SAFEGUARDING ADULT REVIEW REPORT

Mr G

APRIL 2021

MSH Training & Consultancy Ltd

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1. Introduction

1.1 This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of the Royal Greenwich Safeguarding Adults Board (RGSAB), relating to the death of an adult in 2016 (referred to as Mr G throughout this report to preserve his anonymity).

1.2 The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Greenwich in the future.

1.3 The review was conducted in the light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews.

The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

The Department of Health Care and Support Statutory Guidance – published to support the operation of the Care Act 2014, states[1]:

14.163 Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.168 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

1.4 Why was this case chosen to be reviewed?

Initially the case was raised with the RGSAB as a potential case for review in 2018, by the Safeguarding Lead Enquiry Officer at the conclusion of the S42 Enquiry. However, at this stage the case was not considered as a SAR, as it was deemed a single agency case. This decision was re-visited in 2020 by the SAR Panel and it was then accepted as a SAR. The SAR Panel felt there was multi agency involvement and the potential for learning from the case.

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

1.4.1. Brief Summary of the Case

Mr G was 62 at the time of his death. He was of White British ethnicity and lived alone in a first-floor council flat. He was supported at home by his sisters (anonymised. to S1 and S2), one of whom (S1) visited him weekly to help him with shopping and other tasks at home. She also took him out to relieve his isolation and so that he could enjoy fresh air. During these visits she took him for lunch in a local pub and then to the supermarket. He was also supported through a council funded package of care supplied by a Home Care Agency with three home visits a day by one carer (which was later reduced to two visits per day). The carer assisted Mr G with a range of tasks, including personal care, domestic tasks, medication prompting and food preparation. He was able to mobilise inside his flat at the beginning of the period under review, but his mobility deteriorated, and he was largely cared for while either sitting or sleeping on the sofa for the rest of the review period.

Mr G suffered from epilepsy, had a brain injury and was slow to respond verbally. He was a wheelchair user when he had to go out for any distance, but not inside his flat and had a dropped wrist, with limited use of one of his hands. It was significant that he lived on the first floor of a council flat, a building that did not have a lift. His disability made it impossible for him to carry his wheelchair down the stairs to the ground floor and he could not navigate the stairs without assistance. He was therefore unable to leave the flat in an emergency or to socialise. He had a series of falls possibly connected to his seizures, sometimes requiring hospital admissions. Mr G's mental health both in terms of his mood and behaviour also deteriorated over time.

He became increasingly depressed, possibly related to his social circumstances (due to not be able to leave his flat). He also often refused care which he was offered or did not allow carers access into his property. In December 2016 Mr G's Home Care Provider was changed after a review and his Care Plan was revised although difficulties remained in gaining access to him to provide care. His health further deteriorated and he was found by his sister (S1) at home appearing to be barely conscious and acutely unwell. She called an ambulance (LAS) and Mr G was admitted to hospital, where he was found to be suffering from pneumonia amongst other signs of possible neglect at home, which prompted the LAS to raise safeguarding concerns about this. Mr G sadly died within 5 days of being admitted to hospital.

1.5 Timeframe, Terms of Reference, Methodology and Scope

This review covers key periods of contact during 2014-2016 for the case up to the events immediately prior to the death of Mr G and also subsequent work done by agencies after his death until the commissioning of this review in 2020.

The methodology for this SAR was through a collation of Individual Agency Documents and Chronologies submitted by relevant agencies working with Mr G. The Independent Author then collated a combined merged chronology from all the individual agency submissions. The combined chronology was then broken down to several distinct phases of contact called Key Practice Episodes (KPE).

The involvement of services during each KPE was then appraised and underlying factors affecting decisions and actions were then explored to explain the practice in this case and potential wider implications. In order to explore some additional factors and context to the work in the case a series of telephone conversations were held with representatives from key agencies.

1.6 Agencies that had involvement in the case:

- 2 Home Care Providers (anonymised to HCP1 and HCP2)
- Queen Elizabeth Hospital (Lewisham and Greenwich NHS Trust)
- Oxleas Foundation NHS Trust
- GP Surgery
- London Ambulance Service
- Royal Greenwich Adult Social Care Services (JET Team, Hospital Social Work Team, Strategy & Performance Team and Specialist Social Work Team)
- Royal Greenwich Housing Department
- Metropolitan Police (Greenwich Community Safety Unit)
- Care Quality Commission

1.7 Methodological comment and limitations

It was a significant challenge that the review did not start until 4 years after the adult died, and submissions of the documents were also delayed, with further clarification and additional information was requested from some agencies upon receipt of the initial submissions. Further limitations were caused by the CV19 pandemic , the nationwide lockdown and subsequent impact on all services involved with this case. Meetings were held online for the review and conversations undertaken remotely for all professionals involved with the case.

1.8 Parallel Processes

Prior to the SAR being commissioned there were a number of other processes which considered this case. The first was a Safeguarding Adults Enquiry, under Section 42 of the Care Act 2014, then a criminal investigation, which was instigated shortly after Mr G's death and are considered as part of this SAR. This process was concluded in February 2018 at which point the Crown Prosecution Service decided that no charges were going to be brought against any individual or agency. The next process was a Local Authority Complaint raised by Mr G's sister (S2), in October 2018 and completed in May 2019, with all her complaints being upheld upon investigation.

The final process was an Inquest held by the Coroner in November 2020, the outcome of which was of a narrative verdict, which is set out in full in Section 2.6.

Cause of death was recorded as follows.
"1a Aspiration Pneumonia
1b Epileptic Seizure and Frailty

II Brain Injury 1998. Alcohol dependence. Osteoarthritis. Osteoporosis. End of Life Pathway

1.9 Reviewing expertise and independence

An Independent Consultancy undertook the SAR and appointed an Independent Lead Reviewer. All relevant documentation was then shared with and scrutinised by the Independent Lead Reviewer, to compile the Independent Overview Report. Mick Haggar is the author of this Overview Report, which has been completed on the basis of submissions of Individual Agency Documents, conversations with individuals and other reports (outlined above).

1.10 Acronyms used and terminology explained

Writing for multiple audiences is always a challenge. In Appendix 1 we provide a section listing any abbreviations used to support readers who are not familiar with these. In Appendix 2 language and terminology of medical and safeguarding work is explained and referenced. References are also made to key guidance or research in footnotes throughout the report.

1.11 Involvement of family members

The input and opinions of family members of the deceased is an important aspect of the SAR process, both to inform them of the review, and to include them to take account of their first-hand experience of services provided to them/their relative. The sisters of Mr G were contacted and the elder sister (S2, the agreed spokesperson for the family) was spoken with at the beginning of this process and submitted a number of documents which were helpful to the review.

1.12 Role of the SAR Panel

As the accountable body responsible for commissioning this SAR, the Royal Greenwich Safeguarding Adults Board (RGSAB) received updates on progress at Board meetings. A panel of statutory partners were tasked to oversee, manage and scrutinise the work in relation to the SAR, ensuring it remained on schedule, managed any areas of difficulty that arose, and ensured the quality of the report produced in line with requirements. A first panel meeting was convened in July 2020, with further meetings to refine the Terms of Reference and monitor the progress of the Review and this Report is drafted for consideration and approval initially by the Panel, prior to endorsement by the overall RGSAB.

1.13 Terms of Reference/Specific areas of enquiry

The SAR Panel agreed to consider the following aspects of work undertaken with Mr G, due to the specific circumstances of the case. Although, the mandatory areas for a SAR are limited to looking at how agencies worked together to protect adults from abuse, these were extended to include the work done by individual agencies where this was thought to be significant in this case and for wider learning.

The timeframe of practice included in this review was extended beyond the date of Mr G's death, in order to look at both the quality of the subsequent Safeguarding Section 42 Enquiry by Adult Services and the decision-making process followed by the RGSAB when commissioning this SAR. Therefore,
this SAR will cover the period January 2014 to 13 February 2020.

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

- The care provided by the care agency and monitoring of this care
- Healthcare provided by the GP
- Admissions to, and discharge from, hospital
- Mr G's accommodation, environmental factors and interventions undertaken
- Communication regarding Mr G between all health and social care organisations
- The outcome of the complaint made by a family member to the local authority
- The process in agreeing to undertake a SAR and the length of time taken to make this decision.

2. Summary of Case and significance of Key Practice Episodes

The section below sets out a brief summary of the multi-agency chronology of services involvement in the Case. The independent author collated this chronology from the individual agency chronologies and other reports submitted on each case by the agencies participating in this review. As outlined above, the integrated chronology for the case was then divided into a number of Key Practice Episodes (KPEs), which are set out separately along with the significance of practice during each KPE. These are then appraised and analysed further for learning in Section 3 of the report.

2.1. Brief Summary of the case (Pre-Jan 2014)

Mr G grew up locally, he has 2 sisters (S1 lives in Kent and visited him regularly and the other elder sister, S2 who lives in Gloucestershire who was the main family contact for this review) he has 1 brother who lives in Canada and was not involved. His parents remained local until they sadly passed away, his father died in 2012 and his mother in 2014 (after a period in residential care for her dementia). Mr G had been married and was the father to 3 children (2 girls and a boy), however after his divorce in the early 90's he did not have regular contact with any of his children, due to access issues with his ex-wife, despite them also remaining local to the Eltham area. He moved from the 3-bed house he owned with his wife after the divorce and moved into a bedsit. Mr G had trained as a teacher, was interested in photography & cooking, was very gregarious and had lots of friends. His social circle fell away after his divorce and he started to become more isolated. He was also a musician, being proficient in both piano and guitar.

He had a motorcycle accident in the late 80's, which caused him to suffer some mobility problems. In 1994 experienced in first seizure on a trip to Canada and in 1997 he suffered a blood clot on his brain, requiring surgery(craniotomy) to remove. Following this Mr G developed epilepsy, leading to some gradual changes to both his personality and a deterioration in his cognitive functioning, including memory. He was no longer able to play music and started to become angrier at times and more depressed. He was diagnosed with anxiety and depression at this time, then later with alcoholism, although he did not receive treatment for these issues.

He was housed in a first-floor council flat in Eltham and remained there until the time of his death. He first received social care support in 2007, with a package of community care to assist him at home, at which time there were concerns about the living environment, described as poor and there were numerous concerns from his carers and family about mice/insect infestations. He had several hospital admissions following falls and seizures where he sustained head injuries, a fractured knee and shoulder. Following a series of admissions in the years after this Mr G became more immobile, unable to manage the stairs out of his property and became effectively housebound from roughly 2011 onwards. He very occasionally was supported to leave his flat by his sisters (for example attending his parents' funerals and some of his medical appointments) but for the remaining 5 years of his life he remained mainly at home, apart from when visited by family. His sister (S2) felt this had a negative impact on his mood and mental health, whereby he became increasingly depressed.

He did have a re-assessment of needs by a social worker at this time and a plan was in place to support his application for re-housing, however this was interrupted by a further hospital admission for hip surgery. His social work case was transferred to the Hospital Social Work Team and his housing application was not followed up, as after discharge from hospital his case was closed to an annual review, without continuity from his previous social worker. He was assessed by a liaison psychiatrist Duty Dr while in hospital, who recommended medication, psychotherapy, substance misuse services and support to help him cope with his physical disability and social isolation upon discharge. However, none of these services were subsequently offered to Mr G when he returned home.

He had a further hospital admission in December 2012 and a letter from the hospital to his GP described him generally being unwell and withdrawn. He was diagnosed with a community acquired pneumonia and treated with oral antibiotics, during his stay on the ward he was very withdrawn and was not responding to questioning, his family was concerned that he may be depressed, and he was withdrawn. He was seen by the Liaison Psychiatry team who did not think that he was depressed and thought that he was suffering from Dementia, he was referred to a memory clinic. On discharge he was seen by his previous social worker, but his housing situation was not addressed, as he was believed to be on the waiting list for re-housing at this time. In 2013 he was seen at home and assessed by a doctor from the memory clinic, as he had not attended outpatient appointments. The outcome of this assessment was for Mr G to be referred to mental health services and recommended for re-housing, but did not lead to any further work or referrals by the service.

SIGNIFICANCE

Although events set out here are before the period subject to detailed review during this SAR, it can be seen that many of the subsequent issues were of a long-standing nature. In brief these are that Mr G was effectively rendered housebound through a combination of his poor physical health, lack of mobility and residing in a first-floor property without suitable disabled access. It was known by Adult Social Care Services and the Housing department that he required re-housing to meet his needs. The impact of his social isolation on his mood and mental health had been noted by a psychiatrist at this stage. Furthermore, his epilepsy led to a series of seizures, falls, injuries and hospital admissions; all of which resulted in a decline in his physical health and independence. These resulted in Mr G requiring help to manage a number of tasks required for independent living, including meals, housework and managing his medication. These themes continue and are explored in more detail during the periods subject to review during this SAR.

2.2. Key Practice Episode 1: (01/01/14-01/01/16) Health & mobility deteriorate, application made for re-housing

Mr G had a review of his needs by the Eltham Community Assessment and Review Team (CAR Team) in January 2014, at which he was receiving Home Care x3 per day and which also recommended him for re-housing into sheltered housing. He did not want this instead requesting ground floor independent accommodation, with an application subsequently sent to the Housing Dept and his case was then closed for a

further review. In February he was found collapsed in his flat, his carer called the police and ambulance after not being able to access his property.

He was feverish, confused, incontinent and dehydrated when assessed and subsequently re-admitted to hospital. The London Ambulance Service (LAS) raised a safeguarding concern to the local authority, due to his condition-but there were no Local Authority records of whether this was received, nor responded to. After a brief admission Mr G returned home 4 days later and once more carers were unable to gain access to him, resulting in police and ambulance again being called. Although on this occasion Mr G had been sleeping and was not in need of acute medical services, but his GP was informed. An epilepsy review was conducted by a GP Practice Nurse, on 4th February 2014 over the telephone. This followed a number of epilepsy recall invites by his GP, which Mr G did not attend, probably because he had become housebound by that stage. His GP then witnessed a Lasting Power of Attorney form, for Mr G to appoint his sister (S1) to manage his Property & Financial Affairs.

In May 2014 his sister (S1) received permission from the Housing Dept to bid for properties on behalf of Mr G, as he was not able manage his affairs in this regard. An offer was made to view alternative accommodation in October 2014, with 5 days' notice of the viewing. These were sent directly to Mr G, rather than care of his sister (S1), which as he did not respond to a further letter was sent to notify of an intention to remove him from priority for re-housing (although he was not then removed from this list).

In June and September 2014, he was visited at home by community Podiatry services for foot care, at which concerns were raised with the CAR Team about both Mr G's alcohol consumption and the poor state of the flat. There were no records that this was received or responded to by the CAR Team. He was then visited on 4 occasions by community physiotherapy services during December 2014 and January 2015, for supply of equipment, including a commode. He was offered physiotherapy for his mobility issues but did not comply with these. The Physiotherapist contacted the home care agency about the need for medication prompts and were informed about his non-compliance, verbal aggression and not letting carers into his flat. Due to his lack of engagement his case was then closed by physiotherapy after making a fire-safety referral.

There was very little further contact with Mr G in 2015. One further incident of carers not being able to access him, lead to police and ambulance attending in May 2015. At this he accused carers of poisoning him with out-of-date meals, but when this was checked by police all food was in date. Mr G was noted to be intoxicated from his home brewed beer at this time and not in need of admission. He did also present with slurred, slow speech and an unsteady gate when not intoxicated. His GP had a telephone consultation with his sister (S1) in June 2015 where Mr G's mental capacity and chronic alcohol issues were discussed. His sister (S1) stated that she had no Power of Attorney for the medical side (Health and Welfare) and this was going to be discussed because she had an appointment for Mr G with a Nurse. Mr G was brought in by his sister (S1) where he had a physical examination together with social review of his needs. His sister (S1) raised concern about the food Mr G had in his house, which was bought on his instruction by his carers, but he stated that he was not interested in changing. Arrangements were made for blood tests to be performed but

there are no records of whether these were done. A further epilepsy medication review was performed by a GP Practice Nurse in September 2015. He did have 3 visits from community podiatry services later in the year, at which no issues were noted.

SIGNIFICANCE

From the above summary it can be seen that Mr G had some further contacts related to his poor health, both inpatient and community services who visited him at home, as he could not leave the property, however he did not engage well with Podiatry, Physiotherapy, Nursing or Medical input. He was not very compliant with his medication nor with attempts by carers to prompt this. Upon review his medication for epilepsy remained the same. He was also known to be consuming alcohol, which he brewed at home. Concerns were raised in hospital, that his alcohol consumption was damaging to his overall health, the extent of this was not known as recommendations for blood tests did not appear to be followed up. He was however prescribed vitamin supplements. There were challenges to meet his complex health and social care needs, partly due to lack of access to him within his flat and partly due to his reluctance to engage with offers or therapy or support. It was the view of his sister (S2) that changes to his personality, both in low mood and anger were related to his frustrations and social isolation caused by being housebound at this time. It was noted his sister (S1) did manage to assist Mr G to his GP, as she was so worried about his health, but this did not result in any changes to his treatment or further referrals for health services.

His sister (S1) had been authorised as his representative with a LPA for Property & Financial Affairs decisions and to bid for re-housing on his behalf. Despite this the Housing Dept did not liaise with her and continued to communicate directly with Mr G, offering him another alternative property, again with short notice which he was not able to view due to his being housebound. This appears to be a repeat of the previous error, the reason for this is not known. His medical priority was known but the Housing Dept stated during this review that they were not aware of other conditions, such as the state of the flat (with the infestations etc), also what additional support he required. However, his sister reported that there were years of infestations, (vermin, fleas, cockroaches) with 26 visits by Pest Control Officers from 2004-2016.

Direct offer letters were sent to Mr G, but not to his sister (S1) and these were done by Lettings Officers from the Housing Allocations Team, who attempt to match properties to tenants preferred areas, which in Mr G's case was Eltham-one of the more popular areas of the borough. He had also ticked 8 other areas in his original re-housing application form, but lettings officers will tend to offer only in the preferred area, so that people don't refuse suitable offers outside their No 1 area and can then lose their rights. An estimate of the numbers on the waiting list are approx. 20,000 and roughly 1000 properties might come up every year, with 3,000 people deemed to be in priority need. Had there been better communication between the Adult Social Care and Housing Departments, involving his sister (S1) who was known to be his representative & had LPA, he may have been able to be re-housed at this time. Due to pressure on council housing stock Mr G did not receive a further offer. His sister (S1) could in theory bid online for other available properties on Mr G's behalf during

this time, but this was not done, despite attempts to find somewhere-as according to S2 there were no suitable properties found to bid for.

2.3. Key Practice Episode 2: (01/01/16-01/12/16) Hospital admission, second housing offer and problems with Home Care

This period begins in January with another fall at home and subsequent admission to hospital, after Mr G sustained a deep wound and head injury following a further incident of intoxication due to alcohol consumption. He had a CT scan (Computerised Tomography) of his brain done which showed there were enlarged ventricles (cavities in the brain) and widening of the cortical sulci (grooves in the brain surface) consistent with moderate atrophy (this means there was some shrinkage of Mr G's brain). There was low attenuation (less intense image) appearing in the deep white matter suggesting chronic small vessel disease (changes in small blood vessels in the brain) and a chronic infarct left temporal lobe (damage to part of the brain dealing with sensations and hearing). The impact of this physical changes to Mr G's brain on his cognitive functioning was assessed during this admission, with a resulting Montreal cognitive assessment[1] (a brief test for cognitive impairment) score of 6 out of 30 (extremely poor).

He was seen in hospital by a social worker from the Joint Emergency Team (JET). His sister felt he needed an increase in support as he appeared neglected in his self-care, he was unsteady on his feet and unsafe to return home. Discharge was delayed as Mr G was not engaging with either a re-assessment of his needs nor with physiotherapy, he was disorientated in time, person and place. He was then discharged home a week later with his Home Care restarted and increased from x2 to x3 per day, including basic meal preparation (consisting of a bowl of cereal and a sandwich) and personal care support. He was thought at this time to be independent with his medication. He was noted to be incontinent at times and needed help with his commode and a full wash, when he agreed to this.

In February 2016 he was again offered an alternative housing offer, communicated to him directly with 5 days-notice of an appointment to view the property. Once more he was not able to leave his flat to view this property and the following day his carer again requested a welfare check by police as they were unable to access him in his flat. He was found to be safe and well, not requiring a re-admission. In September 2016 he was seen at home with his sister for a care needs review, at which he reported to be unhappy with carers being able to let themselves into his flat. He wanted his key-safe removed from outside his flat but was persuaded by his sister (S1) for this to remain. His review identified that he was not always compliant with his care plan, at times refusing offers of help and at times incontinent. It was also noted that he is unable to leave his flat, feeling frustrated by this and his dependence on others. In November the Care Agency (HCP1) raised a complaint with Adult Social Care about this package of care, this related to increasing difficulties with the access arrangements for Mr G, which led to his case being reallocated to investigate the causes and possible solutions to this, which are dealt with in the subsequent KPE below.

[1] https://www.mocatest.org

SIGNIFICANCE

The above summary revealed that Mr G has suffered a further head injury after a fall at home, did not engage with discharge planning and his needs for care at home had increased. His care review noted difficulties carers had in delivering care, both due to Mr G's non-compliance with care services offered to him and that carers had difficulties accessing his flat. During this period, he was further noted to be at times verbally aggressive to carers and now had a male carer as a number of female carers from the agency had refused to work with him because of this.

Also, in the review his current carer had liaised with his sister (S1) directly for her support in encouraging Mr G to let carers into his block. The key safe was outside the door to his flat, but carers had to negotiate with him via the call bell to open the main door to the block of flats, which they needed to open prior to gaining entry to the outside of his flat. This was done either by using the Trades button, or by calling up one of his neighbours to let them in if Mr G did not respond to the call bell. On at least one occasion he had fallen while getting up to let carers through the main door by pressing the entry button to his block of flats. This also meant it took him a long time to respond to the call bell, due to his physical disabilities and lack of mobility within his home.

The other key issue arising from this period was the failed process again by Housing to enable Mr G to view and respond to the second offer of an alternative ground floor property. Once again communication was made directly with Mr G, rather than via his sister, who had been accepted to bid & represent Mr G in dealings with the Housing Department. Despite this he was given short notice (5 days from the date the letter was sent) to view the flat, which he failed to do, for the same reasons stated earlier above. By the time his sister (S 1) visited and found the letter from Housing, his viewing time had passed, and he was unable to secure alternative accommodation. It had been 2 years since his previous offer and despite his being housebound and this being known to both Adult Services and the Housing Dept, this had not been taken into account in the process for enabling him to view, or decide on, the offer which was made. This was the final offer that was made to him and the failure to take his disabilities into account effectively discriminated against his disability, the reason for the request to be re-housed in the first place and causing him to be unable to move to suitable/accessible accommodation.

2.4. Key Practice Episode 3: (01/12/16-28/12/16) Change of Home Care Provider and Final Hospital Admission

In the first week of December Mr G's case was reallocated to a different worker in the Eltham CAR Team to investigate the complaint raised by the Care Agency, relating to difficulties delivering the package of care to Mr G. The worker liaised with both sisters and recorded their concerns about an increase in the frequency of seizures experienced by Mr G, following which he recovered slowly from by sleeping. This along with his poor mobility inside his flat was thought to account for why he was not opening the door to his carers, rather than a refusal on his part to accept care. Although it was also noted that he had refused to see his GP about his seizures. The option of providing carers with a key fob to enable entry into his block was discussed with his

sisters, but they were not in agreement with this as they were concerned about misuse or loss of this fob by his carers, preferring that carers “buzz” a neighbour who had agreed to facilitate access through the communal front door.

A home visit to Mr G, in the presence of his sister (S 1) was then arranged in the second week of December, to discuss these access difficulties, his not taking his medication properly, not getting on with his male carer and the resulting increase in seizures and related risks to him. An outcome of this meeting was reducing his package of care from x3 to x2 calls a day, as he was regularly not using the allocated 3 calls a day. Mr G stated he was able to manage his personal care (as the flat only had a bath which was inaccessible to him and he therefore could not use, so this consisted of a wash at a wash basin), but he wanted help with meals, shopping, cleaning/tidying his home and monitoring his use of medication. He also requested a change of carer as he did not like his current carer, stating that “he gained access to his flat without alerting him, did not engage with him and did what he wanted to do once in the flat”.

The lunchtime call was therefore removed from his care plan and the morning visit was changed to include leaving Mr G a sandwich for his lunch. His sister also reported a decline in Mr G’s cognitive functioning, resulting in him taking more time to respond and sometimes being unable to respond to statements put to him. Further the difficulties with re-housing were raised at this review, with an outcome this was to be explored by his social worker, who would also look into an alternative home care provider, as the current provider was unable to provide an alternative male worker for him. The Provider (HCP 1) also reported again their difficulties in delivering care, due to Mr G’s non-compliance.

The option of moving his key-safe to the outside of the block was then discussed with the Housing Dept Handy persons team, but due to there already being a number of other key-safes at the communal entrance this was not recommended, although his handset could be moved to be nearer Mr G in his flat, which would make it easier for him to answer without having to get up. This was subsequently discussed with an Electrical Engineer, who agreed to install a new handset accessible to Mr G, at no cost to him. A new Home Care Provider (HCP 2) was then commissioned to deliver the reduced package of care for Mr G, via the Brokerage Team in Adult Social Care. They informed HCP2 that Mr G can be challenging and at times refuses personal care, also that due to his cognitive difficulties he takes time to answer/respond to staff. The HCP 2 Field Supervisor then visited Mr G in the company of his sister to discuss the care plan and reported back to his Social Worker that his flat smelt badly of urine, was very untidy and his needs for weekly shopping had not been included in the care plan, which was then revised to include an extra hour for shopping once a week.

A revised Care & Support Plan was then recorded which specified tasks for HCP2, which included 45 mins in the Morning and a further 30 Mins at Teatime, as follows.

AM. Support with breakfast, empty/clean commode, check medication has been taken as prescribed, clean/tidy up living areas (wash dishes, tidy kitchen, toilet, bathroom) and ensure Mr. G has clean clothes on as due to slow mobility accidents may occur.

PM. Please ensure Mr. G has eaten and taken his medication as prescribed and get him ready for bed. His sister states he sleeps in the sofa and has not slept in his bedroom for well over 20yrs.

Weekly Shopping service on Wednesdays, shopping list to be left by his sister.

In the subsequent HCP 2 Risk Assessment and Support Plan the requirement to prompt Mr. G to take his medication was removed from the plan, as it stated Mr. G was independent with both this and his continence management, which was signed by his sister (S1)-although (according to S2) she may not have noticed this change on the care plan. If Mr. G did not give access to the property, the carer was to contact his sister and the HCP2 office. This service started on the 9th December, with the same male carer providing both calls to Mr. G on every day, with another carer doing his weekly shopping. His case was then closed for a future review by the Social Worker. The carer's records of attendance were documented in logbook, which was left at Mr. G's address, this showed he either refused personal care in the morning and/or stated he had already had a wash before the carer arrived.

In the third week of December, on the 20th, his sister (S 1) visited him as usual and found Mr G to be in a post seizure sleep and he had a further seizure while she was with him. She had left out clean clothes, as Mr G had been incontinent and a note asking the carer to change him. It is at this point that accounts of the carer's conduct have been in dispute with the sister's version of events. I will summarise these separately below, as recorded in the log-book, verbal reports of both parties and subsequent investigations. The discrepancies in the accounts of the carer and S1 were also considered in depth and helpfully during the Inquest and covered the 4 days of the week beginning the 20th December 16. In brief these were reviewed as follows.

20/12/16. AM Carer said he was unable to get in for AM call and contacted S1 by phone, who denied this happened, on balance the Coroner preferred the evidence of S1 that this did not happen. S1 had visited in the morning and found Mr G in a post ictal state (drowsy condition after a seizure) he had been incontinent and S1 left his clothes out and a note for the carer before she left in the afternoon.

20/12/16 PM Carer notes stated he got in and made Mr G a coffee and had a chat, again the Coroner view was that this did not happen, and Mr G was not seen by the carer, there was no mention of a change of clothes or any other notes in the logbook at this time

21/12/16 AM & PM. Carer notes state that Mr G refused to open the door for both calls, he further stated that he contacted S1 on both occasions, she denied these calls took place and again the coroner preferred S1's account. Carer stated he also notified the office of these "no replies", although the office records state that the carer reported he got in, but Mr G refused any care.

22/12/16 AM & PM Carer reported he had no response from the call bell and reported this to both S1 and the office, this again was denied by S1 and again the Coroner preferred her account. There were not notes in the log-book for this day. There was however correspondence from HCP2 to ASC on the afternoon to notify them that the carer had not been able to get in for the AM call, so on this occasion he did indeed

notify the office. There was also a record on ASC notes of a discussion of access difficulties between ASC and S1, where S1 had stated she had been contacted by HCP2 about this.

23/12/16 AM. Carer did get in to see Mr G (he did not answer the call bell, but a neighbour let him in through the main door and he did speak to S1 who gave him the key-safe number for the flat door which was the first time S1 shared the keysafe number). The notes stated that he "met client OK. Chat with him. Refuse wash. Make breakfast with a cup of tea. Clean Up." The carer also stated he changed Mr G's clothes.

S1 visited shortly afterwards, she stated that she found Mr G in the same position he had been on the 20th December, barely conscious, doubly incontinent, not able to speak and the clothes and notes were where she left them on her visit on the 20th.

Mr G was severely unwell on the 23rd, requiring urgent inpatient assessment and treatment. The LAS raised a safeguarding concern with the Local Authority Hospital Social Work team, due to the apparent neglected condition he was in when they attended the scene. The receiving medical team noted that Mr G was confused, short of breath and was thought to have pneumonia and acute kidney injury caused by dehydration and aspiration. He had a grade 2 pressure sore and had dried faeces on him when examined.

He was transferred to the resuscitation unit and seen by Accident and Emergency registrar. He was managed for aspiration pneumonia, given fluids and appropriate antibiotics as well as oxygen. A decision was made that given the severity of his underlying condition and his current acute episode that should his condition deteriorate he would not be for resuscitation. There was a peri arrest call and on a ward round it was decided given his situation with respiratory distress to consider withdrawing treatment and to maintain him in comfort with palliative care support. He subsequently died in the hospital on the 28th December, with the cause of death was recorded as Aspiration Pneumonia, contributory factors being frailty and epilepsy. As Mr G died in hospital and circumstances were not deemed suspicious his death was not reported to the Coroner at this time.

SIGNIFICANCE

The events of the final weeks of Mr G's life have been set out in detail, to illustrate the basis for subsequent investigating actions in the following KPE's and revealed a number of issues in both the commissioning and delivery of home care services. Mr G had complex needs, caused by his physical disabilities and exacerbated by his living conditions. In addition, his cognitive, mood and personality problems made it challenging for his carer to both access him regularly at home and meet his needs for personal care support.

One area of concern highlighted in this episode was his non-compliance with anti-epilepsy medication and an associated increase in number/severity of seizures. Post seizure- Mr G was in a deep sleep and often incontinent, simultaneously increasing his need for care and making it more difficult for carers to gain access to him and meet

these needs. Even when he was seen, he often refused personal care and was known to be unhappy with/aggressive towards his carer.

These issues precipitated an appropriate review of his care plan in response to complaints raised by HCP1 at which both his level of support was reduced and subsequently a new Home Care Provider (HCP 2) was commissioned to take over the delivery of his package of care. This raises the issue of whether in response to challenging Home Care situations an appropriate response is to recommission the service from a new provider, rather than explore in a more holistic way the obstacles to care delivery. As HCP2 were very quickly encountering the same difficulties when they took over the Package of Care, i.e., not being able to regularly get in to see Mr G & his refusal of care services offered to him.

The removal of the task of prompting Mr G to take his medication from the Care Plan when HCP2 took over was also significant, as this was a key medication to manage his epilepsy. Without oversight and monitoring of this, there was no opportunity to manage/reduce the number and severity of seizures, which were becoming more common prior to this time. As set out above Mr G was unresponsive and immobile for some time post-seizure, which meant he could not respond to HCP2 when a home visit was attempted.

This became very significant during December, especially in the week prior to his final hospital admission, when he was known to have had several seizures and possibly more during periods when he was not seen. If not positioned correctly during and after a seizure there is a risk that foreign objects may get inhaled into the lungs, which is known as aspiration and was cited as a subsequent cause of death.

Pneumonia is considered to be a common complication of generalized tonic–clonic seizures (GTCS) and is caused by the aspiration of secretions as airway protective reflexes are inhibited by the seizure[2] and is known as Aspiration Pneumonia. This is what Mr G suffered from when he was admitted to hospital on the 23rd December and was sadly fatal in his case as he died 5 days later. Although Mr G was known to suffer from epilepsy for many years and usually slept off the effects of a seizure this poorly managed condition clearly contributed to increased risks to his health and ultimately to his life.

2.5. Key Practice Episode 4: (29/12/16-20/03/18) Safeguarding Enquiry begins and Criminal Investigation takes over.

Following the death of Mr G in Hospital the Safeguarding Concern which had been raised by the LAS (that Mr G had not been seen, had not eaten, drunk, or taken medication and his flat was in an uninhabitable state) was allocated to a Social Worker in the Hospital Joint Emergency Team. Initial liaison was made with Mr G's sisters, according to the JET team records,(although S1 & S2 have no recollection of this), HCP2, the police and CQC were also notified of the issues identified by the Ambulance Crew. The discrepancies between the sister's (S1) and home carer's

[2] Risk of aspiration pneumonia after an epileptic seizure: a retrospective analysis of 1634 adult patients https://www.sciencedirect.com/science/article/abs/pii/S1525505004001039

accounts of action in KPE3 became apparent at this point. Due to the limited role of the JET Team at this time and the complexity of the safeguarding concerns, the case was then transferred to a Social Worker in the Specialist Team to follow up, this was the usual process, and they requested an internal investigation to be undertaken by the HCP2.

In January 2017 the case was allocated to a Detective Constable (DC) in the Greenwich Community Safety Unit, a department of the Metropolitan Police which deals with both domestic violence and safeguarding investigations. The DC then began a criminal investigation into alleged wilful ill-treatment or neglect (Section 20 & 21 of the Criminal Justice and Courts Act 2015[3]) by the home carer and agency (HCP2). This involved collecting written evidence from the hospital, GP, Adult Social Care and family members. Unfortunately, prior to the DC being able to visit Mr G's address this had been cleared by his sisters at the request of the Housing Dept. During the clearing up multiple boxes of unused medication, including a number of full Dossett boxes, were found in the flat, as well as the Log-book, which was left by the Home Carer. His sister (S 2) took photographs of these and the state of the flat, which were shared with the social worker, police officer (& subsequently with the SAR author). It was at this point in February that the DC requested the Home Care Agency stop their internal investigation and share all relevant records with the police.

Following communication with the Specialist Team Social Worker and Supervision with his manager in March 2017, the Local Authority ceased the Safeguarding Enquiry, pending the outcome of the Criminal Investigation, sharing all the material which had been gather so far with the DC. The police investigations were far from straightforward and the details of the care plan crucial to proving whether neglect had occurred. The Home Carer was interviewed only about the visit on the 23rd December, not the two days prior to this, under caution in June and subsequently the file was sent to the CPS in September for a decision on charging the carer. The CPS requested more evidence be gathered, including signed statements from S1 and the GP.

There was ongoing liaison between the Police Officer and Adult Services for updates on progression of the criminal case. In November 2017 more records were shared of the Adult Services last needs assessment and Care & Support plan with the police, leading to more follow up questions raised by the CPS in January 2018 for Adult Services to clarify aspects of the case. Based on all the evidence received about the visit on the 23rd the CPS took the decision that there was insufficient evidence to proceed with criminal charges against either the carer or care provider. Following this decision not to proceed with criminal action being communicated to Adult Services the Safeguarding Enquiry was re-allocated for this to be completed.

SIGNIFICANCE

This period of involvement showed the complexity of the police undertaking investigations into offences of possible neglect to the criminal standard of proof

[3] https://www.legislation.gov.uk/ukpga/2015/2/section/21/enacted

(beyond reasonable doubt). Expertise in what acts or omissions amount to neglect for social care services required input from a number of different agencies, which led to significant delays in decision making by the CPS, ultimately leading to the decision that charges were not appropriate in the case. Furthermore, the decision taken by the Specialist Social Work Team to suspend their investigation until this outcome was taken caused a 14-month delay in the Safeguarding Enquiry being undertaken by the Local Authority. The impact of this delay on the subsequent investigation is considered below, as well as communication about these processes to the family.

2.6. Key Practice Episode 5: (21/03/18-09/12/20) Safeguarding S42 Enquiry completed, consideration of a Safeguarding Adults Review under S44 of the Care Act 2015[4] . A complaint investigation and an Inquest held.

The Original Safeguarding Enquiry into allegations of neglect by the Home Care Provider (HCP2), which had been suspended in March 2017 was re-allocated to a new Social Worker in the Specialist Team to undertake the Enquiry in March 2018 as the Lead Enquiry Officer (LEO). The Social Worker informed Mr G's sister (S 2), who then resent her photos of her brother's flat, unused medication and copies of the HCP2 logbooks to help inform this enquiry. An external Enquiry report was requested from the Contract manager at HCP2, which was then sent to the LEO.

Due to work pressures the final Enquiry Report was completed by the LEO in July 2018, the outcome of this was that the allegation of neglect by the carer was found to fully substantiated on the balance of available evidence which was gathered. This was based on a combination of poor record keeping, poor information sharing when the carer could not gain access to Mr G and also that on the 23/12/20 the Carer did see Mr G but did not request medical attention for him. Recommendations were made to HCP2 in the subsequent Safeguarding Plan, including further training and monitoring of the Care Worker and the outcome was shared with both Mr G's sisters, the police officer and the CQC inspector responsible for monitoring the HCP2, although copies of the full report were not sent until Data Protection issues were clarified in August 2018. At the conclusion of the S42 Enquiry the case was referred to the subgroup called the SAR Evaluation Group (SEG) of the Royal Greenwich Safeguarding Adult Board, for a decision on whether to commission a Safeguarding Adults Review (SAR).

In October 2018 Mr G's sister (S 2) raised a complaint with the Adult Service Complaints Dept, to request that the care and treatment, including the provision of alternative housing and safeguarding enquiry were unsatisfactory. This was the investigated with an initial response in November, following which further issues were identified by Mr G's sister.

In November 2018 the Head of Safeguarding in the Local Authority screened out the initial SAR referral, in line with the policy in place at the time.

[4] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

Following a thorough review of the complaint by both Housing and Adult Social Care depts, all the areas identified were upheld, with a response letter sent to Mr G's sister in May 2019.

The key areas and findings are summarised below.

I) Mr G was inappropriately housed, requiring a ground flat and many of the problems regarding access for care staff and the social isolation experienced by Mr G would have been resolved if more effort was put into him moving.

II) The process of biding online for vacant properties is impossible for some people, due to their disabilities and Mr G was given very little notice when he was made a direct offer.

III) Both the Home Care Providers that delivered care to Mr G had CQC inspections showing they had not met required standards

IV) The access to Mr G's flat, including location of his key safe and front door release button were not moved to enable him to let carers in.

V) There were long delays in the safeguarding investigation and sharing the subsequent report

Following this complaint, a number of recommendations for improvement were made to both Adult Services and Housing Departments, however the outcome of responding to these are not formally followed up by the complaints dept.

In February 2020 Mr G's sister (S2) then wrote to the Local Government Ombudsman requesting that they also look into her complaint, regarding the request to initiate the SAR. However, due it being outside the 12-month rule for the Ombudsman to investigate this complaint was not accepted by them for further action. The case was then re-considered for a Safeguarding Adults Review in February, with the decision that a Review ought to go ahead and an author appointed in July 2020.

In November 2020 an Inquest was held into the death of Mr G and a decision, including a narrative verdict was issued by the Coroner in December 2020.

"Mr G was a vulnerable isolated cognitively impaired alcoholic man with brain damage and epilepsy from an accident in 2011. He was frail and not easy to care for. He was wheelchair bound and unsuitably housed on the first floor, with twice daily carer support, who sometimes could not get into his flat to attend to him, as he was not always able to get to the handset to admit them. His last medical assessment was in February 2016 and none was requested subsequently.

He did not comply with his anticonvulsant medication, which he was not prompted to take, as it was removed from his care plan. He had a seizure on 20th December but was not attended to by a care worker from then to the 23rd, by which time he was dehydrated, doubly incontinent and with a grade 2 pressure sore. He was admitted to hospital with pneumonia and died of aspirational pneumonia on 28th December.

Mr G died from a complication of epilepsy, which was caused by an old brain injury. Whilst his care and care plans had weaknesses and omissions, none could be found to have contributed directly to his death"[5].

SIGNIFICANCE

During this period of the case 4 separate, but to an extent overlapping procedures were undertaken to explore the issues raised by this case.

a) Safeguarding Adults Enquiry under S42 Care Act 2014. (March 2018-July 2018). This process had been paused for over a year following receipt of the referral, due to the criminal investigations in 2017. However, once the enquiry was re-started no new original material was gathered and decisions were taken on the basis of material gathered during the initial phase in the first weeks and months after Mr G's death. The outcome of this was that the allegation of neglect was upheld.

b) Local Authority Complaints Procedure. (October 2018-May 2019). This process was instigated by Mr G's sister (S2) following the outcome of the above Safeguarding Enquiry and identified broader issues across both Housing and Adult Services, in how they assessed and provided services to Mr G. Although a complex investigation this took 8 months to complete and all complaints were upheld, with a series of recommendations made.

c) Safeguarding Adults Review (SAR). (August 2018-February 2020). This process was initially instigated by the LEO following the Safeguarding Enquiry in 2018 but was screened out of the SAR process. When the case was re-submitted in February 2020 it was accepted for a SAR on this occasion.

d) Ombudsman Review (February 2020-March 2020). This process was instigated by a letter to the Ombudsman, sent by Mr G's sister in February to complain about the delay in instigating a Safeguarding Adult Review. The Ombudsman responded in March, to say that they could not investigate this complaint, as they have a maximum 12 months' timeframe from when the incident occurred, which in Mr G's case they took as the date of completion of the Safeguarding Enquiry (August 2018), as they felt it was from this date that a complaint could have been made.

e) Inquest held by Coroner's Court (November 2020-December 2020). The criteria for reporting a death to the coroner are broadly to investigate where the cause of death is unknown or in suspicious or other circumstances (such as caused by violence or neglect). As Mr G died in hospital his cause of death was known and so it wasn't put forward at this time. The subsequent application was accepted, and the Coroner investigated whether Mr G's death was caused by neglect. The outcome of the inquest was that although failings were identified

in a number of areas, the issue of causality could not be proven to say the various failings contributed to his death.

The delays in concluding some of the processes documented in this section were clearly a source of stress and distress to both Mr G's sisters and should be avoided in similar future cases.

3. Appraisal of practice and learning from Case

3.1. Appraisal of practice and Learning Pre-2014

Mr G's physical health deteriorated significantly in the years prior to the Review, as he suffered a number of falls and injuries, requiring admission to hospital for treatment. His follow up in the community included irregular medical/epilepsy reviews from his GP surgery and both physiotherapy and occupational therapy, which was expected practice at this time. However, his engagement with these services was variable and eventually discontinued.

His housing circumstances were known to be poor and cause for concern from 2007 onwards when his social care provider raised a number of reports on this to Adult Social Care but were not resolved. In 2008 he was deregistered from the waiting list for re-housing as he had not responded to letters about this and it was not followed up at the time. This was pattern which continued during subsequent KPEs but should have been addressed to ensure his housing needs were met. This did not happen and as his mobility deteriorated markedly in the next 3 years, he was effectively isolated and housebound as he could no longer exit down the stairs from his flat unaided, as it was on the first floor. There was no evidence of communication between health/social care and housing services to remedy this situation, which was a gap in practice and showed a lack of coordination between the agencies.

Apart from the unsuitability of his housing in practical terms, the subsequent frustration and isolation, as well as alcohol use began to have a negative effect on his mental health, where Mr G was noted to be suffering from depression. Although treatment for this was recommended when seen by a psychiatrist in hospital this did not lead to any referrals for mental health support. This raises the difficulties of supporting people in the community, with emotional needs arising out of practical problems and it is not known whether he might have benefitted from either medication or other forms of therapy. Mr G did not want any medication but did agree to psychotherapy to help him. He was not offered this help, which was a gap in practice at the time, by his GP, who would normally be responsible for such referrals and his need for this was identified on a discharge summary sent to the surgery. This was a gap in practice.

Further gaps in support following an admission in 2011, where Mr G was left without Home Care for 3 months after an admission to hospital, until he had a reassessment of needs in August that year and Home Care Services were re-started. The new provider identified his poor living environment as a cause for concern, but it is unclear what, if any, attempts were made to resolve this-or indeed how Mr G responded to any efforts to improve his environment. For example, his care plan did not specify what tasks in the home were expected to be done by his Home Carer, beyond tidying up. This was significant as it remained in subsequent care plans, although was clearly insufficient to improve things for him at home and due to his physical problems Mr G was unable to complete the activities of daily living independently. This appears to be a mismatch in his needs for help compared to the services offered to him. Combined with some suspected self-neglect (possibly related to his persistent low mood) his environment was known to be poor over a prolonged period and this in itself may have further contributed to his chronic low mood, leading to a downward spiral.

The issue of re-housing was picked up by his social worker at the review in August 2011. When Mr G was readmitted to hospital after this review his social worker closed the case and it was transferred to a hospital social worker who did not follow up a re-housing application. When he then left hospital his social work file was closed to a 3-month review of services and the need for support for re-housing was not done either prior to or during this review period which was allocated to a different social worker. This was a significant gap in practice from Adult Services and reveals how unmet needs may be missed when case responsibility is transferred between community and hospital social work services.

The reason for this is not clear, but the focus on commissioned services in the absence of other outstanding social work functions may have caused this to be missed as the case was transferred and then closed. It appears that the Care Management model of social care gave insufficient acknowledgement of the need to help/advocate for Mr G to be re-housed. If Mr G had been allocated consistently to the same Social Worker, it is possible this omission could have been avoided and it highlights the risks of lack of follow up for longer term social work support when cases are moved between workers and teams. In 2012 he did have social work involvement, but other than noting he was on a waiting list for re-housing, nothing else was done. If this had been checked with Housing it would have been clear this was not in fact the case, as he had been removed from the waiting list.

There were some good attempts to follow Mr G up at home for an assessment by the memory clinic, after he had been referred during another hospital admission. Mr G had missed 2 appointments for the assessment, due to not being able to get to the appointment so it was good practice to visit him at home. At this it was noted that his main problem was noted as social isolation and need for re-housing, but this was again not followed up.

Summary of Learning from First Period

- **Mr G was known to be in poor physical health and while in hospital he did receive appropriate assessment and treatment for the physical injuries he suffered, but it proved problematic to engage him in community therapy to regain his independence.**
- **He did receive an assessment and package of Home Care, but it was insufficient to maintain a good standard of living for Mr G.**
- **The risk of falls was complicated by both his epilepsy and problematic use of alcohol, he did accept medication for his epilepsy but not suggested assistance from alcohol services.**
- **Mr G also suffered a deterioration in his mental health, including mood, memory and communication difficulties but this was not followed up by his GP.**
- **His mental health when it was assessed by a psychiatrist noted the link between his poor/unsuitable living environment, social isolation and low mood, but this was not communicated by hospital mental health liaison services, either to ASC or directly to Housing services**
- **Mr G was unable to pursue re-housing independently and although this was recognised as an area of need it was also not followed up consistently by several social workers.**

- **Communication between Adult Social Care and Housing Depts did not happen, with both agencies working in isolation, to Mr G's detriment.**

3.2. Appraisal of practice and Learning from KPE 1(01/01/14 01/01/16) Health and mobility deteriorate and application for re-housing

The patterns of decline in physical health continued during this period, with further crisis admissions to hospital after falls at home, but there was no evidence of a risk assessment being done at any stage, by either hospital or community health services. The difficulties with accessing Mr G by home carers led to emergency calls to police and ambulance services, whilst they did gain entry to his flat the underlying problems were not resolved. A Key-pad had been fitted outside his flat, but despite this entry to the block of flats relied either on Mr G opening the main door with a handset, or carers using the Trades button, or calling on another resident to let them in. Also, as he had collapsed behind his front door the key-safe did not allow entry for concerned staff.

His epilepsy also worsened during this period and although he had a series of telephone reviews from a GP Practice nurse, there are no records he was visited at home. The reviews did include his home carers, who at the time were monitoring his medication compliance and had noted his non-compliance with this. Clearly with a chronic serious health condition, such as epilepsy a more thorough review with all involved parties would have given a better picture of Mr G's ability to manage this in the community. Information sharing between health and social care services was not done and this contributed to an inaccurate medical assessment of his ability to control the risk of seizures by regularly taking anti-convulsant medication. As reviews were telephone rather than home visits, his blood levels were not taken which would also have helped a more accurate understanding of medication compliance and related risks to his health.

It was also noted during this time that he presented as confused on admission and was thought to have cognitive damage, at one point dementia was considered. Also, his sister was authorised as the LPA for his housing and financial affairs, witnessed by his GP, which indicates his decision making for these areas was not thought to be in doubt/lacking. However, there are no records to indicate a mental capacity assessment was thought to be needed or was done. This was also a gap in practice and would have helped established whether there were grounds to meet his needs in his Best Interest, if he was assessed to lack capacity. In the absence of this judgement, his sister (S1) was designated as his representative for making applications for re-housing on his behalf. Despite this his sister was not communicated with when an offer of alternative housing was made, so she was unable to represent or facilitate any viewing of the property within the timeframe set by Housing. This led to Mr G losing out on the offer and a letter was sent of the intention to remove him from the waiting list (although despite this offer, he was not removed). This was significant omission by his Housing Officer, possibly by individual error, although highlights a systems issue within the Housing Dept who should have liaised with his representative instead of with Mr G directly. It was known S1 had LPA and could bid for him so she should have been the main point of contact from this point, but it was not done.

Further provision of community health services was done (podiatry for foot care and physiotherapy for mobility & equipment, including a commode), which was good practice. Once again, his compliance with treatment was problematic and led to the physiotherapist closing his case. Communication was made with home carers and they reported practical problems (medication non-compliance, verbal aggression and access difficulties). This was also good practice but it's unclear whether these issues were ever escalated but no changes were made to his care arrangements to address these.

It's also not clear whether these issues were then reported to his GP for a medical assessment of his epilepsy management. It appeared that the chronic poor living conditions were known to those agencies visiting him at home, but once more these do not appear to have been escalated to ASC and were not addressed. It may have been these were accepted as normal baseline conditions for Mr G, rather than an issue of concern and in need of intervention.

For example, Podiatry notes indicate he was seen at home a number of times during this period, but the records state there were no issues, which appears surprising, especially as in 2014 they did raise concerns with ASC about his alcohol consumption and the state of his flat. The concerns which had been raised in 2014 were not responded to or resolved by the Eltham CAR Team at this time, which was another gap in practice. It is possible that as Podiatry had raised these before they did not report them again in 2015, but the fact that they were still the same (if not worse) was significant. It is important that chronic issues of neglect/self-neglect are reviewed regularly to explore the risks, as without long-term input these issues become progressively more entrenched and so difficult to address.

Ongoing concerns were raised by S1 with his GP and she did bring him to the surgery for a medical review in June 2015, including a request for a capacity assessment, but there is no record whether this was done. This is a missed opportunity, as if there were doubt about his capacity (for example to self-medicate) this should usually prompt an assessment. In terms of medication and specifically for an epilepsy review a plan was made to take blood but there were no records to show if this was done and no outcome of this. Again, this is a key issue, as Mr G was either making unwise decisions to not take medication or he may have lacked capacity (possibly associated with his poor memory) to self-medicate, but as there was no assessment it is not known whether he was able to do this. Given that both issues (of capacity and medication) were part of the medical review they should have been clarified.

Summary of Learning from KPE 1

- **A deterioration in health, including further hospital admissions did not lead to any changes to Mr G's community support services.**
- **He continued to suffer seizures, falls and was known to be non-compliant with anti-convulsant medication, but on review (either by phone, or once brought to the surgery) there were no blood tests done and no changes to his medication regime.**
- **Capacity was raised as an issue of concern by S1 in relation to his health but was not assessed**

- **Chronic poor environmental issues were reported by carers and podiatry but there was no investigation or response to this by ASC. This may have led to those agencies becoming discouraged to keep reporting them, they became accepted as normal for him.**
- **Housing Services acknowledged S1 was Mr G's representative but failed to communicate with her and this omission led to an ineffective re-housing offer, which he was unable to view or accept. This led to a further delay in addressing a key risk in respect of his living situation that had negative consequences for his health and safety.**

3.3. Appraisal of practice and Learning from the KPE 2: (01/01/16-01/12/16) Hospital admission, second housing offer and problems with Home Care

The same issues in the 2 previous KPEs continued during the final year of Mr G's life. He continued to suffer further seizures, falls and a hospital admission, where he sustained a deep head injury, with a CT revealing brain shrinkage/damage. The impact of this on his capacity/cognitive function was assessed but not clarified during his admission, which was a missed opportunity. He was noted to be disorientated and confused on the ward but was still discharged back to the same home environment even though it was not suitable. His social needs were reassessed by hospital social workers and his home care was increased with an extra visit, his self-care and continence were both noted to have deteriorated.

However, the same practical problems; of accessing him and of his ongoing refusal of care services also continued. His housing needs were not part of the social work review, which again focussed on commissioned care services in the context of hospital discharge.

His housing needs were again noted but not addressed and once more he was communicated with directly in February for re-housing, but unable to leave his flat and lost out on another offer. His sister was not involved or notified of this process, despite raising this in 2014 the last time he was made an offer. Once more he was then sent a letter to say because he did not attend his offer would be suspended, which was the same error in practice as in 2014, which reveals that there had not been any learning or change in practice from the previous incident.

Due to the persistent difficulties with supporting him at home HCP1 made a complaint to ASC and a review was undertaken, which was good practice. The outcome focussed on the relationship breakdown with his male carer and the result was to change provider, rather than look at the underlying problems with any worker supporting him at home (access, non-compliance, aggression, self-neglect). These issues were the reason for the breakdown and problems with his community care and once again these remained exacerbated, due to Mr G's isolation and low mood. This again shows that with complex clients such as Mr G, a purely Care Management focus and response to change service provider can miss the cause for engagement problems. This is not to say that Mr G may have lost confidence in his main carer, but the need to build and maintain rapport was clearly challenging for any home carer.

The risks to his health and safety, were noted but not formally re-assessed, although it appeared, they had increased with his further deteriorating mental and physical health.

Summary of Learning from KPE 2

- **Capacity issues were again raised but not assessed**
- **Housing Services continued to communicate directly rather than via his representative S1, meaning Mr G again missed out on re-housing, an avoidable error**
- **Health declined further but no changes were made to medication, GP made no home visits to Mr G, although capacity and health concerns were raised by S1**
- **Care needs had increased and become increasingly challenging to meet at home, which was addressed by changing provider, not looking at the circumstances more holistically. for example, no joint review including both health and social care services.**
- **No support offered to Mr G by ASC with re-housing needs, although these were noted again.**

3.4. Appraisal of practice and Learning from KPE 3: (01/12/16-28/12/16) Change of Home Care Provider and Final Hospital Admission.

The new home care provider (HCP2) met and assessed Mr G once they were commissioned after the above review of his care plan, they identified again the same issues of his poor living environment and general poor state of health to ASC. Upon review they felt that they had not been given sufficient background information on his case when they agreed to take over his care plan delivery i.e., the problems faced by previous provider (HCP1) and the reason they handed back the service to ASC, they were not told that Mr G was aggressive and non-compliant with his carers, they recorded he was independent with both his continence and medication, which was not correct. Medical involvement was not sought when prompting/monitoring his medication compliance was removed from his support plan. The HCP2 assessment was inaccurate and not based on sufficient information (either from health or social care services). This gave a misleading picture that under-represented his care needs and associated risks.

However, the assessor did note Mr G slept on his sofa, the flat smelt strongly of urine and was very untidy, all of which were reported to ASC, but there were no attempts or onward information sharing (e.g. incontinence assessments) to address these issues. They were not addressed in the revised care plan (apart from tidy up being included) and so remained unmet needs at this stage. Also, previous intelligence on his care preferences (for example that he preferred female rather than male carers was not passed on to the new provider). When visited for the initial assessment in the presence of S1, a plan was agreed for carers to contact S1 if they were unable to get access to Mr G, it was also expected that the carer would report these to the office, so they could be passed onto ASC.

The HCP2 worker had an undoubtedly challenging task to engage and support Mr G given the above inaccuracies. However, a review of his recording, as set out in the home care logs were misleading, in that each was timed to show care was delivered at the exact time it was expected (10 till 10.45 am and 6 till 6.30 pm), which was unlikely to be correct. Also, these were very brief, often stating he refused care, had already had a wash, but was OK. These issues of non-compliance were not escalated to the HCP2 management team, which was a serious omission and meant these problems were not passed on to ASC.

Also, on the occasions in his final week at home when the carer was unable to gain access, these were not always passed onto the agency, or to his sister. Both of these responses were expected and agreed but were not done, again this was a gap in expected practice by the carer which put Mr G at significant risk. The practical problems of entry through the communal door to the block were not resolved although they were raised by the new provider, which meant that it was difficult to get in to see Mr G. There was a suggested plan to either move his key-safe to the front door (which was not agreed by Housing) or to put his entry phone near to his sofa to make it easier for him to respond (which was agreed by Housing but not done). This omission made it impossible to see him by his carers when he did not open the communal door, which could be either due to non-engagement or to him being in a post seizure sleep. As these occasions were not reported in a timely way it was not known which of these it was.

The issues of Mr G's relationship difficulties and ambivalence in accepting care were known to the Reviewing officer who re-commissioned then Home Care at the earlier review but these were not shared by them with HCP2, neither when the service was proposed at the initial referral stage (when minimal information is generally shared about a case) nor when it was accepted (HCP2 reported that minimal history was shared about his mental health, self-neglect etc). However, in this case the Brokerage Team did e-mail HCP2 to inform them of his need to be encouraged as he can decline personal care and that he processed information slowly.

The discrepancies in the accounts of the carer and S1 were considered in depth and helpfully during the Inquest and covered the 4 days of the week beginning the 20th December 16. On the balance of evidence, the coroner agreed with the evidence of S1 that Mr G had not been seen by the carer between the 20-23 December. If so, it was thought likely that he had not contacted the office about this until the afternoon of the 22nd December and S1 until the morning of the 23rd December. If so, then not only were the carer's notes found on the logbook questionable (stating visits occurred when they did not) but also his communication practice was very poor with both the family and office. It was this misconduct which was the subject of subsequent criminal and safeguarding investigations but learning from this period includes that monitoring and recording of individual home carers working alone was insufficient.

The systems in place by HCP2 for monitoring Home Carers' whereabouts has significantly improved since this time, with electronic tracking and logging in and out and the start and end of home visits. Additional measures have also been taken by the provider to improve communication and assessment when new referrals are received for Home Care services. These changes followed action taken by RBG Commissioners, who had temporarily suspended HCP2 from delivering care in 2017

and instigated a “Providers Concern” Process in conjunction with the London Borough of Lewisham.

When Mr G was subsequently admitted to hospital by the LAS on the afternoon of the 23rdDecember they identified an acute concern (pneumonia, dehydration, confusion, kidney injury, pressure ulcer and dried faeces) which prompted them to raise this as a safeguarding issue of neglect. This was good practice on their part and shows how different their perspective was from the carer’s (who earlier reported Mr G as being OK and having a chat). It may be that the carer had accepted the condition of Mr G and his flat as “baseline, or normal” having become used to it, but to those visiting for the first time both were a serious cause of concern.

Summary of Learning from KPE 3

- **When Home Care Services are reviewed when there are difficulties in delivering care packages, instead of resolving these the package of care may be re-commissioned with a different provider then facing the same challenges.**
- **When Home Care is re-commissioned the information shared with the new provider is incomplete and may be misleading in understanding difficulties in delivering services**
- **When there are problems accessing or delivering care plans more reliable systems for communicating and escalating these are required**
- **When new support plans are re-written, removing medication prompting/monitoring this needs to involve consultation with the prescribing doctor prior to changes being made**
- **When new assessments of need identify serious issues of self-neglect these need to be reflected in the care plan and risk assessment, alongside a referral for safeguarding and consideration of the adult’s mental capacity**

3.5. Appraisal of practice and Learning from KPE 4: (29/12/16-20/03/18) Safeguarding Enquiry begins and Criminal Investigation takes over.

The initial response to the Safeguarding concerns raised by the LAS were the responsibility of the JET Team, who at that stage were based at QEH. They contacted the relevant agencies and gathered information, which was saved in the ASC database (on a form called SVA1 on Framework i). This included requesting an internal report from HCP2 into the conduct of the relevant carer, to clarify the discrepancies in his conduct during the week preceding Mr G’s admission.

This was standard practice for JET to make the first contact and due to the complexity of the case it was then transferred to the Specialist Social Work Team, whose role included undertaking Safeguarding Enquiries to meet the duty under S42 of the Care Act 2014. The case was allocated to a social worker in this team in February, which was a month after it was opened by the JET Team, the reason for this delay is not clear, but did mean there was a gap in following up the initial action by the JET Team at the beginning of January.

JET had also notified the police of the alleged neglect by the home carer and in January 2017, the case was allocated to a Detective in the Community Safety Unit to lead on the investigation. This was standard practice for the police, but due to some staffing issues (including annual leave) there was a delay of some weeks before the officer became actively involved, in the interim S1 & S2 had cleared up Mr G's flat, which compromised any chance for forensic, or other evidence being gathered of neglect from his address.

However, S2 had taken photos of the carer's logbook, the condition of Mr G's address and of a large amount of unused medication which was later shared with both social workers and subsequently the police officer. If there had been better information sharing with his family the police could have seen the conditions in his flat before it was cleared. The HCP2 investigation was halted at the request of the police officer and their records were requested to be secured for review by the police. This was standard practice to avoid any potential contamination of evidence by HCP2, although did mean that the provider was unable to conduct their own enquiries into the carer's conduct at this time.

The Specialist Social Worker who had been leading the S42 Enquiry then had a discussion with both the detective and the Specialist Team manager, following which the S42 Safeguarding Enquiry was halted and all reports gathered to date were shared with the police. No further action was taken by the Specialist Team for the next 14 months, when the police were notified by the CPS that there was insufficient evidence for any criminal charges to be brought in the case. At which point the S42 Enquiry was recommenced (see KPE 5 below). The police enquiry was complicated both by the number of agencies involved and the difficulty in determining whether the criminal standard of proof for neglect was met. Also, due to the working conditions of the Community Safety Unit, which mainly dealt with more urgent domestic abuse investigations, pressures of work contributed to the delays. The CPS requested additional evidence gathering at several points during 2017 upon review of the evidence file, before deciding not to proceed with bringing formal charges against either the HCP2 worker, or the organisation.

Although it was the usual practice for social workers to cease action on an enquiry where the police were leading on a possible criminal charge, this did clearly lead to a long delay in any outcomes for the civil S42 Safeguarding Enquiry process. The Specialist Team made regular contact (September 2017, November 2017, January 2018) with the Detective for updates on the case and for an outcome decision, which could inform more action to conclude the safeguarding process. But the overall delays in completing the Safeguarding Enquiry may have been unnecessary and caused distress to Mr G's family.

Summary of Learning from KPE 4

- **When safeguarding concerns are identified during a hospital admission, initial responsibility is allocated to hospital based social workers, although the concern related to community services. This leads to a delay in action when the case is then transferred.**
- **Where the concern relates to an adult who subsequently dies in hospital, this also contributes to delays, as there is less sense of urgency due to the adult no**

longer being at risk. Other cases tend to get prioritised to protect adults who may remain at risk of further abuse.

- **Delays in agreeing a plan of action for evidence gathering can lead to lost opportunities to gather evidence, for example with this case the sisters cleared the deceased's flat when the condition of his property may have been used of evidence of neglect by the home carer.**
- **There is a culture of suspending safeguarding enquiries where the police are also involved, rather than looking into whether both processes could be undertaken in parallel.**

3.6. Appraisal of practice and Learning from KPE 5: (21/03/18-09/12/20) Safeguarding S42 Enquiry completed, consideration of a Safeguarding Adults Review under S44 of the Care Act 2014[6] . A complaint investigation and an Inquest held.

When the police notified Adult Services that no prosecution was going forward in the case, the Safeguarding Enquiry was re-started 16 months after the referral had been first received. This was concluded with a report 4 months later, that fully substantiated the original allegations. No new evidence was used in order to arrive at this decision, as the Lead Enquiry Officer used the reports, which had been available at the time the case had been previously allocated in 2017. The only new information was the HCP2 report, but this was based on records, which had been shared already with Adult Services by S2. Therefore, the delay had been unnecessary in that the same decision could have been reached when the case was first investigated. This appears to be caused by the received idea that while criminal issues are explored by the police, they lead on evidence gathering and Adult Services suspend any action which might have been instigated.

At the same time the police struggle to establish evidence of neglect as this is not their usual area of expertise, further compounding the delay. It would be much better practice to seek to work together to complete both processes in parallel. Discussing the case with the detective revealed that he would have had no problem sharing any evidence which he had gathered to support a Safeguarding Enquiry. In this case a more active involvement by an allocated social worker and better communication with the police detective would have improved the timeliness and quality of both processes.

The delays outlined above were also compounded by a lack of urgency, due to the adult being deceased, with police resources understandably prioritising ongoing domestic abuse case work, which is the main activity of the police Community Safety Unit. There is no officer dedicated to purely Safeguarding Adults crimes, which can mean these crimes receive less time and resources.

The outcomes of the Safeguarding Enquiry were recorded on the report as a protection plan, which identified a series of recommendations for HCP2, as follows.

- HCP2 to undertake regular checks and monitoring of carers
- HCP2 to provide training for carers in record keeping.

[6] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

- HCP2 to provide training and guidance on when carers should obtain medical advice for clients.
- HCP2 must always be contacted by the carer where there is a no reply.

Although, these were appropriate and helpful, they were not followed up to establish whether they had been done, as the case was then closed to the Lead Enquiry Officer. Also, there was no sanction recommended for the carer, despite the outcome of the enquiry being that he had neglected Mr G. This does highlight an issue in social work oversight of outcomes at the conclusion of the safeguarding process, although action was followed up by RBG Commissioners, in 2017 and 2019. Commissioners collated a series of concerns about HCP2 from quality alerts, complaints and Safeguarding enquiries. These centred on record keeping, visit times and lack of management oversight-all themes which had been found in this case. Commissioners then were involved with colleagues from London Borough of Lewisham, where HCP 2 also had a contract.

The contract was temporarily suspended until sufficient improvements were made, including an Electronic Care Monitoring system (Carers now have to log in when entering and leaving a client's address). With the introduction of this and other measures were in place and evidenced the suspensions were lifted.
The provider took relevant actions and have since demonstrated a much-improved operation and oversight, significantly reducing any risk to service users and being able to demonstrate a safe practice.

The subsequent processes, following both the police and safeguarding enquiries were all clearly delayed and considered the case from a range of perspectives/different procedures, which are appraised below.

Local Authority Complaints Procedure, which considered the case upon the request of Mr G's sister (S2). Although this in itself was delayed the findings outlined in a letter 8 months later upheld all S2's complaints. This was very thorough review of both Adult Services' and the Housing Department's actions in the case and made a series of recommendations for both. However, similarly to the above Safeguarding Enquiry, there was no follow up to oversee and evaluate the extent to which the recommendations were met and that processes were changed to avoid a similar occurrence in future cases. The outcome letter was shared with the Principal Social Worker but lines of accountability for making changes, as identified through the complaint, are not clear. This requires clarification to enable complainants to be reassured that when upheld, their complaints are addressed, rather than just recognised.

The 8-month delay in this complaint outcome had a subsequent impact on S2's next action, which was to raise the issues of a delay in commissioning the SAR with the Local Government Ombudsman. Due to the 12-month time limit set by this body they did not investigate S2's complaint. Usually, at the conclusion of complaints, information is given about raising further issues with the Ombudsman, but given the timeframes in this case, it should have been advised at the beginning, rather than at the conclusion of the complaints process.

Finally, the decision of the Coroner's Court was also delayed by some time, due to the initial view that as Mr G died in hospital, his death did not require a referral to the Coroner at the time (cause of death being known). However, as one of the criteria for the Coroner to hold an inquest is if "there is a question of negligence or misadventure about the treatment of the person who died"[7], so this should be addressed by the hospital to ensure this is done in future similar safeguarding cases.

Summary of Learning from KPE 5

- **Better communication between the police and adult services may permit both safeguarding enquiries and criminal investigations to run in parallel rather than sequentially**
- **Outcomes of substantiated neglect should lead to more oversight of the implementation of recommendations for change as an outcome of the enquiry, either by the Lead Enquiry Officer, or overseen via the responsible commissioner**
- **Outcomes of complaints procedures should also lead to more accountability for changes to both adult services and housing departments**
- **Where complaints are delayed the person raising the complaint should be notified of the 12-month rule for escalation of the issues to the Ombudsman**
- **Also, where a death occurs following concerns of neglect, the doctor signing a death certificate should also report all such deaths to the coroner.**

[7] https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner

4. Findings and Recommendations

This section contains priority findings that have emerged from the SAR. The findings explain why professional practice was not more effective in protecting the adult in this case.

4.1. Finding 1

Where adults are housed in accommodation that they are unable to leave, due to a disability, this should be formally recognised as unsuitable and a priority for action by both Housing and Adult Social Care Departments, who need to work together to ensure suitable alternative and accessible accommodation is provided. Where this is not done it leads to a further decline in the adults' health/wellbeing and exacerbates both the negative impact of the adults' disability and the risks to their safety.

Example from the case

Mr G was housed in a first-floor council flat which was unsuitable for him, due to his physical disabilities as he became unable to exit the property and was effectively housebound for some years prior to his death. It was known in 2011 that he needed re-housing to accessible ground floor accommodation but the process for this was not suitably undertaken, with learning for both Housing and Adult Social Care departments.

He was known to be unable to manage his affairs in relation to the housing bidding process and his sister was authorised to bid on his behalf, however this was not reflected in how alternative offers of housing were made to him. Letters were sent about housing offers directly to him, rather than to his sister and he did not respond in the permitted timeframe. Furthermore, even if he had wanted to view alternative housing, he could not leave his flat to undertake viewings, which were made with sort notice, rendering him disadvantaged and unable to secure more suitable housing.

Communication between the departments and with Mr G/his sister was not effectively undertaken resulting in him being accommodated in unsuitable and unsafe housing during the period subject to the SAR.

Recommendations for the Board to consider

- **Development of a joint protocol between Housing and Adult Social Care Departments, to identify adults physically unable to leave their properties, due to them being inaccessible, and a shared action plan to remedy this.**
- **To also identify those adults who are unable to bid for alternative accommodation and ensure their representative is included in any correspondence about offers of re-housing.**
- **Following a social care assessment that identifies an adult's need to move, support and advocacy should be included as part of a subsequent Adult Services Care Plan to ensure that this is achieved.**

4.2. Finding 2

Adults with epilepsy, resulting in seizures and associated with falls leads to an increased risk of both cognitive and social decline, as well as poor overall health (including incontinence). This can affect compliance with medication and the adults' overall abilities to self-manage the condition, it requires regular monitoring, at least annually (including blood tests) and case management, including home visits by Primary Care Services, in line with Nice Guidelines[8].

Example from the case

Mr G was known to suffer from a serious form of epilepsy and had a number of hospital admissions after falling at home. He was described on several Home Care Support Plans as being self-medicating for his anti-epilepsy medication, receiving regular deliveries of medicine with a repeat prescription from his GP Practice. However, after his death when his sisters cleared his property 22 boxes of unused medication were recovered from his flat. He did not seem to have had any medication reviews, or other monitoring of his compliance and the effectiveness of his medication regime. Clearly as he was not able to leave his flat, he could not attend appointments at his GP Practice, and some attempts were made to review him at home.

He was known to have seizures after which he was drowsy and subsequently sleeping during the day, putting his health and safety at risk. As he did not appear to have his medication prompted, monitored or supervised this oversight currently seems to have led to a downward spiral negatively affecting his mental and physical health, including incontinence issues that were ineffectively managed.

Recommendations for the Board to consider

- **CCG to ensure that Primary Care Services thoroughly review all patients with epilepsy, at least annually. This should include use of the annual review template, as recommended by the epilepsy society[9].**
- **Where the review identifies issues with management of the condition the patient is referred to specialist secondary services for further assessment.**
- **Where social care services or family members are aware that patients are not able/willing to self-medicate, this prompts an unscheduled and multi-agency review of their case.**
- **That where Home Care Providers are supporting adults with epilepsy, they include monitoring, prompting of medication, until a responsible physician approves any changes in medication management.**
- **If Home Care Providers amend care plans to not monitor medication, following an adult stating they are independent this change is highlighted to families prior to the revised Care Plan being counter-signed by them**

[8] https://www.nice.org.uk/guidance/cg137/chapter/1-guidance
[9] https://epilepsysociety.org.uk/sites/default/files/2020-08/PrimarycarereviewtemplateApril2015_0.pdf

4.3. Finding 3

Where Adult Care Services identify the need for Home Care and either commission a new service provider or transfer a current package of care to a different provider, sufficient information on compliance and access difficulties is not always communicated to the proposed service provider. This can lead to unexpected barriers for the provider and result in ongoing difficulties meeting the adult's care needs.

Example from the case

From the conversations with the 2 Home Care Providers involved during the period subject to review there would appear to be learning for Adult Services about the amount of information which is shared with providers when a package of care is either being commissioned or reviewed/transferred to a new service. It seems that little detail is provided about the nature and degree of compliance with assessed needs, access to the client/ issues for carers and the extent of need for daily support when care plans are being drafted. It appears that Mr G's actual level of need for help may have been underestimated which impacted on the suitability and effectiveness of home care services provided to him. For example, he clearly needed some support with medication compliance, upkeep and hygiene of his flat, which were not included in any of his care plans.

He was known to have been aggressive to a number of home carers, leading to 4 female carers (from HCP1) refusing to work with him and subsequently to his carer being a male carer both from HCP1 and then from HCP2 when they took over his package of care. It was thought that his compliance with personal care support, washing etc was adversely affected by having a male carer and he often refused this service. In fact, he often did not allow carers into his flat for a number of reasons. Also, the issue of his incontinence was not covered in any of the care plans, drawn up by the agencies with Mr G and his sister in attendance.

Recommendations for the Board to consider

- **Where a potential new service is being commissioned/transferred through the Brokerage Service, all relevant assessments are included as part of the first conversation, to enable a provider to make an informed view on whether they are willing and able to take on the case.**
- **Where this service involves a risk of non-compliance, or lack of access to the adult, then a fully joined up plan for carers to record, escalate to their managers and for subsequent responses is agreed by all parties, including the adult and their family.**
- **That any ongoing problems with service delivery are reported by the provider, the case is allocated to a social worker, is regularly reviewed and is not closed until an adequate risk management strategy is in place.**
- **Where the above reviews identify risks of self-neglect and concerns about adults' insight into their care needs, the care plan is amended to document these.**

4.4. Finding 4

Adults with chronic physical disabilities, such as epilepsy, are at an increased risk of mental health difficulties and overall cognitive decline, especially where they are housebound. There are not currently clear links between physical health and mental health services to ensure these difficulties are suitably assessed and managed in the community, although they may be in hospital. Also, cognitive decline may indicate the need for an assessment of mental capacity, where decision-making is in doubt, but this is not routinely undertaken.

Example from the case

There are a number of references in document submitted to the review of Mr G's deteriorating mental health, in particular his mood which was described as depressed. He was never assessed or treated for any depressive disorder, which appeared to have been indicated by his presentation. This could have improved his engagement with services and overall wellbeing but does not appear to have been explored further by any health or social care service. He was noted to be depressed while in hospital and agreed to some therapy, but this was not followed up after he was discharged. Undoubtedly this was also complicated by his long-term excessive alcohol consumption, including his history of brewing beer in his flat, at times presenting with signs of delirium tremens at hospital admissions. Again, there was no indication of any assessment or support offered to him from alcohol services.

In terms of his overall cognitive functioning, this also seems to have been raised in a number of contexts as an area for concern, for example in Housing bidding he was described as being unable to manage his affairs. He was known to suffer epilepsy and had a series of head injuries, sometimes with cognitive damage. His personality changed with increased aggression noted, memory difficulties, confusion, and problems with concentration. Despite these concerns there is so far no record of any mental capacity assessment having been undertaken by anyone involved with him. Were this completed and if he lacked capacity this would significantly affected actions that could have been lawfully undertaken in his best interests.

Mental Capacity Act assessment practice was identified as a relevant local issue in another SAR undertaken by the same author last year in RBG and was further noted (in a recent national review of SARs[10]) as the most common area of poor practice in direct work with adults whose case were reviewed in the last 2 years.

Recommendations for the Board to consider

- **Where mental health problems, such as depression, are noted during a general hospital admission, this should be followed up by the responsible physician**

[10]https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

upon discharge, for further assessment and treatment if necessary, based on the clinical judgement of the doctor in the community

- **Where adults are diagnosed with both a mental illness as well as a physical disability, the need for ongoing suitable mental health support should be considered, subject to the clinical assessment of any relevant mental health practitioner. Such support should be reflected in any subsequent care planning**
- **If an adult is known to suffer a long-term condition associated with cognitive decline, this may indicate that their capacity is in doubt and therefore should prompt consideration of a mental capacity assessment, undertaken by the responsible decision-maker.**

4.5. Finding 5

It is common practice in Adult Services for Safeguarding S42 Enquiries to be suspended if a case is also being investigated by the police to avoid the risk of interference with potential criminal evidence. The individual circumstance of the case needs to be considered and discussed between the police officer leading the investigation and Safeguarding Adults Manager to facilitate both processes occurring in parallel, if this is necessary and appropriate. Such a discussion would avoid delays, and identify areas for single agency investigation in order to avoid sub judice. It would also improve the efficiency of both Safeguarding and Criminal Investigations.

Example from the case

After Mr G's final hospital admission and subsequent death in December 2016 a safeguarding concern was raised by the LAS after they had been called to attend his property by his sister on 23/12/16. The process of a S42 Safeguarding Enquiry was started with the case being allocated to a social worker. However, as the information was also shared with the local police, they instigated a criminal investigation to ascertain whether charges should be brough against the home carer/care agency at the time. This was complicated by a number of factors, for example the number of agencies involved and ascertaining to what extent neglect could be proved. This process took over a year before the CPS decided in Feb 2018 there was insufficient evidence for a criminal prosecution in the case and the safeguarding S42 Enquiry was then re-started in March 2018, some 15 months after the referral.

This safeguarding enquiry was undertaken on the basis of reports which were available 12 months earlier and it was not concluded until July 2018, a delay that the Adult Social Care Complaints Manager found unreasonable after the sister raised a complaint about this delay in November 2018. It would appear there is culture of Adult Social Care S42 Safeguarding Enquiries being suspended while police investigations occur but there were opportunities in this case for both process to occur at the same time, with information sharing which would allow a Safeguarding Enquiry to be completed without prejudicing/contaminating evidence for any potential criminal case. This would require careful consideration of evidence sharing between the police and Adult Services but work on this area for future similar cases would avoid such an extensive delay in the process.

Recommendations for the Board to consider

- **Where a safeguarding enquiry has begun and a criminal investigation is also undertaken, there is a plan for information sharing and cooperation, also an agreement whether both processes can appropriately continue to ensure neither process is unnecessarily delayed.**
- **Where there is a plan for these parallel processes to occur together, this includes key markers for any non-criminal enquiries as set out by police investigation team to avoid sub judice.**
- **The final decision as to what can be done as part of a Section 42 Enquiry and what areas that need to be avoided will be the decision of the Officer in Charge of the Criminal Process.**

4.6. Finding 6

The outcomes of either Adult Services' Safeguarding Enquiries or complaints investigations may lead to recommendations for improvements which are not always currently overseen sufficiently robustly to ensure these lead to real changes in organisational practice.

Example from the case

The Safeguarding process took over 18 months in total from the date it was first referred. The Complaints Process took 6 months before a final response was sent. In both processes the outcomes were that the allegations/complaints were upheld. However, there seems to have been little in the way of actions taken following these processes for the agencies/personnel subject to allegations of neglect being substantiated or complaints upheld. Also, recommendations which were made at the conclusion of these processes do not appear to have been monitored or reviewed to see whether or in what way they made any changes or improvements to practice.

Recommendations for the Board to consider

- **Safeguarding Enquiries which identify significant abuse/neglect by a care provider include a plan for service level improvements, which are proportionate to the level of harm and overseen by an appropriate body (for example the provider concerns process, commissioners, or CQC).**
- **That these recommendations are shared with any other provider to ensure that learning from one case can be applied to improve other similar services.**
- **Complaints Investigations which are upheld regarding the conduct of Adult Services are also sufficiently overseen to ensure any recommendations are implemented and effective.**

4.7. Finding 7

When an adult dies and there is also an ongoing, or concluded Safeguarding Enquiry, investigating whether abuse/neglect occurred preceding the adults' death, this information is not currently always conveyed to the registered medical practitioner for them to report this onto the coroner, to consider whether an inquest is required.

Example from The Case

When Mr G passed away in hospital, in December 2016 the doctor who signed the death certificate did not also report the death to the Coroner's Office, possibly as the death was not unexplained and so this was not required at the time. Since this time the Notification of Deaths Regulations 2019 came into force.

"As a result of the Notification of Death Regulations a senior coroner should expect to receive notification of deaths in the following circumstances:

(a)the registered medical practitioner suspects that that the person's death was due to.
(i)*poisoning, including by an otherwise benign substance.*
(ii)exposure to or contact with a toxic substance.
(iii)the use of a medicinal product, controlled drug or psychoactive substance.
(iv)violence.
(v)trauma or injury.
(vi)self-harm.
(vii)neglect, including self-neglect.
(viii)the person undergoing a treatment or procedure of a medical or similar nature; or
(ix)an injury or disease attributable to any employment held by the person during the person's lifetime.

(b)the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);"

Recommendations for the Board to consider

- **That any safeguarding enquiry undertaken into neglect or abuse, either pre- or post-death of the adult, is communicated to the relevant medical examiner and is then included in the reporting requirements for the medical examiner to report the death to the coroner for consideration of the cause of death.**

Mick Haggar
Independent SAR Report Author
April 2021

Appendix 1

List of Abbreviations used in the report

Abbreviation	Full Version	Explanation
RGSAB	**Royal Greenwich Safeguarding Adults Board**	The overarching purpose of the RGSAB is to help and safeguard adults with care and support needs by: • Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance. • Assuring itself that safeguarding practice is person-centred and outcome-focused. • Working collaboratively to prevent abuse and neglect where possible. • Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and • Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area. The Board meets four times a year and has an Independent Chair.
SAR	**Safeguarding Adult Review**	A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. It is a statutory review, commissioned by RGSAB, under Section 44 of the Care Act 2014.
KPE	**Key Practice Episode**	Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term ‘key practice episodes’ to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not

Abbreviation	Full Version	Explanation
		restricted to specific actions or inactions but can extend over longer periods. The term 'key' emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects. https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp
CAR Team	**Eltham Community Assessment and Review Team**	The Community Assessment and Rehabilitation (CAR) Teams is an integrated service that's made up of both health and social care professionals. The service can provide social care support for people who live in the Royal Borough of Greenwich, as well as health services for those with a Greenwich GP. The CAR Teams main focus is to ensure that everyone is given an opportunity to maximise their independence before they are assessed for their longer-term health and social care needs. There are 3 CAR teams covering the geographic areas of Woolwich, Eltham and Greenwich. Each CAR team also has a specialist service linked to it: 1. Greenwich CAR – Specialist Neuro-Rehabilitation Service 2. Eltham CAR - Greenwich Falls Prevention Service 3. Woolwich CAR - Intermediate Care bedded units https://www.greenwichcommunitydirectory.org.uk/kb5/greenwich/directory/service.page?id=p4-jKr_g0O4

LEO	**Lead Enquiry Officer**	An enquiry officer is responsible for undertaking actions under adult safeguarding. In some instances, there is a lead Enquiry Officer supported by other staff also acting as enquiry officers, where there are complex issues or additional skills, and expertise is required. The lead Enquiry Officer will retain responsibility for undertaking and co-ordinating actions under Section 42 enquiries https://www.proceduresonline.com/london/sab/chapters/p_lon_multi_age_sg_proce.html?zoom_highlight=Lead+Enquiry+Officer&zoom_highlight=Lead+Enquiry+Officer
SEG	**SAR Evaluation Group**	The SAR Evaluation Group will be co-chaired by the SAB's Metropolitan Police Representative and by a Senior Officer from Health and Social Care, RBG. Members of the SAR Evaluation Group will have appropriate levels of experience of safeguarding adults work and inter-agency working and will have suitable qualifications and seniority within their agencies. Members will be selected from agencies who are members of the GSAB. Consideration should be given to representation from the following agencies. • - Greenwich Adult Social Care • - NHS Greenwich Clinical Commissioning Group • - Greenwich Borough Police • - Oxleas NHS Foundation Trust (community health/mental health) • - Lewisham and Greenwich NHS Trust • - Legal representative from Royal Borough of Greenwich where required https://www.greenwichsafeguardingadults.org.uk/wp-content/uploads/2019/07/Royal-Borough-of-Greenwich-Safeguarding-Adults-Review-Policy-Procedure.pdf

MAR	**Medicine Administration Record (MAR) Charts**	A MAR chart is a working document used to record administration of medicines. They are normally produced by the pharmacy on a monthly basis at the time of dispensing and are delivered with the medication. All medicines for a client should be listed on an individual MAR chart; items such as dressings with no medicinal content have no legal requirement for MAR records to be kept, but it is good practice to do so for the purpose of creating a clear audit trail. http://www.pharmacy-xpress.co.uk/manuals/training-handbook/9-medicine- administration-record-mar-charts

Appendix 2

List of Terminology used in the report

Terminology	Explanation	Reference
Liaison Psychiatry	Liaison psychiatry is the specialty of psychiatry that deals with this relationship, and the link between people's physical and mental health. Most liaison psychiatry services are based within general hospitals. However, liaison psychiatry services may also work with GPs and with community health services.	**https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/liaison-psychiatry-services**
Computerised Tomography (CT scans)	A CT scan can detect conditions of the brain, like stroke and vascular dementia. The images produced by a CT scan provide detailed information about brain tissue and brain structures.	https://www.bhf.org.uk/informationsupport/tests/brain-scans
Ventricles	Ventricles are cavities within the brain filled with cerebro-spinal fluid (CSF) acting as a 'cushion'. CSF also supplies nutrients to the brain.	https://www.gosh.nhs.uk/conditions-and-treatments/conditions-we-treat/ventriculomegaly
Sulci	In neuroanatomy, a **sulcus** (Latin: "furrow", pl. *sulci*) is a depression or groove in the cerebral cortex. It surrounds	https://en.wikipedia.org/wiki/Sulcus_(neuroanatomy)

	a gyrus (pl. gyri), creating the characteristic folded appearance of the brain in humans and other mammals. The larger sulci are usually called fissures.	
Low attenuation	**Attenuation** is a feature of **CT**, and **low attenuation means** that a particular area is less intense than the surrounding.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2884142/
Pneumonia	**Pneumonia is swelling (inflammation) of the tissue in one or both lungs. It's usually caused by a bacterial infection. It can also be caused by a virus, such as coronavirus (COVID-19).**	https://www.nhs.uk/conditions/pneumonia/
Aspiration	Pulmonary aspiration is the medical term for a person accidentally inhaling an object or fluid into their windpipe and lungs. This can lead to coughing, difficulty breathing, discomfort, and sometimes choking.	https://www.medicalnewstoday.com/articles/324611
Aspiration Pneumonia	**Aspiration pneumonia** is a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs. Signs and symptoms often include fever and cough of relatively rapid onset. Complications may include lung abscess.	https://en.wikipedia.org/wiki/Aspiration_pneumonia
Generalised Tonic-clonic Seizure	This type of seizure (also called a convulsion) is what most people think of when they hear the word "seizure." An older term for this type of seizure is "grand mal." As implied by the name, they combine the characteristics of tonic and clonic seizures. Tonic means stiffening, and clonic means rhythmical jerking.	https://www.epilepsy.com/learn/types-seizures/tonic-clonic-seizures
Thiamine100s tds.	**Thiamine** (**vitamin B1**) is **used** to prevent or treat low levels of **vitamin B1** in people who do not get enough of the vitamin from their diets. Most people who eat a normal diet do not need extra **vitamin B1**. **Thiamine** (**vitamin B1**) is **used** to prevent or treat low levels of **vitamin B1** in people who do not get enough of the vitamin from their diets. Most people who eat a normal diet do not need extra **vitamin B1**.	https://www.ebmconsult.com/articles/thiamine-administration-before-iv-glucose-alcoholics

Carbamazepine 400 mgs bds.	Focal and secondary generalised tonic-clonic seizures, Primary generalised tonic-clonic seizures	https://bnf.nice.org.uk/drug/carbamazepine.html
Calcichew 1 tablet bd.	Calcichew-D_3 Chewable Tablets may be used as an adjunct to specific therapy for osteoporosis or as a therapeutic supplement in established osteomalacia, pregnant patients at high risk of needing such a therapeutic supplementation or malnutrition when dietary intake is less than that required.	https://www.medicines.org.uk/emc/product/5231/smpc#gref
Folic acid 5 mgs daily.	Folic acid is the man-made version of the vitamin folate (also known as vitamin B9). Folate helps the body make healthy red blood cells and is found in certain foods. Folic acid is used to treat or prevent folate deficiency anaemia	https://www.nhs.uk/medicines/folic-acid/
Alendronic Acid 70 mgs once a week	Alendronic acid is a type of medicine called a bisphosphonate. It helps your bones stay as strong as possible. It can help if you have or are at risk of getting a health problem called osteoporosis. This is where your bones get weaker and more likely to break.	https://www.nhs.uk/medicines/alendronic-acid/
Post ictal state	The **postictal state** is the altered state of consciousness after an epileptic seizure. It usually lasts between 5 and 30 minutes, but sometimes longer in the case of larger or more severe seizures, and is characterizedby drowsiness, confusion, nausea, hypertension, headache or migraine, and other disorienting symptoms. Additionally, emergence from this period is often accompanied by amnesia or other memory defects. It is during this period that the brain recovers from the trauma of the seizure.	https://en.wikipedia.org/wiki/Postictal_state