Kingston upon Thames Safeguarding Adults Board

L Safeguarding Adults Review: Overview Report

Author: Clive Simmons
Date: August 2019
Review Date: TBC

Contents

1. Introduction 3
2. Circumstances leading to the review 4
3. Pen Picture.....5
4. Facts..... 6
5. Critical analysis of facts..... 23
6. Findings..... 38
7. Recommendations to improve services and reduce risk..... 39

1. INTRODUCTION

1.1. The Kingston upon Thames Safeguarding Adults Board commissioned a Safeguarding Adults Review at a SAR Sub-Group meeting on 12/03/19, following the death of Mrs L, an older person, in Kingston Hospital on 27/11/17. L had been admitted to hospital from Galsworthy House Nursing Home on 23/11/17 with an infected sacral pressure ulcer. This followed a history of self-neglect, whilst a range of health and social care agencies endeavoured to provide support.

1.2. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when certain criteria are met. These are:

- When an adult has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected, and;

- There is a concern that partner agencies could have worked more effectively to protect the adult.

1.3. Safeguarding Adults Reviews are required to reflect the six Safeguarding Adults principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership and accountability.

1.4. The aims of the Safeguarding Adults Review are to contribute to the improved safety and wellbeing of adults at risk and, if possible, to provide a legacy to L and support to her family.

1.5. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis of the facts with findings (what went wrong and what went right), recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

1.6. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has conducted research by critically analysing Individual Management Reports, chronologies and relevant records held by involved agencies and by interviewing representatives of agencies; culminating in a presentation to the Kingston upon Thames Safeguarding Adults Board for endorsement and

a planned Safeguarding Adults Review multi-agency workshop to progress wider learning from the review.

1.7. The review refers to contextual information from 2012 and concentrates on the most relevant period, from April to December 2017.

1.8. A contribution by family to the review has been enabled through a meeting by the Reviewing Officer with A (brother-in-law) and V (related to brother-in-law).

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

- Peripatetic Manager – Caring Homes
- Deputy Manager – Galsworthy Nursing Home
- Adult Safeguarding Lead - Your Healthcare
- Team Leader – Your Healthcare, Impact Team
- General Practitioner – Groves Medical Centre
- Safeguarding Adults Lead - SWLSTG Mental Health Trust
- Team Manager – SWLSTG Mental Health Trust, OPCMHT
- Team Manager – RBK, Adult Social Care, MH Social Care Team
- Team Manager – RBK, Adult Social Care, Access Team
- Safeguarding Adults Lead Nurse – Kingston Hospital
- Tissue Viability Nurse (TVN) Specialist – Kingston Hospital
- Junior Sister, Emergency Department – Kingston Hospital
- Lead Nurse, Safeguarding Adults – Kingston CCG
- Adult Safeguarding Lead – Richmond CCG
- Community Nursing – Hounslow & Richmond Community Healthcare NHS Trust (via email)

2. CIRCUMSTANCES LEADING TO THE REVIEW

2.1 Mrs L had lived independently, with minimal support, in her home within Richmond Borough until she was admitted to Kingston Hospital in July 2013 with an infected leg ulcer. She transferred to Galsworthy House Nursing Home in August 2013 with high dependency physical health care needs. L experienced a significant deterioration in her physical and mental health from about April 2017 and more prominently in November 2017. This, combined with non-acceptance by L of some essential care and treatment, culminated in her admission to Kingston Hospital and her death on 27/11/17.

2.2. The Kingston upon Thames Safeguarding Adults Board was satisfied that the conditions for a Safeguarding Adults Review were met regarding L

as, at the time of the incident, she was an adult with care and support needs who it is suspected may have died due to neglect or self-neglect, and it is suspected that services should have been more proactive in protecting her; meeting the conditions outlined in The Care Act 2014, Section 44.

2.3. The review has also overlapped with a Coroners' Inquest, which concluded at a hearing on 16/05/18 with an outcome of death by natural causes. Cause of death was confirmed as (1a) Sepsis, (1b) pressure sore and (2) frailty, chronic kidney disease.

2.4. The Safeguarding Adults Review has been completed by an Independent Reviewer from March to August 2019, following agreement to SAR Terms of Reference and the receipt of Individual Management Report requests by May 2019. The role of the Reviewer incorporates responsibilities as the Safeguarding Adults Review panel meeting chair and the author of this overview report, alongside the development of a multi-agency action plan and an executive summary report. It is anticipated that the report will be published on the Safeguarding Adults Board website, as is the standard practice.

2.5. The overview report and the composite action plan will be presented to the Safeguarding Adults Board SAR Subgroup and to the SAB Executive Board for endorsement and monitoring.

2.6. The Safeguarding Adults Review has focused on the following key themes, as agreed at the initial planning meeting:

- The effectiveness of intervention in meeting physical health needs
- The effectiveness of intervention in meeting mental health and mental capacity needs
- The effectiveness of multi-agency communication, risk assessment and safeguarding adults in improving safety and wellbeing
- The compliance of agencies with relevant legislation, policies and procedures, and whether these were fit for purpose
- The organisational, resource and environmental impacts on decision-making

3. PEN PICTURE of L

3.1. L was born in North Germany, the youngest of three sisters and a brother (all of whom she survived). Her father served as Mayor of their home town. She met her husband from England, C, when she was working as a translator and he was with the British Army in post-war Germany. They married and settled in London with his parents, before moving on their own to a flat in Richmond. L and her husband did not have children. Her husband died

in 2005 and L never overcame her grief, for some time visiting his nearby grave on a daily basis.

L was fluent in English, German and French languages and she travelled frequently, including to Germany. She had started medical training, which was interrupted by war, and she later worked in the Richmond Records office.

Her family state that L hated leaving her own home to live in a nursing home and that she 'took to bed' from the moment she arrived. They are uncertain as to the reason for her withdrawal from support but mention that she became frightened and suspicious of others, could not accept her disability, was in great pain when receiving care, and also that this was in keeping with her nature. She is described as having a very determined character. Her family say that she could be very kind and caring towards people whom she liked, or otherwise to people whom she disliked. Towards the end of her life, L had limited contacts, except regular telephone calls with two brothers-in-law and a sister-in-law in France.

4. FACTS

Prior to May 2013

4.1 On 13/02/12, L underwent a right knee replacement at Kingston Hospital.

4.2 In 2013, L continued to live alone and independently in her own home in Richmond, receiving practical support with shopping, cooking, cleaning and laundry. Richmond and Wandsworth Social Services do not have a record of L declining support in the community. A record of L's engagement with Community Health Services, as contextual information, could not be obtained in the completion of this review.

May 2013 to March 2017

4.3 A vascular surgeon at Kingston Hospital documented on 09/05/13 that L had a grade 3 pressure ulcer on her left leg. Her family confirm that she experienced leg ulcers from about 2010 and had attended appointments at the Chelsea and Westminster Hospital. There is no indication that a safeguarding adults response was considered at this time.

4.4 On 23/07/13, L was admitted to Kingston Hospital due to infected leg ulcers, hypothermia and general ill health. The hospital made a referral to Richmond Social Services on 04/08/13 for a nursing home placement on discharge and her brother-in-law, A, looked for a suitable home in liaison with Social Services. At this point, L was found to be bedbound and had high dependency care needs. There was no further hospital admission until 23/11/17.

4.5 On 12/08/13, L was discharged from Kingston Hospital to Galsworthy House Nursing Home. The home caters for up to 72 elderly residents,

providing residential, nursing and dementia care. The placement was initially on a respite basis and self-neglect in the community was noted as a factor, as L was unable to care for herself at home and had a difficult engagement with the visiting care team. L was supported in bed at the nursing home and initially expressed a wish to walk again and return home. She was supported by a Physiotherapist with the aim of enabling her to sit in a chair, but the service ceased due to a difficulty with engagement. Her family believe that her leg ulcers improved whilst residing in the nursing home.

4.6 A plastic surgeon at Kingston Hospital reported on 16/08/13 that the leg wounds were slowly improving, the dressings were more comfortable, and that LW was not fit for further surgery.

4.7 On 22/08/13, a Your Healthcare Tissue Viability Nurse (TVN) visited L at the nursing home for the first time. The medical history recorded by the TVN does not refer to any mental health concern. The TVN advised staff to apply dressings from toe to knee and provided assessment and advice, including advice on pain relief.

4.8 On 29/08/13, the same TVN visited jointly with a leg ulcer specialist. They redressed L's legs with her consent and advised staff at the home that dressings should be changed every three days. There was no complaint of pain at this time. A Galsworthy House Registered Nurse reported that L was resistant to care, at times directing staff on what products and dressings were to be used. L had double incontinence and at times declined support with changing continence pads when they were wet and soiled. She had developed a grade 2 pressure sore to her sacrum, which may also have been attributable to being confined to bed. The sore was described as a small skin break to her right buttock, measuring a half-centimetre. The TVN encouraged L to move onto her side and she was able to change position up to a point. A Proshield skin protectant was applied, which treats minor wounds but does not protect the skin from pressure ulcers. Staff at the nursing home were advised to contact the TVN if a review or advice were needed.

4.9 A Galsworthy House report, dated 10/09/13 and held at Groves Medical Practice, confirmed a medical history of venous leg ulcers. This condition is described by Kingston Hospital as a natural process, involving faulty heart valves which cause poor blood circulation or supply back to the heart, and usually affects lower limbs. It is generally due to factors such as ageing, poor nutrition, being confined to bed and skin damage, relating to pressure. The condition is improved by mobility, compression (tight bandaging), and elevating legs (as helps venous return of blood due to gravity, but can lead to sores on buttock). This is a different pathology to an arterial supply sacral pressure sore, experienced by L at a later stage (and covered later in this report), which relates to blood circulation from the heart outwards. The report also indicates a history of renal failure, right knee osteoarthritis, anaemia, fractured vertebrae and cataract extraction. L was prescribed BuTrans

transdermal patches for pain relief and Amitriptyline (an antidepressant that is also prescribed to treat chronic rheumatic pain).

4.10 On 18/11/13, L became a permanent resident at Galsworthy House Nursing Home on a private basis.

4.11 L was registered with the Groves Medical Centre from 13/12/13.

4.12 On 11/06/14, a Continuing Care Assessment completed by a Continuing Health Care (CHC) nurse, with a nursing home Registered Nurse (RN) present, incorporating a health needs assessment. L was deemed to be capacitated to take part in the assessment and she fully contributed. She stated that she had previously lived with her husband, who had died approximately 7 years ago, that she did not cope well after his death and was subsequently detained under the Mental Health Act. The Registered Nurse said that L can be very particular about which staff she allows to care for her (beyond a reasonable realm of choice), which was presenting a challenge to the home. There were no concerns about cognition and L was able to make decisions about her daily care. L said that she was not depressed but felt sad due to the losses in her life, including her independence and her husband. She confirmed a concern about the personalities of some staff, with those she likes making her feel better and those she does not like making her feel low in mood. L explained that she was staying in bed all the time as her leg was painful when she moved, and that this was due to a previous fracture. The assessment concluded that L required a change in position every 5 hours, dressings to bilateral leg ulcers twice weekly, and medication; including Amitriptyline, Trimethoprim and BuTrans transdermal patches. There were no nutritional concerns and no other pressure ulcers at this time. The BuTrans transdermal patch was discontinued at the nursing home on 10/09/14 and the home regularly offered paracetamol, at times documenting as refusing or not required.

4.13 On 09/03/15, Galsworthy House referred L to the TVN for advice as at times she was presenting as non-concordant with care. The same TVN as previous visited on 23/03/15, with a nursing home Registered Nurse also present. L was staying in bed all day through choice. She said that she could not lie on her side due to a previous fracture of her vertebra and her knee was very fixed and unable to bend. L was able to pull herself onto her left side, without difficulty, to enable examination of her sacrum. There was a very small area of superficial scuffing to her left buttock, which had almost healed. She was heavily soiled with faeces and was supported by cleaning. L was lying on a towel at all times, which she said she needed in case the continence pad leaked. She was declining to use sheets and wished also to be covered in towels. L also asked for a towel to be placed over the bed rail bumpers as she said that she was allergic to the material (which it is understood would not have been the case). The TVN explained to L the importance of changing position in bed. L responded that she needed to sit up in bed for activities and that she could move herself around. The TVN noted that L was at risk of

pressure damage, explaining the risk to her, but that her skin was intact at that time. She considered that L had mental capacity (unclear if relating to the risk of declining care) and had no disturbance of the mind or brain. The TVN closed her involvement at this point.

4.14 A Deprivation of Liberty Safeguards (DoLS) Mental Health Eligibility Assessment (form 4) was completed on 10/07/15, following a referral by the nursing home to Adult Social Care for a DoLS authorisation. L was assessed as having the mental capacity to decide whether to be accommodated in the nursing home; understanding her physical health concerns and why she could not live alone, and retaining and weighing up this information. L said that she had struggled since death of her husband, had leg ulcers and could not walk, needed help with activities of daily living, and that it was impractical for her to leave the nursing home.

4.15 On 14/07/15, a DoLS Age, Mental Capacity, No Refusals, Best Interest Assessment (form 3) was completed, based on a Best Interest Assessor visit to L on 29/06/15. A previous visit had been cancelled as L had not engaged with the assessor. On this occasion, L engaged well, said that she was happy with the care that she was receiving in the nursing home, and planned to move to a flat with family support when she was fit enough. L presented with some paranoid ideas, stating that 'they are watching me.' It should be noted that this did not trigger a referral for a mental health assessment. She was reluctant to be supported by any other members of staff than a particular nurse, unless he was on leave, and two carers attended due to her mistrust of staff. There was no apparent confusion or memory impairment. Galsworthy staff advised that L's capacity fluctuated and that she could present at times as paranoid. It is the view of the General Practitioner in this review that acute onset paranoia appeared suddenly in July 2015. L was nursed on pressure mattress, was reluctant to accept medication and medical interventions, and was deemed to possess full mental capacity. As part of this review the Deputy Manager, a Registered Nurse at Galsworthy House who was familiar with L, confirmed that she believed L had capacity to make decisions in relation to her care needs. She added that L spent most of her time in bed through choice, having had the ability to sit out of bed in a chair, from her admission to the nursing home throughout her stay. L felt more comfortable in bed with many of her personal belongings around her. She expected care to be delivered according to her wishes and she did accept support with personal care, dressings and medication (although she would query the prescribed drugs). L did not like new people in her presence and would send many visitors away due to her suspicion of them. She experienced delusions for some years at the nursing home but it is understood that she only presented as anxious about her physical health decline in the months before she died. L never asked to go home.

4.16 From 14/10/15, the Your Healthcare Impact Team provided regular dressing prescriptions for L's leg ulcers through 2016 and 2017, up to the next

TVN visit. The Impact Team is an acute nursing service for the receipt of dressing prescriptions from all nursing homes in the Kingston Borough. The team receives referrals, wound assessments and care plans from referring nursing homes and reviews these before prescribing. The service does not usually visit residents, as nurses within the homes are considered to have expert knowledge, and L was not visited on this basis. The referral for L was not seen as unusual and there was no mention of a sacral pressure ulcer. The service did not have any concerns about the information received from the nursing home. Your Healthcare did not have any further involvement with L after March 2015, aside from dressings prescriptions, until November 2017.

4.17 A Funded Nursing Care (FNC) review was completed on 17/03/16, during which L gave an accurate account of her care needs. Her medical history was recorded and there was no reference to mental health needs. It was noted that her behavioural needs had reduced and that she liked certain carers, with no concerns raised regarding this. There was a general comment that L had mental capacity (possibly related to the review), presenting with a cheerful disposition and with no indication of distress. L was watching television and chatting to staff. She believed that she was being monitored and said that 'they think I am a spy.' Nutrition remained a low level need as she enjoyed food. L did not accept the use of a hoist to measure weight, but there were no concerns in this regard. The leg ulcers had reduced considerably in size and no further ulcers had appeared. There is a record of an air mattress in use, which corresponds to a note in 2014, and the referral to the TVN in November 2017 refers to an overlay pressure relieving mattress. There was a Waterlow score at this time of 16.

4.18 A Galsworthy House care plan in March 2016 identified that L had mental capacity, was very articulate and was able to communicate her wishes. It was noted that she was in charge of her own affairs with support from A, who it was believed had Power of Attorney. L was drinking and eating unassisted, had severe venous ulceration to both legs which were dressed every 3 to 4 days, and pressure areas were intact. She was nursed on an air mattress with towels on top. This should have been a concern as the towels would have been a layer between her skin and the air mattress, reducing the benefit of the mattress and also possibly soaking any urine spillage and leaving this against her skin. L often declined repositioning in bed. She liked to lie on her back for comfort and in order to watch television and see through the window. L accepted support with repositioning for personal care but not otherwise. She received full assistance with personal hygiene and dressing, and declined monthly weighing due to the pain involved. There had also not been a record of weight prior to admission to the nursing home. The General Practitioner was fully aware of the general situation. L managed a normal diet with medium portions. She had double incontinence. Galsworthy House representatives consider that, at this point, L was compliant with care.

4.19 A Groves Medical Centre record on 27/04/16 states that L received regular dressings through 2013 and 2014, alongside episodic antibiotics to cover the infection and chronic leg problems. There is a note of a recurrent infection in her lower leg, for which she was prescribed Amitriptyline and Gabapentin. L was receiving regular reviews of medication, bloods (showing anaemia) and dressings to her legs.

4.20 Galsworthy House made a further referral for a DoLS authorisation on 28/07/16, due to the use of bed rails and resistance to support, and a DoLS Mental Health Assessment (form 4) was completed on 30/07/16. This confirmed that L had mental capacity specific to her placement. During the assessment, L presented as irritable and impatient. She was aware that she had complex medical needs and was unable to weight bear or walk, requiring support with activities of daily living. It was considered that L had a mild cognitive impairment, secondary to dementia, but not of a severity to impact on her mental capacity. It should be noted for the purpose of this review that at no time had there been a screening for or formal diagnosis of dementia.

4.21 A DoLS Standard Authorisation Not Granted (form 6) was completed on 10/10/16 on the basis that the mental capacity requirement was not met, as L was deemed to possess full mental capacity in relation to her residence and care at the nursing home.

4.22 On 04/01/17, a Groves General Practitioner visited L at Galsworthy House to complete a review and, for the first time, concern was raised about her poor appetite. Low mood was also noted as a concern. There is no indication of the cause of these factors, including whether these may have been a reaction to declining physical health and mobility. The GP advised staff to provide encouragement to L. A further visit was completed on 11/01/17. L presented as confused and was unable to recognise family members, which did not appear to be explored or explained. Staff were advised to monitor.

April to November 2017

4.23 A further DoLS Request for Standard Authorisation (form 1) was completed on 27/04/17 by Galsworthy House and forwarded to Adult Social Care, as L appeared to lack mental capacity concerning her safety and was often reluctant to receive care. This presents as the first significant recording of L declining considerable aspects of care and treatment at an increasing level. L required the support of 2 staff for all activities of daily living. It was noted that the person holding an Enduring Power of Attorney (not A at this point) was revoking his authority. Also, L was described as living with dementia, in the absence of a clinical assessment to determine whether this was the case.

4.24 A Solicitor acting for A sent a letter to the Groves Medical Centre on 26/05/17, requesting a 'solicitors' Mental Capacity assessment to support an application to the Court of Protection for deputyship, covering financial and

health and welfare areas. In response, it is understood from a Groves representative that a General Practitioner completed an assessment and confirmed that L lacked capacity in relation to both aspects. However, there is no record to confirm this and the assessment is not understood to have involved a formal Mental Capacity Assessment.

4.25 On a General Practitioner visit to L on 21/06/17, it was noted that L had a poor appetite. Advice was given to arrange blood tests and a dementia screening (which did not take place).

4.26 From 27/06/17 to 15/11/17, there is a record of 6 prescriptions for dressings.

4.27 A General Practitioner visited L on 05/07/17 and noted delusional thoughts and paranoia. L believed that her family had been cloned. She was also losing weight. A referral was made for a DoLS authorisation and also for a Psychiatric assessment.

4.28 The first record of involvement by the Kingston Older Persons Community Mental Health Team (OPCMHT), part of South West London and St George's Mental Health trust, was on 06/07/17, on receiving the GP referral on the same date. The team is led jointly by a Social Work Team Manager and Consultants, working in partnership. It provides mental health assessment, treatment and social care in a range of settings, with an emphasis on community care, to older people. The Trust does not have a record of any known psychiatric history prior to this referral.

4.29 On 07/07/17, an OPCMHT Occupational Therapy duty visit to L was undertaken. A presenting concern was noted as paranoid ideation over the previous few months, with L believing that staff had installed cameras and that people were clones. It was also a concern that L had become more withdrawn. She had a reduced appetite and weight loss, eating selectively but not exhibiting any ideas that her food was being poisoned. L had reduced interest and no longer listened to music or watched films. She was seen in her room, lying in twisted position on her back in bed. L calmly and insistently said that she would not answer any questions as she was perfectly happy and that whatever she said would be distorted. The plan at the conclusion of this visit was for the nursing home to initiate a food and fluid chart and for a further Multi-Disciplinary Team Meeting (MDT) discussion.

4.30 A Continuing Care Assessment, scheduled for 13/07/17, was cancelled. L continued to be cared for as an FNC resident and a review of this status was due, as the previous review had been completed on 13/03/17. The reason for cancellation is not known and the intention was to rearrange the appointment, but this did not take place. In terms of any significance to the delivery of nursing care, at this time there was no skin breakdown to her bottom or sacrum. Had the review been undertaken, there may have been a note as to whether L was more resistant to care. It is unclear whether this would have

been a trigger for wider concern, as the mental health concern and declining support were already known.

4.31 The General Practitioner rang the OPCMHT on 17/07/17 to confirm that bloods had been taken but that an Electrocardiogram (ECG) was not possible as there was no appliance at the nursing home and it was unclear whether L could attend the surgery. It should be noted that there is a Rapid Response Team with a mobile ECG machine, but this may not have been available in 2017. This contact followed a request by the OPCMHT for results of the blood test on 13/07/17.

4.32 An OPCMHT Consultant visited L on 19/07/17 and recorded an impression of late onset psychotic disorder, with a differential or preliminary diagnosis of presenting factors; depression, dementia, refusing all medication, very psychotic and weight loss. It should be noted that depression and dementia had not been formally diagnosed. The Consultant spoke with L's sister-in-law, who agreed to discuss the option of covert Olanzapine with A, L's brother-in-law.

4.33 The Consultant sent an email to the OPCMHT Team Manager on the same day, requesting Community Psychiatric Nurse (CPN) input. The communication identified that L had a late onset psychotic disorder, was very resistive and was refusing medication. It was further noted that family agreement to covert Olanzapine was awaited. A formal Mental Capacity Assessment in this regard and a formal assessment, if completed, was not recorded. A Community Psychiatric Nurse (CPN) was allocated at an MDT meeting.

4.34 Also on the same day, the OPCMHT Consultant sent a fax to the General Practitioner (GP) regarding the visit. This stated that L had been seen on that day, was very psychotic and refusing medication. L was described as not having the capacity to refuse the medication and that her brother-in-law and sister-in-law agree with using covert medication. The GP was advised that weekly CPN visits would commence. L had become paranoid in recent months; she believed that relatives were cloned and often spoke to them as though they were dead; and that anything she said would be recorded and twisted, so that she often refused to speak to professionals. At times, L mentioned being poisoned. L was described as not resistant to full nursing care received, at times tearful but not appearing to be overtly depressed to staff, experiencing pain when moved but not when still, refusing all medication since admission to the care home (although the nursing home states that this began at a later point). A preliminary diagnosis of persistent delusional disorder was stated, pending the exclusion of delirium. There was a possible depression, but this was not evidenced at the time. The plan was outlined as administering covert Olanzapine and providing weekly CPN monitoring. The OPCMHT were awaiting physical health information from the GP on delirium.

4.35 On 19/07/17 the GP visited L at Galsworthy House. The surgery records indicate that the CPN had recommended a blood test and an ECG and that a Psychiatrist had visited but L was uncooperative.

4.36 On 22/07/17, the OPCMHT received a referral from the GP to complete a Mental Health Assessment.

4.37 On 25/07/17, an OPCMHT Community Psychiatric Nurse visited L as her care coordinator. The CPN recorded that L presented as pleasant, said she was fine and kindly asked her to leave as she did not wish to talk. A staff nurse at the home advised the CPN that, since starting Olanzapine on 22/07/17, L was engaging and smiling more, her appetite had increased and she was eating three meals a day daily, she no longer talked about her family having been cloned and she was not resistant to personal care. The CPN provided feedback to the MDT on 26/07/17 and planned to visit again on 08/08/17.

4.38 A risk assessment was completed at Galsworthy House in August 2017. This concluded that there was a high risk of pressure ulceration due to immobility, that L had been made aware of the importance of changing her position frequently but most of time declined to do so and preferred to stay on her back. She was considered to possess full mental capacity in this regard.

4.39 On 09/08/17, the CPN and a student nurse visited, but L was declining to see any visitors at the time. They were advised by an RGN on duty that L was compliant with medication and personal care and was eating well. At a subsequent MDT, the Consultant noted the absence of psychosis.

4.40 A Care Programme Approach (CPA) Review was held by the OPCMHT at Galsworthy House on 15/08/17, at which L, the Consultant and student were present. It was agreed that L was doing well after commencing Olanzapine and the outcome of the recent visit was noted. L was discharged by the OPCMHT following this review.

4.41 A letter by the Consultant Psychiatrist on 15/08/17 reported a significant improvement in L's mental state, that her agitation and psychotic symptoms had disappeared. The Consultant considered that L did not have the mental capacity to discuss medication and that covert medication should be continued in her best interests.

4.42 On 16/08/17, the GP visited L at Galsworthy House. L refused a blood test and an ECG and was deemed to have full mental capacity.

4.43 On 23/08/17, an OPCMHT administrative letter was sent to the GP, stating that L had been visited on 15/08/17. This noted that L's mental state had significantly improved since commencing Olanzapine, she was allowing care (including dressings), was eating limited amounts and did not appear to be losing weight, but was refusing to be weighed. Any psychotic symptomology had totally disappeared. It was felt that L did not have the mental capacity to enter into discussions about medication and that it was in

her best interests to continue with covert administration to maximise her quality of life. The letter recorded that L was to be discharged back to Primary Care. There was no further OPCMHT involvement until 21/11/17.

4.44 The GP visited L on 06/09/17 in relation to her experiencing a poor appetite. A referral was not made for specialist dietician support at any time by either the GP or the nursing home.

4.45 A further GP visit was completed on 26/09/17. The record of this visit shows that L was considered to have capacity, was declining blood tests and wished to be left alone. A point was raised to discuss an advanced care plan with family if L was refusing hospital admission.

4.46 The GP visited L again on 03/10/17 and 17/10/17. L still had a low nutritional intake and was taking a Fortisip supplement twice daily.

4.47 In the Galsworthy House daily notes on 03/11/17, there is a report of a wound noted on her right buttock, which is the initial recorded evidence of the sacral pressure ulcer that led to hospital admission later in the month.

4.48 In daily notes recorded at Galsworthy House from 04/11/17 to 23/11/17 (there were entries for all days), there is an indication of further deterioration in L's condition and an increasing tendency to decline support. The notes confirm that L had little appetite and Fortisip supplement was provided, there was variable acceptance of repositioning, and the wound on her buttock was being cleaned and redressed.

4.49 A Galsworthy House wound assessment chart on 13/11/17 noted a grade 3 pressure sore on L's right buttock, measuring 5 centimetres by 2 centimetres.

4.50 An urgent referral was faxed on the same day by Galsworthy House to the Tissue Viability Nurse, requesting advice and a reassessment due to the grade 3 pressure ulcer on L's buttock, with the same measurement provided. The referral was picked up by the TVN on 16/11/17 and recorded by the TVN as received by her on this date. The TVN rang Galsworthy House on 16/11/17 and a home visit was arranged for 20/11/17. The delayed response was due to an administrative error and, as the service is advisory and the nursing home had expertise in this area of care, the error is unlikely to have impacted on L's care.

4.51 On 14/11/17, the GP visited L at Galsworthy House, noting the sore on her buttock and that her appetite was low.

4.52 On 15/11/17, a risk assessment review was completed by Galsworthy House. It was recorded that L had a pressure ulcer on her sacrum and that this had been referred to the TVN on 13/11/17, with a delay until the TVN visited on 20/11/17. The agreed action was to encourage frequent position change, although this was mostly declined by L; to complete an intake, food

and fluid chart; and to ensure frequent continence pad checking and changing. A referral was not made to the dietician at this point by the nursing home or the GP.

4.53 On 16/11/17, Kingston Adult Social Care Access Team received a safeguarding adult's referral from Galsworthy House, relating to a grade 3 pressure ulcer, caused by an unwise decision to decline repositioning in bed; and also declining treatment. It was stated in the referral that L had capacity to make this decision and that staff had explained the risks to her of remaining in the same position all the time. They had also referred to the TVN service. As part of this review, the Galsworthy House Deputy Manager commented that at the time she felt she needed multi-agency support in deciding what to do; that she asked for urgent Social Work allocation and was advised that this would take a few days, but had not occurred by the time of hospital admission.

4.54 The Access Team sent a referral to the Mental Health Social Care Team (within Kingston Adult Social Care) on 19/11/17. This relayed the following areas of concern; that L was refusing food and drink, repositioning, and hospital admission for intravenous antibiotics. It was noted that the pressure sore on L's buttock was now grade 4. L had been advised of the risks involved in these decisions. The purpose of the referral was stated as to request an urgent Mental Capacity assessment (MCA) on basis of fluctuating mental capacity, due to non-compliance with treatment and inadequate food and drink intake. L was considered to meet the threshold for a section 42 Safeguarding Adults Enquiry; with the intention to discuss concerns with L, establish her capacity to refuse treatment, complete a risk assessment and develop a multi-agency protection plan and, if appropriate, ask the Power of Attorney to make a best interest decision. It is unclear whether the Power of Attorney status of A had been confirmed at this time.

4.55 A Consultant Psychiatrist letter on 19/11/17 stated that L had no previous psychiatric history and over several months had become paranoid, with a diagnosis of Persistent Delusional Disorder. It was noted that L had been refusing all medication since her admission to the nursing home and was spending increased time in her room. The Galsworthy House Deputy Manager states as part of the review that L had stayed in her room since admission.

4.56 L was visited by the TVN on 20/11/17, having been referred by Galsworthy House due to rapid deterioration over the previous 48 hours; specifying a rapidly deteriorating category 4 sacral pressure ulcer (8cm x 5cm), deep tissue damage and a high risk of sepsis, but no reported pain in this area. It was also conveyed that L was incontinent of urine and faeces; required sufficient calories and protein to promote wound healing, but was declining to eat and was only drinking Fortisip supplement drinks. L was stated to be bedbound and needing 2-3 hourly repositioning to relieve pressure, but was refusing to be repositioned in bed. She had pain to her back and was declining an analgesic, but accepted paracetamol. Galsworthy House added that L's brother did not have Power of Attorney at this point, as it was not

activated. This was because she was considered to have capacity and was able to engage in discussion about her care.

4.57 A formal Mental Capacity Assessment (MCA) was completed by the TVN on 20/11/17, recorded in case notes and forwarded to the Mental Health Social Care Team (MHSCT) on 22/11/17. This is the first evidence of a recorded, formal MCA. L was assessed to lack mental capacity to make decisions concerning treatment of the pressure ulcer and that a Best Interest Decision should be taken regarding hospital admission. However, there was also reference in the report to variable capacity and it is unclear whether this related to capacity to make specific decisions or capacity at different points in time. The TVN explained the risk of infection and sepsis to L and concluded that she was unable to connect information on the pressure sore with her personal circumstances, and was therefore unable to weigh information. L was assessed to be able to understand and retain information, and to communicate her wishes. There was no underlying mental health diagnosis. The TVN advised staff to complete observations and blood tests. She further asked the nursing home to ask the GP to review mental capacity and consider hospital admission in L's best interests, as her wound was deteriorating rapidly. In response to this request, the GP decided not to refer to the OPCMHT for a psychiatric assessment until she had received family feedback on their views about hospital admission.

4.58 Galsworthy House records on 21/11/17 show that L said she understood the risk of an untreated pressure ulcer, including septicaemia, but did not wish to be admitted to hospital. This was understood to be due to her concern about a 'bad experience' previously at Kingston Hospital, although there is no apparent exploration or explanation of this concern. The risks of declining support were discussed with L and she stated that she wished to be left alone.

4.59 On 21/11/17, Galsworthy House emailed a second Safeguarding Adults referral to the Access Team, relaying information about a GP visit to L on the same day. The GP had completed what was understood to be a mini mental health assessment and was of the opinion that L had variable capacity. L was adamant that she would not agree to hospital admission and that her wishes must be respected. The risks of not attending hospital had been explained to her and A, her brother-in-law in France, was identified as having Power of Attorney for health and welfare and finances. He was very unwell, but L said that she would not make any further decisions until he visited. Galsworthy House had spoken to A's wife and explained that a referral to the Princess Alice Hospice for end of life care was the only other option. It is unclear whether this option was shared with L. AW and family were due to have a family conference on the same day and would report back to Galsworthy House. L was not believed to be in pain at the time. The GP said that she would speak with the OPCMHT Psychiatrist for further advice on hospital admission.

4.60 On 21/11/17, The Access Team contacted the TVN, who confirmed that L had a grade 4 pressure ulcer. The TVN confirmed that she had attempted a Mental Capacity Assessment (MCA), but when the pressure sore was raised, L closed the conversation and refused to engage further.

4.61 On 21/11/17, the Access Team contacted the Galsworthy House Deputy Manager, who confirmed that the TVN had visited on 20/11/17. The Deputy Manager clarified that the pressure sore had been aggravated by double incontinence. L consistently refused repositioning in bed, declined to eat but was taking Fortisep supplement, wished to be left alone, was at high risk of septicaemia, and was deemed to have capacity following the TVN assessment but that this was variable. The Access Officer advised that the GP should complete an MCA if there were concerns about mental capacity and, if appropriate, request urgent hospital admission. The Deputy Manager at Galsworthy House agreed to follow this up and also to contact A as the Power of Attorney.

4.62 Later on the same day, the Access Officer sent an email to Galsworthy House to confirm progress with allocation to conduct the Safeguarding Adults Enquiry, relating to the pressure ulcer and apparent fluctuating capacity. The Access Officer agreed to request urgent allocation but said that it may take a few days for allocation and a visit to be completed. Galsworthy House were advised, if immediate concerns for medical intervention arose, to ask the GP to complete a formal MCA to determine mental capacity to refuse repositioning, food and drink, and hospital admission. If lacking capacity, a Best Interest Decision should be undertaken by the Power of Attorney, Health professionals, under DoLS or as a Mental Health Act Assessment. Galsworthy House were asked to have a risk assessment and protection plan in place, pending social work allocation, and this was copied to Groves Medical Centre.

4.63 On 21/11/17, the Access Team Senior Social Worker (SSW) triaged the Safeguarding Adults Referral and forwarded this to the Mental Health Social Care (MHSC) Team duty tray, reinforced by an email to the MHSC Team Manager to recommend an urgent Safeguarding Adults Planning Meeting. The referral was received by an MHSC Team duty worker, who discussed this with the Team Manager. It was acknowledged that there was not a diagnosis of dementia, there was a diagnosis of persistent delusional disorder, and that L had been discharged from the OPCMHT in July 2017. The Duty Worker rang the GP and left a message, requesting urgent discussion on safeguarding and a Mental Capacity assessment (MCA).

4.64 On the same date, the Access Team Duty Officer rang the OPCMHT and spoke with an Occupational Therapist. The team had not received a referral from the GP. It was recognised that L was previously known to the team and had a diagnosis of persistent delusional disorder. Information was relayed that L had a grade 4 pressure ulcer and was refusing care and nutrition. The GP was concerned about whether L had mental capacity to consent to treatment and it was unclear if, underpinning this, she was psychiatrically unwell at the

time. The Access Officer was advised that a GP referral was required in order for the OPCMHT to complete a mental state assessment. Following discussion between the OPCMHT member receiving the call and their Team Manager it was agreed that, if an urgent referral was received, this would be discussed in the MDT and L's mental state could be assessed the following day. However, the OPCMHT would not assess L's capacity to make decisions regarding her physical health, which would have to be completed by the GP or London Ambulance Service (LAS). The team member spoke again to the Access Team Duty Officer to confirm that a GP referral would be awaited. The Access Team Duty Officer was unclear if the GP had formally assessed mental capacity regarding a specific decision and were awaiting the outcome of the GP discussion with family, one of whom apparently held Power of Attorney status.

4.65 Later on the same day, the Access Officer rang Galsworthy House, to be advised that the GP may have completed a Mini Mental State Examination (MMSE), rather than a Mental Capacity Assessment (MCA). The Access Officer was informed that L wished to be left alone. The TVN had spent a long time with L on the previous day, discussing the grade 4 pressure sore and the serious risk of death. In response, L repeatedly said that she accepted this. L was not eating or drinking enough to promote any healing of the pressure ulcer to occur. Her brother-in-law (as Power of Attorney) and sister-in-law were due to ring back that afternoon from their home in France, to feed back the outcome of the family meeting. A was unwell and it was unclear whether his illness was such that it may impact on his ability to act as Power of Attorney. The nursing home were continuing to encourage L to turn in bed and take in fluids, without success, and considered that there was an urgent need for a psychiatric assessment to establish whether the persistent delusional disorder was impacting on her decision-making. Galsworthy House had telephoned the OPCMHT regarding a psychiatric assessment, but were advised that the team could not act until it was in receipt of a GP referral.

4.66 Subsequently, the Access Officer rang the GP to request a copy of the MCA assessment that was understood to have been completed on the same day. The GP had visited L and noted that there had been a rapid deterioration of the sacral pressure sore. Hospital admission was discussed with L for fluid, protein and nutritional intake. L responded that she did not wish to be admitted to hospital for treatment. She was made aware that she may die unless admitted. L said that she wanted A to visit her and to decide with her. The family had been contacted to support in deciding on the appropriate course of action.

4.67 The GP advised that a mental capacity assessment had been completed verbally, without a record. She confirmed that she had known L for some time and her mental capacity had not changed, including in regard to pressure sore treatment and nutritional intake. The GP confirmed that the Mini Mental State Examination (MMSE) score had not changed over the previous few months. She clarified that a request for a copy of the mental capacity assessment

should be put in writing and left for her at Galsworthy House. The GP said that she was waiting on family feedback before deciding on a referral to the OPCMHT for a psychiatric assessment, Mental Health Act (MHA) assessment or referral to the Princess Alice Hospice for end of life hospice care.

4.68 The Access Officer consulted with the Access Team Manager and rang the OPCMHT to ask if they would accept a referral from the Access Team as a Safeguarding Adults action. The response was that a GP referral and clarification of the request were required.

4.69 The family contacted Galsworthy House to advise that they wished L to be nursed at the nursing home and referred to Princess Alice Hospice. This information was relayed to the Access Team and then to the MHSCT.

4.70 Adult Social Care sent a letter to Galsworthy House, advising that if L deteriorates, the GP should conduct a Mental Capacity assessment (MCA). The GP confirmed as part of this review that L had experienced a very rapid deterioration over the week prior to hospital admission.

4.71 A Safeguarding Adults Planning Discussion was held on 21/11/17, involving the MHSCT Manager and Enquiry Officer only, without invitations to other agencies. The case notes indicate that the GP considered L to have full mental capacity, but that it had to be established if a formal assessment had been completed and if this was decision-specific. It was believed that an MMSE, with a score of 14/30, had been completed rather than an MCA. The TVN had confirmed to the MHSCT that L did not have capacity to decide on treatment for the pressure sore and that, due to the risk of death, a best interest decision should be taken to arrange admission to hospital. The family of L wished her to be nursed at Galsworthy House, with palliative care input from the hospice if needed. The Safeguarding Adults Enquiry was closed on 24/11/17, as L had by that time been admitted to hospital for treatment of pressure ulcers.

4.72 On 22/11/17, Galsworthy House advised the GP that L's mental capacity was unclear due to recent mental health issues and that admission to hospital was necessary in her best interests. The GP agreed to contact the OPCMHT and advised repositioning every 2 hours. She visited L and completed a mental health assessment. As regards mental capacity, she recalls that L was very clear about declining hospital admission and met all four criteria to establish that she possessed the capacity to decline hospital admission. The GP explained to L the need for admission to hospital, but she still did not wish to go. L stated to the GP that she wished to see her brother-in-law and that she could not be forced to go to hospital. The Adult Social Care Access Team asked the GP to put the Mental Capacity Assessment on a form but, as recalled by the GP, neither knew which form she should use. The GP considers that she completed a formal MCA regarding hospital admission but that she did not record this.

4.73 On 22/11/17, the GP sent a letter to the OPCMHT, confirming the outcome of the MMSE test (14/30), that in past week L had developed a pressure ulcer which required hospital admission for treatment but that she was refusing, as she had also done in the past. The GP could not decide, based on the patient history, whether refusal was due to a mental illness or possible dementia, which the surgery had been aware of as a possibility but that it had not been formally diagnosed. The GP requested an assessment of her 'mental health capacity' in order to decide if she needs to be sectioned for admission to hospital, which suggests that a Mental Health Act (MHA) Assessment was being considered.

4.74 The Mental Health Social Care Team (MHSCT) forwarded the Safeguarding Adults Referral to the Adult Social Care North Locality Team Leader, on the basis that the GP had referred to dementia, requesting attendance at a safeguarding meeting that was likely to be held the following day. The MHSCT confirmed that a Best Interest meeting, involving the family, GP and nursing home would be arranged. The Galsworthy House Deputy Manager contacted the MHSCT to say she had asked the GP for an urgent psychiatric assessment, with the aim of hospital admission.

4.75 The OPCMHT Manager discussed L with the Consultant on 23/11/17 and agreed to ring the GP to clarify the task, as the referral received mainly related to refusing physical treatment. A call was made to the surgery receptionist and the outcome was to await a phone call from the GP; possibly to discharge if a call was not received.

4.76 On 23/11/17, A visited L at Galsworthy House. She recognised her brother-in-law and, when he relayed that 'they want you to go to hospital, will you please go', initially L said that she would not agree to admission. A left L to further discuss the situation with nursing home staff. He returned to see L in her room and advised that transfer to hospital was being arranged. When told this, L responded that "I do not have a choice do I?' L was admitted to Kingston Hospital on the same evening.

4.77 An admission review was completed by a doctor at Kingston Hospital on 23/11/17. Admission was recorded as due to an infected sacral pressure ulcer, which was described as venous and foul smelling; dehydration due to reduced eating and drinking for a few days; on antibiotics prior to admission; and that L denied pain or discomfort. A treatment plan was established, including pressure relieving care.

4.78 Kingston Hospital medical documentation in clinical notes on 24/11/17 recorded an impression of severe Sepsis due to multiple sources of infection, acute kidney injury and potential gastro intestinal bleed. L had a poor prognosis.

4.79 A referral was made to the Psychiatric Liaison Team, a Mental Health Trust resource that is based at Kingston Hospital, to determine if mental

illness was impacting on L's refusal of care. However, L had died before she could be seen by this service.

4.80 On 24/11/17, the TVN provided a record in the Kingston Hospital clinical notes. This stated that L had very fragile skin, small skin tears to her elbows and upper arms and extensive bruising to her lower arms. L said that she had not fallen and had not experienced ill treatment at the nursing home, adding that she liked living there. The cause of these injuries was not established. It was further noted that L had a grade 4 sacral ulcer (measuring approximately 8cm x 8cm), with bone felt at the ulcer bed, soft necrotic tissue on the right heel, at least grade 3 pressure damage to the left heel, superficial leg ulcers to the right leg, and a deeper leg ulcer with loss of skin layer to the left leg. A TVN specialist wound and pressure relieving care plan was put in place.

4.81 On 24/11/17, a Social Worker from the MHSCT Duty visited Galsworthy House to find that L had been admitted to hospital the previous night. He relayed this information to the OPCMHT Manager, who confirmed that she would ring the Kingston Hospital Psychiatric Liaison Service as the nursing home had reported that L was experiencing paranoid delusions, although the home did not consider that these were linked to her refusal of treatment and to the pressure sore.

4.82 The OPCMHT Community Psychiatric Nurse (CPN) rang the Kingston Hospital Ward Sister and was advised that L had settled on the ward, but was refusing to eat beyond a mouthful of food. The CPN relayed the Team Manager request for the Psychiatric Liaison Service to see her.

4.83 The Safeguarding Adults Concern was received by Adult Social Care from Kingston Hospital. This referred to a grade 4 pressure sore on L's sacrum, at least a grade 3 pressure ulcer on the right heel, a necrotic scar on the left heel and sepsis.

4.84 On a Doctors ward round at Kingston Hospital on 25/11/17, it was recorded that L was very unwell.

4.85 On 26/11/17, the Critical Care Outreach Team at Kingston Hospital recorded that there was no improvement in L's condition. Sepsis and dehydration were evident and the prognosis was poor.

4.86 An OPCMHT letter to the GP on 26/11/17 concerned the GP referring L back to the team. It referred to the TVN assessment that L did not have mental capacity to make decisions about the treatment of the pressure sores, and that it was appropriate for the TVN to have completed this assessment as it related to physical health. L was discharged from the OPCMHT as she had been admitted to Kingston Hospital.

4.87 L died in hospital at 20.50 on 27/11/17.

4.88 On 28/11/17, the Access Team made the decision to progress the Safeguarding Adults Enquiry to the planning discussion stage. The enquiry was assigned to the North Locality Team allocation tray to progress and was allocated to a Social Worker on 29/11/17.

4.89 On 28/11/17, a Safeguarding Adults Practitioner at Kingston Hospital advised the Access Team of the intention to request that a Doctor refers L to the Coroner.

4.90 The Safeguarding Adults Enquiry was closed on 01/12/17, following a visit by the Social Worker to Galsworthy House on same day, as the nursing home had already raised a safeguarding concern regarding the grade 4 pressure sore on 21/11/17 and it was considered that this had been addressed by the OPCMHT and closed on 24/11/17.

4.91 On 21/03/18, the Coroner requested all Safeguarding Adults, Mental Capacity Assessment (MCA) and Best Interest Decision records, along with case notes.

5. CRITICAL ANALYSIS OF FACTS

5.1 Overview

It is important to note that all involved staff in the agencies contributing to the care and treatment of L demonstrated a commitment to provide a sensitive, personalised and effective service. This included exhaustive efforts to explain to L the risks of not accepting support and ultimately hospital admission. Furthermore, L was very determined to remain in control of decisions about how her needs would be met, up to the final few days of her life.

However, there were significant deficits in individual and, more significantly, collective efforts by agencies to address increasing risk, which reduced the potential for L to receive planned support during the month preceding hospital admission.

5.2 The effectiveness of intervention in meeting physical health needs

Galsworthy House: It is apparent that L experienced chronic leg ulcers from about 2010 and that there was some improvement in this condition at the nursing home. On admission, L required high dependency nursing care in bed and often declined aspects of care, with evidence that staff made every effort to provide sensitive and attentive support.

A care plan in March 2016 shows that L was generally compliant with care. Leg ulcers were dressed and intact. L had double incontinence and

accepted support with personal hygiene and dressing. She was eating and drinking unassisted, although not accepting a monthly weight test due to pain. However, L was presenting some concerns as she reduced the benefit of an air mattress by using towels, which placed her skin integrity at risk. Also, she often declined support with repositioning, unless as a part of personal care.

The Deprivation of Liberty Safeguards (DoLS) referral in April 2017 raised significant concerns about the level of nursing needs and withdrawal of L from some aspects of support.

A further risk assessment in August 2017 raised some increased concern regarding the high risk of pressure ulcers due to immobility. The risk was explained to L and she continued in her wish to remain on her back, which she found comfortable.

On 3/11/17 a record is made of the appearance of a wound to L's right buttock (otherwise described as a sacral wound), which is the first indication of the pressure ulcer that led to hospital admission. This was described on 13/11/17 as a grade 3 pressure ulcer and an urgent referral was made to the TVN service. Whilst nursing care was provided during this period and the TVN service is advisory, this constitutes an unreasonable delay in making the referral.

A risk assessment on 15/11/17 referred to the pressure ulcer and a continued plan to encourage frequent position change (although L was mostly declining), a food and fluid intake chart (due to poor appetite and the related risk to pressure ulcer healing), and frequent checking and changing of continence pads. Also, the risk of declining support was explained to L. However, a referral was not made by the nursing home for specialist dietician support, despite L consistently refusing food and fluids.

A Safeguarding Adults referral was made the following day by the nursing home to Adult Social Care, with information on the grade 3 pressure ulcer and that L was declining essential care, which clearly amounted to serious self-neglect. A further Safeguarding referral was made on 21/11/17 and it is notable that the nursing home also made contact with the GP, OPCMHT and family during this period in an effort to rally a multi-agency response to address the increasing risk.

Community Health: The Tissue Viability Nurse (TVN) provided consistent worker support and visited L at the nursing home twice in August 2013. Advice was provided on dressings, pain relief, changing continence pads (L was at times refusing) and repositioning in bed.

The risks presented by non-compliance with care were explained to L by the TVN when she visited for a second time in March 2015. On this visit, L was soiled and was also using towels on top of the pressure mattress, presenting a further risk to skin integrity.

A Continuing Care Assessment scheduled for July 2017 was cancelled and this may have been a further opportunity to raise wider concerns about self-neglect.

The delay in referral of the sacral pressure ulcer to the TVN from 3/11 to 13/11/17 was compounded by a further delay, as the TVN did not pick up the referral until 16/11 and visited on 20/11/17. This delay, due to an administrative error, was unfortunate. However, it is unlikely to have impacted significantly on care, as the service is advisory and L was receiving full nursing care. Kingston has two TVNs and the Your Healthcare Safeguarding Adults lead has assured that there are no resource issues in providing a timely service.

Groves Medical Centre: L registered with Groves Medical Centre in December 2013, about four months after her admission to Galsworthy House. A surgery record in April 2016 indicates that treatment and regular monitoring were in place, due to a recurrent leg infection.

On two GP review visits to L in January 2017, poor appetite was noted for the first time and staff were advised to encourage L with nutritional intake. There is no indication that the cause was further explored or explained.

The GP completed three recorded visits to L in June and July 2017. Poor appetite and weight loss were noted as concerns and a blood test was advised and completed. An Electrocardiogram (ECG) could not be arranged at the time.

On five recorded visits by the GP from August to October 2017, the primary purpose was noted as monitoring the continuing poor nutritional intake. L consistently refused blood tests and an ECG. A Fortisip supplement was administered. This concern did not lead to a referral to a dietician by the GP for specialist advice. It is understood that the surgery may recommend high calorie food, then a supplement drink if this is not working, and consider referral to a dietician if specialist support is required due to a persistent concern. In these circumstances, there does appear to have been a consistent concern, aligned with other risk factors. The GP suggested a discussion with family about developing an advance care plan if L was to refuse hospital admission, which demonstrated clear forward thinking, although there is

no indication of this being followed through by any agency and was not evident in the final weeks prior to hospital admission.

The GP was very involved in the assessment of L's needs during November 2017. A rapid deterioration in the condition of the sacral pressure ulcer was noted in the week prior to hospital admission, alongside poor nutritional intake. The GP advised L to accept hospital admission for fluid, protein and nutritional intake, and explained the risk of death if this course was not followed. L continued to decline hospital admission, wishing her brother-in-law to visit and advise. The GP supported this action which, aside from considerations on urgency and mental capacity, demonstrated a personalised approach.

SWLSTG Mental Health Trust: The Older Persons Community Mental Health Team was involved with L from 06/07/17 to 23/08/17. Whilst this involvement was primarily concerned with mental health (covered in the next section), there were closely aligned physical health considerations. An Occupational Therapy visit to L on 07/07/17 noted reduced appetite and weight loss, leading to a recommendation to put in place a food and fluid chart to monitor intake.

The mental health diagnosis provided by the Consultant Psychiatrist on 19/07/17 was subject to the exclusion of delirium and L was discharged before this was confirmed. As identified in the Trust IMR, these screening results may have changed the care and treatment plan.

Physical health was not recorded in detail on Trust RIO recording system within the care plan and risk assessment templates. The discharge letter on 16/08/17 does not refer to physical health needs and the care plan notes were not shared with family, which should have occurred within local procedures, subject to consent, capacity and best interests. However, the recording omission was not significant as physical health was clearly not the primary concern of the Trust involvement and L was in receipt of full nursing care.

Adult Social Care: Kingston Council Adult Social Care had not been involved with L prior to a Safeguarding Adults referral in November 2017, as she transferred privately to the nursing and had previously resided in another borough; aside from Deprivation of Liberty Safeguards (DoLS) assessments (covered in the next section). The Safeguarding response is addressed in section 5.4 of this report.

Kingston Hospital: There was involvement by Kingston Hospital in May 2013 when L was diagnosed with a grade 3 pressure ulcer to her leg, followed by admission to hospital two months later with an infected leg ulcer. There is no indication that self-neglect and a Safeguarding Adults

referral were considered at this time, or questioning as to why L had become very dependent in terms of her physical health, although a referral was made to Adult Social Services for a nursing home to be sought. L was transferred to the nursing home in August 2013. It is acknowledged that this episode was prior to the implementation of the Care Act and is not considered within the recommendations of this review.

The next involvement by Kingston Hospital was the admission of L on 23/11/17. It is understood from a tissue viability specialist at the hospital that, on admission, it was too late for the sacral pressure ulcer to heal and the standard pressure ulcer pathway was followed; involving antibiotics, dietician support, pressure relieving equipment and regular turning. Alongside the pressure ulcer that had significantly deteriorated and led to her death, L was also experiencing fatigue and was not eating or drinking. Whilst in hospital, there is no documentation to say that L declined care and treatment, but this may be because she was very unwell at this stage.

5.2. The effectiveness of intervention in meeting mental health and mental capacity needs

Galsworthy House: On admission to the nursing home in August 2013, it was evident that L had experienced a significant increase in her level of dependency, particularly in the development that she was spending all her time in bed, and this was seemingly beyond the extent of her physical health deterioration. It was known that L had not come to terms with the loss of her husband, her independence and the home that they had shared. Whilst staff at Galsworthy House made considerable efforts to engage with L and she had said that she was sad but not depressed, there does appear to have been a missed opportunity from the time of her admission for the nursing home to have further explored the level of loss and a potential link to her declining support, possibly leading to counselling support. This applies to all agencies involved in the care of L.

On referring for a DoLS authorisation in July 2015, Galsworthy House were aware that L was experiencing paranoid ideas. This should have led to a request via the GP for a mental health assessment at this stage, rather than two years later, and the nursing home were in a pivotal position to raise this.

In the March 2016 care plan, it was noted that L possessed mental capacity relating to decisions about her care needs. This judgement was not based on a formal Mental Capacity Assessment. It appears

that there may have been grounds for concern regarding mental capacity since July 2015 to warrant a formal MCA. The risk assessment in August 2017 and the Safeguarding Adults referral on 16/11/17 repeated this judgement on mental capacity.

Galsworthy House acknowledge that a basic care plan was in place, with limited activities, and that changing needs were not reflected in care planning. An electronic care plan system has been introduced to improve the standard of care planning. Increased isolation and the potential impact on mental health was not incorporated. The nursing home have also implemented life stories with residents, linked to activities, to improve this aspect of care. As part of this review, it was noted by Galsworthy House that L experienced a significant deterioration in mood during the final three months of her life, without any clear reason being found for this.

A Deprivation of Liberty Safeguards (DoLS) referral by the nursing home in April 2017 raised concern that L lacked mental capacity to make decisions about her safety. It was further recorded that she was living with dementia, although there had been no screening or formal diagnosis. The referral noted that the Enduring Power of Attorney was being revoked by the previous holder.

In a nursing home record on 21/11/17, it is clear that the risk of refusing hospital admission for treatment of the pressure ulcer was explained to L and she continued to decline admission. However, L commented that she had a previous 'bad experience' at Kingston Hospital and also that she wished to be left alone. There is no indication of an attempt to explore the basis of these comments to potentially facilitate agreement to admission, however unlikely this may have been.

Community Health: A Continuing Care Assessment was completed in June 2014, at which time L was considered to have capacity to make decisions about daily care, without the need for a formal assessment. L advised that she was sad but not depressed about the loss of her husband and of independence, and that she had previously been detained in hospital under the Mental Health Act. There does not appear to be a record with any of the involved agencies of a formal admission, or of an attempt to clarify this information. Also, whilst there was some engagement with L about her emotional wellbeing and she said that she was not depressed, this was an opportunity to consider and discuss the merits of bereavement counselling and the exploration of a possible link to declining support.

When the TVN visited in March 2015, she considered that L had the mental capacity to understand the risks presented by non-compliance with care, as explained to her, without recourse to a formal assessment.

A Funded Nursing Care review was undertaken in March 2016, in which L continued to present with paranoid thoughts, and this still did not lead to a referral at the time for a mental health assessment.

The first evidence of a formal, recorded Mental Capacity Assessment was completed by the TVN on 20/11/17. Whilst this was commendable in providing a thorough assessment and did state that L lacked the capacity to make decisions about her care and treatment, there was a lack of clarity as L was described as having variable capacity in relation to decisions about her care needs; 'it appears that her capacity is variable.' This could have meant that she did have capacity if related to time, or that she did not have capacity if related to specific decisions. It was also noted that there was no underlying mental health condition. The TVN did advise the nursing home to seek a GP Mental Capacity Assessment as L did not cooperate with the assessment. As this did not take place by any involved agency, there was not a clear Mental Capacity Assessment in the final weeks and days that could potentially have led to a Best Interest Decision to arrange hospital admission earlier. However, this is by no means certain as L's wishes would still have been taken into account and admission against her will may have been detrimental to her wellbeing in her final days. The TVN also raised the option of end of life care as an alternative to hospital admission. This this does not appear to have been fully considered by agencies in view of L's withdrawal from care.

Groves Medical Centre: During the two GP visits to L in January 2017, low mood and confusion were identified. Staff were advised to encourage L but there was no indication that underlying causes of her low mood were explored.

In May 2017, Groves Medical Centre provided information to a solicitor acting for A that L lacked mental capacity in relation to both finance and health and welfare decisions. The correspondence has not been retained and the information does not appear to have been founded on a formal, recorded Mental Capacity Assessment.

On three recorded visits to L in June and July 2017, the GP noted delusional thoughts and paranoia. A referral was made to the Older Persons Community Mental Health Team (OPCMHT) for a psychiatric assessment, resulting in the initial contact by this team within a couple of days. Contact was maintained and later in the month the GP referred again for a Mental Health Assessment, leading to a prompt Community

Psychiatric Nurse (CPN) visit to L. The GP also advised dementia screening but this did not happen.

In the August and September 2017 visits, L was considered to have full mental capacity (a general comment), without a formal Mental Capacity Assessment. L had also stated a wish to be left alone, which does not appear to have been further explored or explained.

As aforementioned, the GP was very involved in the assessment of L's needs during November 2017. A Mini Mental State Examination (MMSE) was completed and it is unclear whether a Mental Capacity Assessment was undertaken. There was not a formal, recorded assessment at this time and there appears to be a continuing uncertainty about the formal recording of MCA in primary care. However, the GP recalls that L had full mental capacity specific to the decision about hospital admission. There was a missed opportunity for a clear MCA by the GP or TVN (as the decision related to physical care) and consideration of a, Best Interest Decision. The GP had decided to await family contact, in accordance with L's wishes, before referring to the OPCMHT for a psychiatric assessment, and this referral was subsequently made on the day prior to hospital admission.

SWLSTG Mental Health Trust: As mentioned in the previous section, the Older Persons Community Mental Health Team (OPCMHT) was involved in the assessment and treatment of L's needs from 06/07/17 to 23/08/17, in prompt response to a GP referral for a psychiatric assessment. It is noteworthy that the first tangible, recorded evidence of delusional thoughts was in June 2015, approximately two years earlier. There was no previous psychiatric history known to the Mental Health Trust and the accuracy of the reference by L to a Mental Health Act Assessment following the death of her husband has not been established.

An Occupational Therapy assessment visit on 07/07/17 highlighted presenting paranoid ideation and loss of interest. This was followed on 19/07/17 by a Consultant Psychiatrist visit. A preliminary diagnosis of persistent delusional disorder was diagnosed. This was seen as having occurred over recent months and presenting factors were noted. These included depression as a possibility, but not evidenced on this visit. Other presenting factors were dementia, refusing medication, very psychotic and weight loss. The inclusion of depression and dementia as possible factors are noteworthy as these had not been formally screened or diagnosed at any point.

Weekly visits by a Community Psychiatric Nurse (CPN) were also arranged and a visit was undertaken on 25/07/17. Although L did not

engage, the nursing home reported significantly improved mood and appetite. Also, L was not exhibiting any delusional thoughts and was accepting support with personal care. This positive change was also evident on a visit by the OPCMHT to L on 09/08/17 and at a Care Programme Approach (CPA) meeting, involving L, at the nursing home on 15/8/17. The continuation of covert administration of Olanzapine was recommended on the basis that the Consultant Psychiatrist did not consider L to have capacity to enter into a discussion on medication and the prescription was seen as in her best interests. The prescription was clearly a medical judgement and the impact on L's wellbeing was very apparent. However, it is a concern that a formal, recorded Mental Capacity Act Assessment and related Best Interest Decision were not completed. It is understood that a Mental Capacity Assessment form and a combined MCA/Best Interest Assessment form are available on the RIO recording system. All Mental Health Trust practitioners who have been trained in the Mental Capacity Act are expected to record a formal MCA assessment on the available form, which was not completed in this instance. It is therefore not evidenced whether a formal MCA assessment was undertaken. L was discharged back to primary care on 23/8/17.

A potential link between the persistent delusional disorder and L declining aspects of care was addressed as treatment was provided, which impacted positively on the mental health condition and acceptance of care and treatment. The possibility of depression and dementia were not investigated following the positive outcome, therefore leaving these potential factors as unclarified.

An Occupational Therapist in the OPCMHT received contact from the Adult Social Care Access Team on 21/11/17 as the next involvement by the team. The OT confirmed that a referral had not been received from the GP to request a Mental Capacity Assessment and that this would be inappropriate as the decision related to physical health needs. A referral was received from the GP the following day and, whilst the request was unclear, this appeared to relate to a Mental Health Assessment and the possibility of compulsory hospital admission. The team were unable to make contact with the GP before admission was arranged the following day to clarify the request. There is not a standard form for GPs to request OPCMHT assessments, which the Trust Safeguarding Adults lead considers would be beneficial. Contact was made with Kingston Hospital on 24/11 and 26/11/17 for updates and confirmation that the Psychiatric Liaison Service at the hospital was involved. It would clearly not have been appropriate for the OPCMHT to have completed a Mental Capacity Assessment relating to a decision about physical health needs. It is unclear whether there were grounds for an updated psychiatric assessment or formal Mental Health Assessment, to consider the

possibility of a current mental disorder that was impacting on L's capacity to consent to care and treatment of physical health needs, and possibly towards compulsory admission. In the event, there was very limited time and L was admitted to hospital on the basis of family support.

Adult Social Care: There are Adult Social Care records of three Deprivation of Liberty Safeguards (DoLS) assessments during the relevant period. A DoLS assessment in July 2015 provided the first tangible evidence of L experiencing paranoid ideas and also referred to her struggling since the death of her husband. In July 2016, a DoLS assessment referred to L declining care. A DoLS referral in April 2017 provided a record of L declining care at a level of significantly increased concern. Mild cognitive impairment, secondary to dementia, was referred to, although this had not been screened or formally diagnosed. Whilst a DoLS authorisation was not granted on any of these occasions due to L having mental capacity related to residence and care at the nursing home, these did present opportunities to recommend consideration of a mental health assessment.

5.3 The effectiveness of multi-agency communication, risk assessment and safeguarding adults in improving safety and wellbeing

Overview: Despite some deficits in the responses of individual agencies, as outlined in the previous two sections, it should be acknowledged that all individual agencies acted tirelessly to assess and meet L's needs in a personalised and effective manner, and there was evidence of communication between agencies. However, there was a clear indication of serious self-neglect from at least April 2017, if not before. The most significant deficit highlighted in this review was the absence of an early, multi-agency safeguarding adults/ risk assessment meeting; in which L, family and all interested agencies could have ensured a clear assessment of physical and mental health needs and mental capacity; with the development of a protection plan or risk management plan that anticipated the pathway options to be decided upon at a later stage. This would have required updating at an urgent Safeguarding Adults Planning Meeting in November 2017, which did not take place.

With specific regard to mental health, it is also noteworthy that L had experienced significant losses in terms of her husband, her independence and her home. Whilst agencies endeavoured to engage with L and these areas were discussed on occasions, there does appear to have been a missed opportunity by agencies collectively to have considered a more indepth scrutiny and possible counselling support,

particularly as it is not known how significant these factors were in L's withdrawal from acceptance of aspects of care and treatment.

There is inevitably some overlap in this section with the previous two sections of the report, to ensure comprehensive coverage and clarity.

Adult Social Care: The Safeguarding Adults response by Adult Social Care in November 2017 is addressed as the first agency in this section, due to the Local Authority responsibility as the lead, coordinating agency.

On 16/11/17, the Access Team received a Safeguarding Adults referral from Galsworthy House, relating to a grade 3 pressure ulcer and declining care and treatment. Social work allocation was agreed but the referrer was advised that this would take a few days, and assignment had not occurred by the time that L was admitted to hospital a week later. A very thorough response was provided on a duty basis, but this could not replicate an urgent, focused and coordinated response by an assigned social worker to self-neglect (dependent on mental capacity), and was compounded by some uncertainty with regard to which team was responsible to progress the safeguarding enquiry. The referral was passed internally to the Mental Health Social Care Team on 19/11/17 regarding the pressure ulcer (now described as grade 4) and declining care and treatment. It was clarified that the threshold for a safeguarding enquiry was met and that a multi-agency protection plan, Mental Capacity Assessment and possibly a Best Interest Decision were the required steps.

A second Safeguarding Adults referral was sent by Galsworthy House to Adult Social Care on 21/11/17, updating that the GP had completed a mental health assessment, capacity was variable and family contact was awaited. This was forwarded by the Access Team to the Mental Health Social Care Team duty tray, with an email to the Team Manager, requesting an urgent Safeguarding Adults Planning Meeting. In the absence of urgent allocation, the Access Team completed considerable telephone activity on this date, in an effort to progress a coordinated and effective response. The Access Officer rang the GP to leave a message regarding Safeguarding Adults and a Mental Capacity Assessment. He then rang the Tissue Viability Nurse, who advised that she had attempted a Mental Capacity Assessment but that L did not engage. This was followed by a phone call to the nursing home and the Deputy Manager agreed to ask the GP to complete a Mental Capacity Assessment, towards a possible Best Interest Decision on hospital admission, and to contact the family. The call was backed up by an email (copied to the GP) and a letter, which added a request to undertake a risk assessment and to prepare a protection plan. The

Access Officer rang an Occupational Therapist (OT) at the OPCMHT, was advised that mental capacity (including whether the GP had assessed this) and an underpinning mental health condition were unclear and the team could not assess L's mental health without a GP referral; also that family contact was awaited. A further phone call was made to the nursing home and it was updated that L was aware of the risk of death and wished to be left alone. The Access Officer rang the GP, who acknowledged rapid deterioration in L's physical health and was awaiting family contact before referring to the OPCMHT for a psychiatric assessment or considering hospice admission; adding that mental capacity was unchanged. A further call was made to the OPCMHT, to be advised that a GP referral and a clear request were awaited.

A Safeguarding Adults Planning Meeting was recorded on the same day, involving the Mental Health Social Care Team (MHSCT) Team Manager (Safeguarding Adults Manager) and a Social Worker (Enquiry Officer). This covered appropriate planning areas, to establish if a formal Mental Capacity Assessment had been undertaken and was decision-specific, and the most appropriate option. It was noted that the GP considered L to have the mental capacity to make decisions about care and treatment, the Tissue Viability Nurse (TVN) considered that she did not have capacity and that a Best Interest Decision to admit to hospital was required, and the family/Power of Attorney wished LW to remain at the nursing home and to receive hospice care if required. This meeting did not satisfy the urgent requirement for a multi-agency Safeguarding Adults Planning Meeting, possibly with family linked in through teleconferencing if still in France, to address these issues.

The Mental Health Social Care Team (MHSCT) transferred the Safeguarding Adults referral to the North Locality Team on 22/11/17, with a request to attend a possible Safeguarding Adults Planning Meeting the following day, on the basis that the GP had said L was living with dementia. An MHSCT Duty Social Worker visited the nursing home two days later, to be advised that L had been admitted to hospital the previous evening.

A Safeguarding Adults referral was received by the Access Team from Kingston Hospital on 24/11/17, due to sepsis, and a decision was taken on 28/11/17 to progress to the planning decision stage. A Social Worker in the North Locality Team was assigned the following day and the enquiry was closed on 01/12/17, on the basis that the Safeguarding Adults concern had already been addressed.

Galsworthy House: On admission to the nursing home in August 2013, self-neglect and a difficult engagement with services were noted, without consideration of a Safeguarding Adults referral at this time.

The DoLS referral in April 2017 provided the first significant recording that L, who had high dependency physical care needs, was often declining care. This should have led to a referral to Adult Social Care for consideration of a Safeguarding Adults Enquiry/ multi-agency risk assessment meeting, due to self-neglect. Throughout the period from April onwards, the nursing home was best placed to recognise the risk factors and should have been more proactive at this time in requesting safeguarding and multi-agency risk assessment support.

The sacral pressure ulcer was initially noted at the nursing home on 03/11/17. A wound assessment chart on 13/11/17 recorded that this was a grade 3 pressure sore on L's right buttock, measuring 5 centimetres, leading to a referral to the Tissue Viability Nurse on the same day. Whilst L was receiving full nursing care, this did constitute a delay in seeking specialist advice. The presence of a grade 3 pressure ulcer and the significant self-neglect factors led correctly to a Safeguarding Adults referral on 16/11/17. It is evident that the nursing home were very proactive at this stage in raising concerns with relevant agencies and seeking a multi-agency response, which was not sufficiently forthcoming.

Community Health: A Continuing Care Assessment was cancelled in July 2013 and, whilst this coincided with a period of improvement in L's mental state and acceptance of support, it is possible that this may have triggered a multi-agency assessment.

The Tissue Viability Nurse was not involved in 2017 until November, so could not have triggered a multi-agency response earlier in the year. It is evident that the TVN did attempt to engage with other relevant agencies during the period of involvement in November 2017 although, along with other agencies, was in a position to have requested an urgent multi-agency risk assessment meeting at this stage.

Groves Medical Centre: It should be acknowledged that the GP was extensively involved in the assessment, care and treatment of L's needs from April 2017 and previously, with a clear sensitivity to the views of L and her family. There is a record of the GP noting poor appetite and weight loss in June 2017 and after, leading to blood tests and supplementary fluids, but not to a dietician referral. A screening for dementia was advised but not followed through. The delusional thoughts and paranoia were noted and a referral was made in July 2017 for a psychiatric assessment. It does appear that the OPCMHT had some difficulty in obtaining the outcome of screening for delirium. The GP was also in a position to have requested a multi-agency safeguarding and risk assessment meeting from April 2017 onwards. In September 2017,

the GP did record a need to discuss a care plan with L's family in event of hospital refusal, which demonstrated foresight at this time, but this was not followed through.

During November 2017, the GP maintained close involvement and endeavoured to engage with relevant agencies. The uncertainty regarding whether a formal Mental Capacity Assessment had been undertaken did detract from the potential for a clearer multi-agency approach at this stage. The GP was clearly anxious to receive the views of the family/Power of Attorney as part of the multi-agency decision making, and this was appropriate.

SWLSTG Mental Health Trust: The OPCMHT was involved in the prompt and effective assessment and treatment of L's mental health needs from July to August 2017, with a positive impact on physical health care, despite concerns about whether a formal, recorded Mental Capacity Assessment had been undertaken. The decision to discharge L to primary care in August 2017 (although delirium clearance had not been received) is understood as there had been a significant improvement in mental health and physical health functioning due to the intervention of the team, and L was in receipt of full nursing care and weekly GP visits. However, in view of the presenting high dependency needs and self-neglect which remained as risk factors, the OPCMHT was also in a position to have prompted a multi-agency safeguarding adults/ risk assessment meeting. As a related point, it is unclear whether L was experiencing dementia, or depression due to the losses in her life, and these could have been further screened to ensure that L's voice was adequately heard as part of a multi-agency risk assessment.

During November 2017, the OPCMHT did engage with other agencies in seeking clarity regarding the potential GP request. Whilst it is understood that a referral is required from the GP to initiate action, it is a consideration whether earlier direct contact with the GP was merited due to the urgent circumstances, possibly leading to an updated Mental Health Assessment to underpin a GP or TVN Mental Capacity Assessment. In the event, the GP had decided to await family contact prior to making a decision about hospital admission or end of life care, and this led directly to hospital admission.

5.4 The compliance of agencies with relevant legislation, policies and procedures, and whether these were fit for purpose; and organisational impacts on decision-making

Galsworthy House: When L was admitted to the nursing home in

August 2013, there was knowledge that she had a grade 3 pressure ulcer and self-neglect in the community prior to admission was also noted. Whilst this was prior to the Care Act 2014 and is not included in the review recommendations, this should have prompted a Safeguarding Adults referral to Adult Social Care. The significant increase in the withdrawal from care and treatment by L around April 2017, should also have led to a Safeguarding Adults referral at this point. When the sacral pressure ulcer was noted as having deteriorated to grade 3 on 13/11/17, the nursing home did raise a Safeguarding Adults Concern three days later. Whilst this should have been on the same day to meet timescale guidelines, it was nevertheless fairly prompt and full nursing care was in place.

The significant and consistent deterioration in appetite from about June 2017 should have prompted a referral to the dietician, although it is acknowledged that this would have been advisory and the home were following a nutritional plan, joint with the GP.

There was an apparent delay by the nursing home in making a referral to the Tissue Viability Nurse in July 2017, although the referral was made promptly on noting deterioration of the sacral pressure ulcer to grade 3 and L continued to receive full nursing care during this period.

Your Healthcare: A Continuing Care Assessment was cancelled in July 2017, although this was due and no reason was apparently given. This was at a time of improved circumstances but may have contributed to a multi-agency perspective on risk if it had taken place.

There was a delay in the Tissue Viability Nurse picking up a referral by the nursing home from 13/11 to 16/11/17, due to an administrative error. This is unlikely to have been significant in that L was receiving full nursing care and contact was made with the home on 16/11/17, leading to a decision to visit four days later.

Groves Medical Centre: The grounds to refer to a dietician for advisory support would also reasonably have applied to the GP.

As part of this review, the GP has confirmed that L demonstrated the mental capacity to make decisions about her care and treatment; that she was able to understand, retain and weigh up information, and was able to communicate her wishes. However, this was not formally recorded as a Mental Capacity Assessment at the time and therefore did not meet the requirements of the Mental Capacity Act. This highlights the absence of a clear recording format within primary care.

SWLSTG Mental Health Trust: The decision to authorise the covert administration to L from July 2017 followed consultation with family and was clearly effective. There was also a clear comment that L lacked mental capacity to discuss this treatment and that the circumstances meant that covert administration was in her best interests. However, the Mental Capacity Act requires that a formal, recorded Mental Capacity Assessment is completed that evidences a strict checklist and that Best Interest Decision requirements are met. These standards ensure that a service user is only deprived of liberty if there is evidence that this is appropriate under legislation. The Mental Health Trust has forms for this purpose on the RIO recording system and these were not completed in this instance.

The decision to discharge L to primary care in August 2017 was made prior to the receipt of a test to rule out the possibility of delirium.

Adult Social Care: The responsibility to raise a safeguarding adults concern in April 2017 also applies to Adult Social Care, on receipt of the DoLS referral which indicated possible self-neglect.

A Safeguarding Adults concern was received by Adult Social Care on 16/11/17 and, whilst a prompt decision was made that the circumstances met the Section 42 threshold conditions, a multi-agency Safeguarding Adults Planning meeting had not been arranged by the time L was admitted to hospital on 23/11/17. This did not meet timescale guidelines or the urgency and demands of the situation. There was a lack of clarity about which team would take responsibility to proceed with the enquiry.

Kingston Hospital: The responsibility to have raised a safeguarding adults concern in August 2013 also applies to Kingston Hospital.

5.5 The resource and environmental impacts on decision-making

All agencies: Whilst the reviewer acknowledges that all Health and Social Care agencies are committed to providing a professional service within a context of increasing demand and reducing resources, a lack of resources was not raised as having a direct impact on any decisions or actions by involved agencies.

Admission to the nursing home appears to have contributed to L's feelings of loss, by giving up her home and experiencing increased dependency. However, L was able to receive full nursing care and access to other services. The review has not established any environmental impacts on decision-making.

6. FINDINGS

6.1 **Overview:** As previously noted, there is clear evidence that all agencies involved in the care and treatment of L endeavoured to meet her needs address risks in a personalised and professional manner, both individually and through communication with each other. The findings address those areas in which it is considered that agencies, individually and collectively, could have been more proactive in safeguarding L. These are identified as primary or secondary considerations, based on an estimation of the impact on L's safety and wellbeing.

6.2 **Finding 1 (primary) –** As an overview for consideration by the **Safeguarding Adults Board**; all agencies involved in the care and treatment of L from April 2017 did not sufficiently recognise the serious escalation in self-neglect (assuming L had mental capacity to make decisions about care and treatment) and the increasing risk that was apparent from around this time. This led to a missed opportunity to come together in a coordinated Safeguarding Adults/ risk assessment planning meeting at an early stage, which would have enabled increased clarity about the presenting needs and pathway options available at the point of crisis intervention in November 2017.

6.3 **Finding 2 (primary) –** As an overview for consideration by the **Safeguarding Adults Board**; all agencies involved in the care and treatment of L missed an opportunity to further explore possible mental health concerns of depression and dementia, as potential underlying reasons for L declining support; and in a wider sense to adequately engage in professional curiosity and active listening to L's voice.

6.4 **Finding 3 (primary) - Adult Social Care** did not provide a timely Safeguarding Adults response in November 2017, particularly in the absence of a multi-agency Safeguarding Adults Planning Meeting, and there was a lack of clarity about team responsibility.

6.5 **Finding 4 (primary) -** The **OPCMHT** did not provide a formal, recorded Mental Capacity Assessment in July 2017, in relation to covert medication, that would meet the requirements of the Mental Capacity Act 2005.

6.6 **Finding 5 (primary) -** The **GP** did not provide a formal, recorded Mental Capacity Assessment in November 2017, in relation to hospital admission for care and treatment, that would meet the requirements of the Mental Capacity Act 2005. There was an absence of a clear recording format for this and possibly also for referring to the OPCMHT.

6.7 Finding 6 (secondary) - The Mental Capacity Assessment completed by the **Tissue Viability Nurse** in November 2017, whilst this was thorough, recorded and completed in difficult circumstances, was not sufficiently clear by referring to variable capacity without explanation.

6.8 Finding 7 (secondary) - The **OPCMHT** did not await the exclusion of delirium, which the Trust considered to be delayed, before discharging L to primary care. The recording of physical care needs, and any potential link to assessed mental health needs, on the RIO recording system could have been more comprehensive.

6.9 Finding 8 (secondary) - A **GP** referral to a dietician for specialist support seems to have been warranted from about June 2017, given a consistently poor nutritional intake despite the provision of supplementary drinks, tests and monitoring.

6.10 Finding 9 (secondary) – Whilst **Galsworthy House** endeavoured to meet L's needs in difficult circumstances, and to engage other agencies, a referral for dietician support should have been considered from around June 2017.

6.11 Finding 10 (secondary): Galsworthy House should have made a more prompt referral for Tissue Viability Nurse (TVN) support in November 2017.

6.12 Finding 11 (secondary) – There was an unreasonable delay in the Your Healthcare **Tissue Viability Nurse** picking up a referral from the nursing home in November 2017, which was due to an administrative error. It is not considered that this delay significantly impacted on the support to L.

6.12 Finding 12 – It is not possible to conclude whether a more coordinated multi-agency response would have led to earlier hospital admission, or indeed if this would have been in L's best interests, and it is therefore inconclusive whether her death due to the sacral pressure ulcer was avoidable or preventable.

7. RECOMMENDATIONS TO IMPROVE SERVICES AND REDUCE RISK

7.1 Recommendation 1 (primary): The Safeguarding Adults Board to oversee a clear procedure and understanding within agencies of multi-agency Safeguarding Adults and risk assessment responsibilities in response to self-neglect; incorporating professional curiosity in determining mental health factors that may underpin risk. [Findings 1,2,3]

7.2 **Recommendation 2 (primary):** The Safeguarding Adults Board to oversee evidence that all agencies have clear Mental Capacity Act procedures, recording forms and training in place. [Findings 4,5,6]

7.3 **Recommendation 3 (secondary):** The Older Persons Community Mental Health Team (OPCMHT) to ensure that there is adequate recording of relevant physical health conditions on RIO and that patients are not referred back to primary care until all the required checks are completed. [Finding 7]

7.4 **Recommendation 4 (secondary):** Groves Medical Centre and Galsworthy House to review practice concerning referrals for specialist dietician support. [Finding 8,9]

7.5 **Recommendation 5 (secondary):** Galsworthy House to ensure that staff are aware of the need for timely referral for Tissue Viability Nurse support. [Finding 10]

7.6 **Recommendation 6 (secondary):** Your Healthcare to ensure that a robust administrative process is in place to receive and promptly respond to referrals for the Tissue Viability Service. [Finding 11]