with their specific detailed responses to questions.

As well as the IMR from the GP practice we reviewed the GP medical records and all associated correspondence. This covered the entire timespan that Mrs D was registered with the practice.

- We asked the Fire Brigade for a chronology, but they could not supply one as they never had any contact with Mrs D or her family.
- We reviewed the available electronic social services records on site at the organisation's headquarters.

We met Mrs D's main carer, her granddaughter with her supporter on 16th September 2019

We visited Mrs D's GP practice on 14th October 2019 and met with a GP and the assistant practice manager

After analysing and synthesizing the information we used a Nominal Group Technique (NGT) to theme and rank the issues.

A narratively driven report was presented in draft, along with key findings and thematic analysis. This was presented to the panel and revisions were made in line with the panel discussion. Contributing organisations had the opportunity to comment on factual accuracy.

Nina Murphy Associates LLP

Nina Murphy Associates is the leading provider of professional services to a large list of respected clients within the Health and Social Care Sectors.

In addition to the generic advice and reviews we offer a range of services to support any Health and Social Care Organizations in discharging their responsibilities . This includes writing overview reports in both adult and child cases and other statutory investigations such as domestic homicide and death in custody reviews. We also have experience of producing learning lessons report.

We provide a service that offers evidence-based reports, in line with the specific guidance and framework for the type of care being investigated. This approach has led to the development of a replicable process.

We base our reviews on standardised root cause analysis (RCA) methodology If necessary, we will amend the methodology to take account of specific issues related to the review being undertaken.

Our reports are written in clear and straightforward language and easily accessible to all interested parties.

We aim to establish objective and open relationships with the services being reviewed and the panel.

We ensure that our findings are clear and evidence based and that the recommendations which flow from these are logical, achievable and will directly impact on improvement.

All of the reviewers and assurance team have specific training to undertake clinical reviews, they have been trained to review records and to consider these against the relevant standards.

All of the reviewers and assurance team are conversant with the requirements of Safeguarding Adults Reviews and the specific terms of reference for this review.

More information is available on our website at:

www.ninamurphyassociates.co.uk

Terms of Reference – Mrs D

Overarching aim and principles of the SAR

The purpose and underpinning principles of this SAR are set out in section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures. All Royal Borough of Greenwich Safeguarding Adults Board (GSAB) members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR panel members are senior representatives of the three statutory agencies, local authority, CCG and Police and will arrange to meet as required to oversee the SAR process.

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

Legislation

Section 44 of the Care Act 2014 places a statutory requirement on GSAB to commission and learn from SARs in specific circumstances, as laid out below, and confers on GSAB the power to commission a SAR into any other case:

> *'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) The adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or*
>
> *c) The adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.*
>
> *…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 -*
>
> *d) Identifying the lessons to be learnt from the adult's case, and*
>
> *e) Applying those lessons to future cases.*

- Care Act 2014 and statutory guidance (DH 2014);
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015);
- London Multi-Agency Safeguarding Adults Policy and Procedures;
- GSAB Procedures for Safeguarding Adults Review and Multi-Agency Reviews (2016)
- The General Data Protection Regulation 2016/679 implemented on 25 May 2018

As the accountable body responsible for its commissioning, GSAB will receive updates on progress of this SAR at Board meetings.

SAR subject

The summary of details of the subject of this SAR are:

Name	Age	DoD
Mrs D	67	20/12/2017

Brief summary of concerns that triggered this SAR

Mrs D lived with her daughter and grand-daughter and received support from her GP and Community Mental Health Trust. She also had on-going appointments at the hospital in relation to a brain tumour.

A referral was made to the Fire Service a month before she died, the outcome of which is unknown. It is believed that Mrs D was resistant to receiving care and support, although an assessment had not been completed. However, it is believed that a referral had been made in 2008. It is known that there had been a mental capacity assessment undertaken regarding a previous decision and it was considered that she did not have capacity at that time.

It is understood that Mrs D had not been seen for two months prior to her admission to hospital from home in December 2017 with grade 4/5 pressure ulcers. Mrs D subsequently died. There has been a serious incident enquiry undertaken by the Community Mental Health Trust.

The case was referred to the SEG by Designated Lead for Adult Safeguarding Greenwich Clinical Commissioning Group and discussed on 22 August 2018 and it was considered that it did meet the criteria for a SAR. The SAB Chair agreed with this recommendation on 23 August 2018.

SAR Methodology

The SAR should cover the time period from September 2016 to the 20th December 2017.

Agencies are asked to provide information detailing their involvement during this period within their chronologies and provide a summary of any relevant information that falls outside of this period.

Chronologies and IMRs should not be anonymised initially, that will be undertaken at a later stage in the review process.

Guidance on methodologies can be found in Safeguarding Adults Reviews under the Care Act: implementation support.

Aims of Safeguarding Adults Review

To identify whether there were any gaps or deficiencies in the care, support and treatment of Mrs D.

To identify if Mrs D's death was predictable and/or preventable.

To identify areas of best practice, opportunities for learning across organisations and areas where improvements to services might be required which could help prevent similar incidents from occurring.

Specific areas for review

The SAR investigation (and by extension all contributors) will consider and reflect on the following:

Review the care and support, treatment and services provided by the local authority, hospital, Community Mental Health Trust, GP, CCG and Fire Service and any other relevant agencies to Mrs D with specific attention to inter-agency working in relation to safeguarding Mrs D.

Review whether local Safeguarding Adults Policies and Procedures were properly followed, addressing the six principles of safeguarding.

Review the effectiveness of care planning for Mrs D and support provided to her family.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Review the issues raised by the Serious Incident Inquiry and any actions taken following this.

Provide a written report to the Royal Borough of Greenwich Safeguarding Adults Board that includes measurable and sustainable recommendations.

Timescales for completion

This SAR will commence January 2019 and should if possible, be completed within six months.

SAR author

The SAR author commissioned should be sufficiently skilled and experienced in Safeguarding matters as set out in GSAB Procedure for SAR and multi-agency review 7.1. The independence of the author should be evidenced by the fact that they have never had direct or indirect involvement with the subject of the review; nor, line management responsibility for any staff writing a report for the SAR.

Confidentiality

In line with the confidentiality statement, all communication regarding this SAR that contains personal and/or sensitive information must be sent securely using the secure email addresses provided. Please contact the GSAB Manager with any queries as to how to securely contact another panel member. Requirements in respect of the General Data Protection Regulation 2016/679 implemented on 25 May 2018 will be adhered to throughout the process and legal advice will be sough regarding this matter prior to completion of the report.

Evidence and submissions to the SAR

It has been agreed that the following organisations are to be asked to submit evidence to the SAR:

Organisation/service area	**Nature of the evidence to be submitted**	**Deadline**
Local authority	IMR	
Community MH Trust	IMR and RCA	
GP	IMR	
Hospital	IMR	
Fire Service	IMR	
Police	IMR	

SAR report and publication

NMA has been appointed to author the SAR report, the content of which is to be in line with section 7.14 of GSAB Procedure for SAR and multi-agency review and the London

Multi-Agency Safeguarding Adults Policy and Procedures. It must contain the transparency of analysis necessary for others to scrutinise the findings.

It is expected that an anonymised version of the full SAR report or the executive summary will be published on www.greenwichsafeguardingadults.org.uk unless there are exceptional circumstances meaning this would not be appropriate. On completion of the report, the SAR panel will recommend to the GSAB how to publish the report, setting out clear reasons for the recommendation.

Timings for publication may be affected by any criminal proceedings and court case, and the SAR report may be held for publication until such time as the proceedings/ case has concluded it can be published. In the meantime, any lessons learned can be taken forward immediately.

Disclosure and confidentiality

Confidentiality should be maintained by all GSAB members and organisations involved in this SAR, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency and sharing of information in order for an effective SAR to be completed in the public interest, in line with Section 44 of the Care Act 2014, section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

All GSAB members and organisations involved in this SAR commit to co-operate in and contribute to this SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, GSAB may use its powers under Section 45 of the Care Act to obtain the relevant information.

The SAR Author may wish to review an organisation's case records and internal reports personally, request additional records and relevant policies/guidance, or meet with review participants.

Individuals will be granted anonymity within the SAR report and will be referred to as Mrs D.

Communications and media strategy

Communications advice will be provided and the communications approach managed

by Royal Borough of Greenwich communications department. All media queries will be referred to Royal Borough of Greenwich, unless criminal proceedings are ensuing in which case all media queries will be referred to the Metropolitan Police Service.

Legal advice

Legal advice to the Royal Borough of Greenwich Safeguarding Adults Boards will be arranged by the Royal Borough of Greenwich legal department to ensure the SAR process and final report complies with legal requirements and safeguards all parties.

Liaison with the police, criminal justice system and coroner

The SAR Author in conjunction with the GSAB Manager will be responsible for ensuring appropriate on-going liaison with the Crown Prosecution Service, Coroner and the Police if and as required.

Links to parallel reviews

The SAR Author shall keep under review any links to other reviews of practice, such as domestic homicide reviews, serious incident reviews, Children's Serious Case Reviews or a SAR being conducted by another SAB, where known.

Funding and resourcing

The funding of this SAR will be provided by the GSAB.

Review of Terms of Reference

In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the SAR progresses but must be approved by the Chair of GSAB. These terms of reference were approved at Safeguarding Adult Review Panel Meeting on 24 October 2018.

References

Classification of pressure ulcers

http://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf

Interface safeguarding and pressure ulcers- January 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756243/safeguarding-adults-protocol-pressure-ulcers.pdf

Hoarding

https://www.mind.org.uk/information-support/types-of-mental-health-problems/hoarding/#.XdAvjS2cY1g

Greenwich Briefing on Hoarding

https://www.greenwichsafeguardingadults.org.uk/wp-content/uploads/2019/02/ripfa_frontline_briefing_working_with_people_who_hoard_web_jan17_.pdf

Royal College of Psychiatrists Hoarding

https://www.rcpsych.ac.uk/mental-health/problems-disorders/hoarding