Kingston Safeguarding Adults Board

Safeguarding Adult Desktop Review in respect of Mr E

Final Report December 2018

Background information

Further to the unexpected death of Mr E in February 2017 the Kingston Safeguarding Adult Board (KSAB), Safeguarding Adults Review (SAR) sub-group considered if the death of Mr E met the criteria for a Safeguarding Adults Review. At the SAR sub-group meeting held 28th June 2017 it was agreed that a SAR should be commissioned, and actions taken regarding funding and identification of an independent reviewer.

Subsequently Judi Thorley (Independent Reviewer) was approached to carry out a Safeguarding Adult Review (SAR). Initial contact was made in the autumn of 2017, the independent reviewer was asked to undertake a desktop review SAR, Terms of Reference/contract attached at Appendix 1. Due to the complexities of the case, the independent reviewer advised that for the desk top safeguarding review to be productive, interviews with key staff and agencies would be undertaken. The delay in commencing the SAR is identified in the minutes of the SAR sub-group meeting held on 10th January as being due to issues in agreeing funding for the SAR. Also, at the meeting on 10th January 2018 the Serious Incident Investigation (SI) carried out by Kingston Hospital was discussed and it was noted that 'relevant actions had been taken.' However, the matter meets the criteria for a SAR and it remains important for the action plan to be reviewed with learning shared across agencies'.

Due to the delay in commencement of the Review and the agreed timeframe Judi Thorley requested to work with a colleague, Moira Angel, to carry out the review and provide a report to the SAR sub-group in August 2018, meeting within the SAR subgroup timeframe. The Review was subsequently considered by the KSAB in November 2018 – the Board made some minor changes to the Review, which were discussed with the Lead Reviewer and the final report is planned for publication in 2019.

Methodology

This is a "desktop" safeguarding adult review that has taken a thorough consideration of paperwork including the Kingston Hospital Serious Incident Review (SI), interviews with key people from a range of agencies which have provided information, timelines and valuable insights resulting in a comprehensive overview to the reviewers. The findings are substantiated using the evidence gathered and where it is the view of the reviewers this is stated. The broad questions for interviews are attached at Appendix 2. All interviewees were made aware that notes of interviews were being taken to aid the reviewers in completion of the report. This review did not allow for full transcripts

or checking of notes with individuals. A list of those interviewed is attached at Appendix 3.

This report outlines the facts and timeline prior to and following the death of Mr E and presents recommendations that should assist the SAB and organisations concerned to take steps to ensure the learning from the death of Mr E is embedded in each organisation, across boundaries and the whole system. The report refers to Mr E to protect and respect anonymity.

Brief Pen picture

Mr E was an elderly gentleman originally from Italy. He had been married for many years but sadly lost his wife in 2005. He lived in his owner-occupied home in Kingston. He had a son who lives in the North-West and a granddaughter who lives overseas. The GP records state that Mr E's son would visit once a week (not clear or corroborated in other notes if this was continuous) and care agencies all had contact with the son. Mr E had a good neighbour who called on him regularly and helped with chores such as shopping. From the information available Mr E was a practicing catholic and his faith was important to him. Mr E was hard of hearing, preferring to communicate face to face. Mr E used a walking stick and was an insulin dependent diabetic, for which he required additional support for insulin administration and monitoring from District Nurses since 2016. Mr E's mental health first deteriorated in 2006, when following the death of his wife in the previous year, he made an attempt to end his life. Mr E's mental health and anxiety meant he was prone to self-neglect particularly related to his diet. Mr E often stated that he felt lonely. In the 6 months prior to death Mr E presented with increasing risk of falls and personal safety e.g. incident of leaving the gas on and stating people were in his home.

Mr E was supported with a care package consisting of 3 calls per day from 'Alpenbest' care agency (since 2015) and 2 calls a day for insulin administration and diabetes monitoring from 'Your Healthcare', District Nursing team.

Facts (what happened) a timeline

Care Timeline: These key episodes/notes are taken as written, from case records, using the details therein. The intention is to show critical points in the pathway of care for Mr E, to enable his story to be clear and to enable learning by all organisations.

2005/2006	Mr E's wife died, and it was at this time he became known to mental health services. He was depressed and tried to kill himself. Although he had since mentioned he wanted to die notes are clear that there was never any intention to take his own life since that period. It is mentioned here to give context with regard to his mental health wellbeing over many years.
November 2014	Mr E fell down stairs at home, reablement to support, appointment to be made at the memory clinic, monitoring re medication and mental health needs. Consideration that Mr E's bed be brought downstairs.
January 2015	It was reported that Mr E was scared to get into bed at nights and was distressed, tearful and was suffering from panic attacks. GP referral for assessment re package of care (RBK notes)
Jan/Feb 2015	Reports between Jan and Feb indicate that Mr E had back pain and low mood. Rapid response service and assessment by Community Mental Health Nurse following GP referral. Reablement and meals on wheels requested urgently following assessment.
6th February 2015	Mr E's first appointment at the memory clinic. Adult at risk assessment – moderate to high risk with a risk rating of 12 which is high risk.
9th February 2015	Care plan and budget for package agreed. Referral to District Nurses for monitoring of insulin and pressure areas. Seen by Consultant referral to Home-treatment for review and monitor of medication.
Jan- March 2015	Between Jan and March 2015 care needs increased, fall necessitating hospital admission and further unwitnessed fall whilst an inpatient. Reablement services were put in place x 2 (a day) key safe was installed, careline ordered and as stated in the notes ''DWP referral made. Reassign to Assessment Reablement Team (ART) for support planning and RAS.'' District Nurse referral to dietician.
16th April 2015	Mr E was self-administering insulin at this time, however there was a need to have carefully timed calls to coincide with his need to take his insulin. Alpenbest care made attempts to find an Italian carer. *(Reviewer note: not clear if this was ever achieved)* Mr E refused care on occasions turning the carers away, sometimes saying carers arrived too early. On 16th April the case was closed as he refused to have ongoing support. (*Reviewer note: not clear what else was put in place*) CMHTOP, CPN, were monitoring his mental health. He has a longstanding history of depression/anxiety and so known to this team. Frequent contact with his son who along with his neighbour were helping him with shopping. Continuous discussion re the funding of care
5th June 2015	DN, rapid response and Staywell concerns re Mr E lack of food wandering outside without clothes on and generally not managing at home. Meals on wheels refused and some challenging behaviour issues reported.

27th October 2015	RBK notes indicate Alpenbest Care to start again, half hour calls on Monday, Wednesday and Friday to support personal care.

No further notes/entries until January 2016 from paperwork provided	
18th January 2016	Mr E left gas on the cooker and house was full of gas. Windows and doors had to be opened to air the house. Added to risk factors
8th February 2016	Fall reported by Alpenbest Care on morning visit. Noted to have bruise to right side of eye and little finger on left hand swollen. DNs and next of kin informed (*Reviewer note: no record of action)*
February/March 2016	Alpenbest support plan changed to accommodate issuing medication
20th August 2016	Fall reported. Carer called 999, sent Mr E to hospital due to high levels of sugar Admitted to Blyth ward. 'Mr E has POC funded by CMHTOP''
27th August 2016	Discharged home with an increased package of care following referral (22.08.16) for assessment of possible increase in calls
8th September 2016	Mr E displays significant concerns with regard to his physical health and his inability to eat appropriately and continence issues.
26th September 2016	Community Psychiatric Nurse (CPN) updated care plan to include managing diabetes better. District nurses to educate Mr E and administer Insulin. Also referral to GP for physical health checks Plans to set up a communications book between Carers and District Nurses
18th November 2016	Taken by ambulance to Kingston Hospital due to unwitnessed fall. Admitted under the medics. District Nurse telephoned hospital to advise of their concerns re increased confusion, often sitting in chair covered in faeces and using towel in trousers to cope with incontinence
2nd December 2016	Discharged from hospital, package of care re commenced
3rd December 2016	Another fall reported to the carers by neighbour. 999 calls made. Mr E refused to attend hospital.
5th December 2016	Increased swelling to elbow, face and knee. 999 call and Mr E taken to A&E via ambulance, admitted to Kingston hospital. Fracture to elbow, cast applied.
6th Dec 2016	Mr E discharged and care restarted. He had a fractured elbow with cast in place. A referral was made to the community falls clinic (*Reviewer note: there was a waiting list and Mr E never attended).*
27th December 2017	4.45pm the community matron visited Mr E and informed the social worker that he was more confused.
28th December 2017	London Ambulance service raised a safeguarding/welfare concern following call from District Nurse. District Nurse attended and found Mr E confused, strong smell of gas from the gas fire which was on but not lit. Forwarded to CMHT
29th December 2016	Mr E's son informed by the CMHT that Mr E had left the gas on and was asked to have the gas disconnected. Both the fire and the cooker. Mr E's son is quoted as saying he thought this confusion was because of his blood sugars. The son was informed that once the care-coordinator on her return (leave?) would arrange a professionals meeting. Plan for gas cooker and gas fire to be disconnected. (*Reviewer note: No note of what was put in place for warmth or heating food)* *Reviewers note: Query re capacity assessment, higher POC? Are risks escalating?*

7th January 2017	District Nurse called 999 and Mr E attended A&E via ambulance due to self-reported fall. Assessed by In-reach Occupational Therapist, safe to return home with re-start of package of care.
8th February 2017	Assessment in care management plan as risk to self-low
10th February 2017	Contact by passer-by to police with concerns for welfare as in street stating teenagers in his house. Street Triage attended, notes say ''no concerns''
12th Feb 2017	Carer and District Nurse found Mr E on the floor and sent him to hospital via ambulance. Seen in A&E and then admitted to Blythe Ward due to fall and acute confusion. He was treated with IV fluids and under investigation for infected legs
14th February 2017	Records show case allocated for review (RBK record on 23rd of Feb said review had been completed on the 14th Feb) Note on file that there are some concerns about Mr E's physical and mental health and safety. He believed two girls had entered his house but police found no evidence of this. Electronic referral completed by Charge Nurse requesting Assessment re package of care on discharge.
22nd February 2017	Ward sister said Mr E was not medically fit for discharge. OT assessment noting memory problems/retention of information, prompts needed for activities of daily living. Recommended increase in package of care to 4 (QDS) daily visits plus continued twice daily visits from District Nurses for insulin administration and diabetes monitoring.
23rd February 2017	Occupational Therapist (OT) electronic referral sent to Single Point of Access for re commencing package of care. NB: 2 differing entries observed where OT recommending QDS care visits and another OT stating Mr E can go home with three daily visits (TDS).
23rd February 2017	Electronic referral sent by Ward Sister to Single Point Access alerting District Nurses of discharge on 24th February and need to recommence twice daily visits to administer insulin and monitor diabetes
24th February 2017	Mr E discharged Reported in GP notes care from Alpenbest Care was restarted by CPN (although some confusion in other notes re this) RBK notes say care started at lunch time that day
27th February 2017	A care worker found Mr E on the floor. They called the paramedics who arrived promptly, but Mr E died in hospital from cardiac arrest (cause of death as stated in notes) at 11.37am. RIP.
28th February	District Nurses raised a safeguarding concern regarding not being made aware that Mr E had been discharged and to recommence twice daily visits.
28th February 2017	RBK received a telephone call from Safeguarding Lead Kingston Hospital requesting a copy of the safeguarding concern form to forward to the coroner and also confirming that they are undertaking a safeguarding investigation. Notes indicate that the coroner now had sight of this/involved.
28th February 2017	RBK reported that there appeared to be some confusion at the hospital about who would be restarting Mr E's carers (RBK notes by ALF). (In 2016 Mr E was receiving care from MH Care co-ordinator under CPA)

1st March 2017	Safeguarding to progress to planning/strategy stage following coroner investigation

Response by Mr C (son of Mr E) sent after the SAR was completed

A big error was made by the hospital not sending email to correct department. This resulted in death of my father due to not having insulin and sugar levels must have been horrendously high. My Dad must have been very lethargic and tired and thirsty in those few days. Eventually his body could not take anymore.

This is about as bad as it can get. Hope lessons will be learnt from this and checks should be made by carers and nurses that log books are filled in and checked on each visit. If this had been done by Carers they would have spotted that no insulin had been given.

This is very upsetting.

Key themes from the Review

- Person centred care
- Communication
- Care coordination
- Multi-disciplinary/agency working
- Mental Capacity Act
- Leadership and ownership of the process of care
- Leadership and ownership of the investigation
- Understanding of the methods of investigation and action planning No shared learning

Findings (what went wrong and right, any areas of good practice, gaps/missed opportunities)

- It is important to note that even though the Serious Incident (SI) stated the root cause as the IT error, we have found that this was only part of the picture. There were a number of issues which aligned allowing things to fall though gaps. Whilst there was very good intention from each agency, the collective action did not always ensure the best outcome for this man. During the period of him receiving care there is good documentation with all those professionals involved raising concerns, describing the problem and there were good attempts to put in place numerous supports, some of which was implemented.

- It was very clear, in looking at the situation retrospectively, that no **one** professional was leading the care and therefore a decision to 'act' regarding safeguarding concerns and alerts that Mr E was not coping were delayed. There was a very clear missed opportunity at the end of December 2016 to bring all the professionals together to discuss the risk and agree a plan. It is recorded that this was the intention. Ironically, the week before Mr E's death, all those involved began to see that they needed to come together to discuss his situation, but this did not happen. Had this meeting been held prior to Mr E's leaving hospital then it could be argued that the District Nurses would have known he was coming home. This lack of coordination cannot be laid at any one person or agency's door, but these findings should prompt bringing all the parties together to discuss the timelines, the gaps and opportunities and the learning.
- There was a good Care Programme Approach (CPA) Risk Assessment and care plan which includes the fact that Mr E had Diabetes and his physical and mental health care was documented in one plan. However, when there were changes in the way mental health social work was delivered in Kingston, under a revised agreement with RBK and the Mental Health Trust; it is not clear who and which organisation took responsibility for the care coordination. When the changes occurred, the responsibilities changed. There was an ongoing discussion about what care coordination was versus care management and who in the system was responsible. Whilst this should not be overstated in this case it is often assumed that changes to systems & processes are somehow known by everyone and the organisational memory stays on in the individuals. This is at best unhelpful and worst dangerous and risky. There should be a way of communicating when one system transfers to another. In this case the Community Psychiatric Nurse (CPN) continued to ensure that carers were in place for Mr E but some professionals were not clear if care should be/was now managed by a Social Worker or other colleague undertaking case and or care management. Essentially there was confusion in the system.
- The notes from the agencies are acceptable and, in some cases, good in terms of content but are very difficult to navigate to find a clear pathway of care for Mr E and indeed to understand Mr E's holistic needs and wishes. The notes are at times confusing, when cross referenced with each other. Again, there had been a systems change with regard to different recording systems and a change over from 'Rio' to 'Unify'. There should have been a flag on the system to identify people like Mr E with increased needs and where possible reasonable adjustments were needed. This would have been an opportunity for a health passport/ 'About Me' plan.
- Mr E was living alone in his own home and was increasingly vulnerable. There were good attempts by the professionals to communicate with him and to find the best support for him. The notes reflect compassion and a good understanding of need. In fact there are some reasonably good examples shown in notes. However, there is no real pen picture of Mr E and this is

especially so in the Kingston Hospital Serious Incident (SI) Report. It may not be apparent when the notes are shared for clinical purposes, but this stands out to the Reviewers. There must always be a quick way of recognising the individual in any care investigation. The lack of detailed pen picture of Mr E may also have led to a lack of coordination. What was important to him, the best ways of communicating with him, what else could be done to meet his wishes, who would be best to support when crisis situations arose should have been included/ evidenced. This was an opportunity for proactive and reactive plans to support Mr E and also carers/professionals and others important in Mr E's life such as his neighbour. There were times that Mr E refused care or was confused about what was on offer. There was an opportunity here to work with Mr E, to agree with him the kinds of intervention, the staff skills required, including planning for refusal of care and when Mr E presented with increased confusion in terms of his package of care. There did not appear to be an escalation plan for when this occurred and some acceptance of the situation which meant Mr E was at times left vulnerable. If new care workers/professionals were involved they would struggle to be specific about types of intervention or when escalation was needed.

- Mr E was well known to many services, with a detailed package of care that was well established since 2015 and ironically this may also have contributed to a professional 'over-optimism' as everything carried on the same and periods of crisis were managed by hospital admissions.
- Mr E was known to be at risk of falls but never attended a 'Falls Clinic'. A referral was made on the 6th December 2016 and Mr E was on the waiting list but he did not have the opportunity to attend. This was a missed opportunity and the referral should have been made earlier.
- There was good evidence of compassion and understanding of Mr E's needs from individual professionals but collectively it did not always appear to be a coherent approach. It was not always clear who was responsible for leading the care. The parts did not add up to the best 'whole' experience for Mr E. The system has to 'design in' and make explicit their ways of ensuring person centred care. This was not helped by the IT system change highlighted.
- There was some evidence of managing risk, including the assessment of Mental Capacity but some of the commentary in the notes suggests that there was indecision and a lack of a timely approach in professionals coming together to consider and plan for the risks. Whilst there was good recognition of the vulnerability of Mr E, it was not clear who was willing to take responsibility for coordinating and 'managing the risk'. Again, it needs to be clear who is the lead professional and how they bring the rest of the Multi-Disciplinary Team together.
- The discharge process did not work for Mr E. This was recognised by organisations at the time after his death, but there was insufficient cross organisation training in place. Neither was there coordination internally in the hospital or across adult social care and community services. This was the case

regardless of the IT issue. There is good evidence of improvement but at the time of Mr E's death the discharge process did not work. There was no 'fail safe' or back up to the electronic referral. There was, however, a discharge date set, which is good practice. Good discharge planning is critical for all patients but particularly for vulnerable older people. The restart of care for Mr E was muddled and several notes reflect this. As Mr E had a plan in place, prior to hospital admission, this should have been a simple process. There are many mechanisms and levers to facilitate good discharge planning including local and national standards. It is clear, in retrospect, that for Mr E the good practice steps to facilitate effective hospital discharge didn't happen. The lack of a discharge summary on the last hospital admission to go with Mr E as the patient and to be sent to the GP is a gap and contributory factor in the resulting outcome for Mr E.

- Communications with the family - Whilst there was some communication with Mr E's son there was not a joined-up approach to this. Assumptions were made that this was being done by 'others'. There was no communication with Mr E's son when a decision was taken to commission this review. The reason for this was because it took some time to obtain the funding for and then to commission a Reviewer. Mr E's son was informed once the Review had commenced.
- The Post-Mortem and the Coroners instructions state that there is a question about the circumstances surrounding Mr E's death and that his death may have been avoided.
- Different recording systems compounded the issues with communication across multi-agencies and whilst work has been undertaken in the hospital to remedy this and at least try and find better ways of interfacing across agencies; this remains a problem across Kingston.
- The understanding of the SAR process and the real benefits of a SAR were underestimated by some of the partners and whilst the SI Report gave some real consideration to the IT issue; it was not a whole system review of the situation and the learning from the SI Report was not shared. The Kingston SAB was therefore right to insist on the matter being considered for a SAR so that all partners have the confidence in its outcome and the learning and cross organisational change to follow publication.

Good Practice (Care)

- There was evidence of good record keeping
- Following the intervention of the Independent Chair of the SAB and the financial support by the CCG there has been increased pace to deliver this Safeguarding Adult Review
- CPA risk assessment and plan includes Diabetes so evidence of physical and mental health needs being assessed

- Evidence of the Care Agency and other professionals continually alerting the statutory agencies about concerns
- Referral to safeguarding by District Nurse and London Ambulance Service
- Following the SI Review, Kingston Hospital NHS Trust changed their IT processes regarding discharge
- Discharge training has been put in place
- Frailty pathway now developed and in early stages of implementation

Gaps in Practice (Care)

- The Kingston Hospital SI Review is clear in its focus on the IT issue but there was no evidence of follow-up to electronic referrals as part of the discharge process (in other words a failsafe system)
- Whilst good attempts were made to communicate across health and social care organisations, there was no single agency taking leadership and responsibility for Mr E's care.
- The communication records show good detail of the problems Mr E was facing and there were missed opportunities to consider a Multi-Disciplinary Team meeting, particularly at the end of Mr E's life.
- It was unclear from written notes reviewed how communications between the care agency and all other agencies/organisations involved were acted upon in providing care and support to Mr E e.g. communication with District Nurse re diabetes. (*Please note that Care Agency were not interviewed and may need to be followed up when agreeing an action plan)*

Good Practice (Investigation)

- Recognition of need for a safeguarding adult review
- Good professional relationships across the health and social care system

Gaps in investigation process

- Lack of evidence of learning across agencies despite there being 18 months since Mr E's death and particularly follow-up to the SI Review findings. The SI findings and specific actions for Kingston Hospital in relation to the SI are now closed. Wider learning across agencies will take place following publication of the Safeguarding Adult Review.

Missed opportunities

- There were a number of opportunities when Mr E was presenting with increased needs and vulnerability, particularly during 2016. Whilst individual agencies were raising concerns, the safeguarding process, despite an alert from the Ambulance service was not initiated.
- Use of Mental Capacity Act (MCA) - there were various attempts at assessing Mr E's mental capacity but there was no multi-disciplinary team (MDT) meeting to agree his best interests or adjustments to be made in his best interest
- No MDT meeting to discuss escalating concerns. There were many opportunities for times of escalation and 2 distinct times at the end of December 2016 and whilst in hospital prior to discharge on the 24th February 2017, for this to happen
- Missed opportunity to use a person-centred approach to enable joined up working to support Mr E and for all partners to address the issues with his family if appropriate
- Joint investigation using multi-agency safeguarding procedures could have been initiated immediately or shortly after death or upon receipt of the Serious Incident investigation
- Shared learning across all organisations, which will be facilitated by the KSAB.
- Use of system levers to drive up quality of discharge and prevent readmission e.g. re-admission within 30 days.
- Consideration of the use of Advocacy - and how Mr E's voice could be heard to meet his wishes so that any collective actions were personalised

In conclusion, based on the findings above and using the experience and knowledge of the Reviewers with the benefit of hindsight, the view taken is that harm was caused to Mr E. This incident could have been avoided. The reviewers did not have access to the post mortem results or any first-hand sight of the Coroner's letters but believe that our findings concur with the post mortem.

Learning: Recommendations for improved services and related actions

There should be health and social care system learning to focus on looking back to one month prior to first hospital admission for Mr E, within the 6-week period leading up to death. This should take account of the new frailty pathway and unit planned with this case used as a focus to create a better way of recognising vulnerability in older people.

The SAB may wish to consider a learning event, which should use the Root Cause Analysis process to review the pathway for Mr E and which can support development

of the frailty pathway. This event could include the care agencies, professionals and those commissioning health and social care.

Discharge

- Commissioners in the system should address whether more work needs to be undertaken in respect of people who are readmitted to hospital within 30-days. Consideration of the use of intervention to support admission avoidance and self-care/self-management should be reviewed jointly between health and social care colleagues.
- Discharge planning and coordination should be reinforced through clear joined up policies and procedures across health and social care.
- Training for discharge should be done jointly with all the relevant agencies present. This should be audited.
- Discharge planning to start on admission and consideration to be given on how the role of discharge co-ordinator works and to be reviewed by KH
- There should also be an agreed process for bringing together all the relevant people in to a meeting to discuss next steps when somebody is being discharged from hospital. The multi-disciplinary team should be responsible for next steps in care.
- The system should ensure that the appropriate leadership is in place at all levels to ensure safe discharges. Health providers should have clear processes in place for quality related to discharge, understood by all parts of the system.
- A flagging system or routine way of highlighting patients who have had several hospital admissions and have complex or multiple needs which may require adjustments should be in place both in hospital and in the community.
- Complex discharges from hospital should be audited by commissioners. Learning should be shared across all organisational boundaries
- There should be a clear policy/protocol between organisations recognising the deteriorating patient. Each organisation should reflect on what good looks like for them and what is in place already but be prepared to create a joint protocol.

Electronic Systems:

- Single Point of access, there should be collective review of how this system works and additional ‘fail safe’ mechanisms such as follow up telephone call initiated prior to discharge implemented.
- The hospital have put in place some ‘fail safe’ checks regarding emails and transfer of referrals but this needs to be joined up with other parts of the system.
  - The suggestion here is to have a day where professionals get together to ‘test’ the system using real case studies and improvements should be owned

by all partners. The SAB should ask for assurance on this and the CCG should lead the work with all partners.

Care coordination

- Consideration should be given to reviewing and describing care coordination. This should make clear to all organisations their responsibility to lead care and ensure responsibility to coordinate care in each case, especially where there is vulnerability or complex care.
- There should be a mechanism for all agencies to agree who is the coordinator at any given time in patients care. Appreciation of individual roles and clarity of who is acting when should be clear.
- The Care Programme Approach (CPA) should be revisited and training provided with all agencies to clarify understanding, expectations and responsibilities. Mr E's experience can be used as an example to test out understanding.

Person centred care

- Putting the person at the centre requires knowing the person at the heart of their care needs. A strong pen picture should be created for each client/patient receiving care at home. This should outline key information they wish to share about themselves including what is important to and for them and include escalation and contingency planning.
- Hospital 'Passports'/ 'About Me' booklets for patients who have increased/complex needs and communication difficulties can support continuity of care and 'knowing' the person, this should be explored as a system approach.
- Shared notes are good practice and whilst organisational divides hinders progress on this it should be a priority from this case.
- Recognising the deteriorating patient - this needs to be considered collectively and training together on best practice in record keeping would strengthen this.

Safeguarding

- It is acknowledged that a great deal of improvement has been made at SAB level and in the respective organisations but there should be greater commitment to Making Safeguarding Personal using the principles in the Care Act. If the safeguarding route had been used from the onset this would have aided bringing everyone together to discuss the death and learn from it sooner but also give a clearer process to follow. This would not have hindered the SI process.

- The early safeguarding referral was closed (although it is still sitting open on the system). Closing it was not appropriate and this should be reflected on in the learning event but also clarity of where/who checks the closure of referrals, monitoring and audit

Systems issues and learning

- This incident was initially investigated as a Serious Incident (SI) Review and the findings were never shared with the Community NHS provider and therefore there has been neither shared learning nor a commitment to the action plan. It is noted that it is NHS practice for SI Reviews only to be shared within the organisation that conducted them and with Commissioners.
- There was delay in committing to seeing this as a safeguarding issue and this compounded the decision making. The national policy is clear and should have been followed.
- Regular audit should be in place through each organisation and across the system in particular related to discharge.
- The system would benefit from reviewing their method of assessing risk for vulnerable people and timeliness of safeguarding referrals.
- There is a commitment from the SAB partners to train together; Joint SAB training currently takes place and will also include hospital discharge planning training together, building on the improvements already made since this incident.
- Commissioners across health and social care need to be assured that there is consideration, and application in practice, of the parity of mental health and physical care needs
- Senior leaders should reflect on this report and their own decision making collectively as part of the learning event.

Judi Thorley, RNLD, RN, Dip HE, MSc Independent Reviewer

Moira Angel, RNLD, RNCT, MBA, BA Hons, PH Member Supporting Reviewer

Safeguarding Adult Desktop Review re Mr E

Appendix 1

Contract/Terms of Reference/Agreed terms:

Judi Thorley (Reviewer) with the support of Moira Angel (Reviewer supporting) will undertake a Serious Adult desktop review from which a full SAR may be recommended. The Review is on behalf of the Royal Borough of Kingston upon Thames, in respect of Mr E.

Aims

The review will be undertaken in a professional manner and will involve a commitment to enhance the safety and wellbeing of adult(s) at risk and, if possible, to be a legacy to the service user and a reassurance to the family.

Objectives

The review will endeavour to achieve shared learning and will cover background information, a pen picture of the service user, key themes, facts (what happened), findings (what went wrong and right), a timeline and recommendations for improved services and related actions.

Process

The review will comprise research including scrutiny of documentary evidence (i.e. records and reports), a review meeting and, the completion of a Desktop Review report and action plan (Appendix 4). The review will also include presentation to the relevant Sub-Group and, if required, Safeguarding Adults Board.

Safeguarding Adult Desktop Review re Mr E

Appendix 2

What do we need to establish?

The review will endeavour to achieve shared learning and will cover background information, a pen picture of the service user, key themes, facts (what happened), findings (what went wrong and right), a timeline and recommendations for improved services and related actions.

Questions for interviewees

1. Set out the reason for the review and how it will be conducted (interviews, review paperwork, report back with recommendations)
2. What it will cover and what it won't. Explain our roles, fair process etc.
3. Establish the interviewees relationship with the case
4. Ask to give timeline and history of what happened in their view, facts, interventions and actions
5. Identify areas of good practice, areas of concern/gaps and inconsistencies
6. What worked well, what could have been done better?
7. What was the multi-agency response and involvement to/with the RCA?
8. What learning has been identified and taken place?
9. What do you understand the coroner to be asking for?
10. What else can be done?
11. What is your understanding of actions further to the safeguarding referral?
12. What would you like to see as an outcome of this desktop review?

Notes/documents reviewed:

- Safeguarding referral
- Notes from DN team manager
- Post incident review gap analysis SW London and St Georges MH trust
- Community referral forms
- Notes provided by RBK Council
- Staff showed us extracts from notes on line
- Serious incident report

Safeguarding Adult Desktop Review re Mr E

We have reviewed notes provided to us and some that were requested. We are aware that there may be notes we have not seen and in the limited time available we were only able to interview key people.

Appendix 3

Staff interviewed on 18th & 19th June 2018

Your HealthCare

- Susan Fitzgerald Adult Safeguard Lead
- Lesley Channer Community Nurse manager

South West London and St George's Mental Health NHS Trust

- Patrick Bull Safeguarding Adults Lead

Kingston Hospital NHS Trust

- Kerrie Reidy Safeguarding Adults Lead Nurse
- Berenice Constable Head of Nursing
- Katie Hollis (Matron, Elderly Care), author of the RCA for the SI investigation

Royal Borough of Kingston Adult Social Care

- Ru Gunawardana Senior Practitioner Adult Safeguarding
- Iain Richmond Service Manager - Mental Health Kingston Adult Social Care

Kingston & Richmond NHS Clinical Commissioning Group

- Peter Warburton Lead Nurse Safeguarding Adults
- Sarah Loades, Lead Nurse Safeguarding Adults
- Laura Jackson, Quality Manager and Continuing Healthcare Lead

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