Safeguarding Adults Review report for "James"

1. Introduction

The Croydon Safeguarding Adults Board (CSAB) undertook a s44 Care Act 2014 Safeguarding Adults Review (SAR) to review the circumstances leading up to the death of James.

The purpose of a Safeguarding Adults Review is not to reinvestigate or to apportion blame but to identify the lessons to be learned from the matter, so those lessons can be applied to similar situations in the future. This Review makes recommendations on what needs to be done to put the learning identified into practice, to contribute to service development and improvement.

The Board, and its SAR Subgroup, will monitor progress on the implementation of that learning and will ensure that the learning from this Review is widely disseminated.

2. Decision to arrange for a Safeguarding Adults Review

CSAB received a referral requesting consideration for a Safeguarding Adults Review regarding James from the South London and Maudsley Hospital NHS Trust (SLaM), following the death of James. The referral said that James's death came a few days after he was discharged home following a stay in hospital. It said that there was cause for concern about the effectiveness of the work agencies did together around the time of his discharge from hospital and in the days leading up to his death.

Croydon SAB decided that the information in the referral gave reasonable cause for concern about how agencies worked together to safeguard James, and that it gave cause to suspect that his death may have resulted from abuse or neglect. This meant that Condition 1 was met under s44 Care Act 2014, and a SAR was necessary.

3. Review Process

Individual Management Reviews (IMRs) were requested from SLaM, Police, ASC, GP and CUH and below are key points raised from these IMRs with further information included within the chronology. The SAR subgroup agreed the James request met the criteria for a SAR and the group discussed an appropriate methodology to use. As the IMRs had demonstrated thorough reviews had been carried out by each agency which had led to clear actions being identified, it was agreed that a "critiqued chronology" method was appropriate.

The chronology is at Appendix 1 below.

The Terms of Reference focussed on the following Key Lines of Enquiries:

1. Family involvement, communication across agencies with family.
2. Record keeping – accurate records including full details of NOK.
3. Sharing of Information
4. Hospital discharge/discharge planning
5. Mental Capacity Assessment.
6. Escalation – when to escalate concerns to other agencies and management

4. JAMES – Summary

James was an 80-year-old single man, from a white Irish background. Prior to his retirement he had worked for British Telecom. James lived alone in a council property. He was living independently with no need for any care and support services. During his childhood he had Polio. This impacted in his mobility, and he used callipers. He had no children and had a nephew and niece. His nephew shared that James was independent however found personal care difficult and required support with shopping. His nephew said that James had isolated himself due to Covid-19 and following the death of his sister.

James was admitted to Croydon University Hospital (CUH) on 29 December 2021 following a fall at home.

While in hospital, he was referred to the Older Adult Psychiatric Liaison Service (SLaM) who identified low mood and suicidal ideation within the context of the recent bereavements of his last two siblings. During the admission he was treated for community acquired pneumonia, hospital acquired pneumonia and Covid 19. He was started on the antidepressant mirtazapine.

A best interest meeting was arranged on 20th April 2022 by Croydon Council Adult Social Care which James's nephew and niece attended. Hospital medical staff attended however there was no psychiatric professional at the meeting. The outcome was that James should return home based on the decision-maker however, family and other professionals strongly disagreed with this decision.

James was referred to the Older Adults Community Home Treatment Team (HTT) and assessed and accepted on 25/04/22 due to his suicidal ideation. Discharge on the 23/03/22 was postponed and was finally discharged to home on the 10/5/22 with double handed care support and 4 x daily visits.

There was limited multiagency communication regarding medication arrangements, care agency details and the district nurse plan. There were several problems at home including no hot water or heating and care workers being either unable or unwilling to give medication.

On 18/05/2022 a member of staff of the HTT called the London Ambulance Service due to their concerns over James presenting as physically deteriorated and unresponsive. He was taken back to hospital where he was diagnosed with a right sided pneumonia. James sadly passed away on 20/05/2022.

5. Key Points from Information Gathered

a) **SLaM**

- Managing high risk cases in the community – Trust incident reporting was not adhered to, so senior managers were not made aware of the significant and increasing risk. There was limited formal multiagency co-ordination or communication evidenced in the clinical records.
- Mental health and self-neglect – approaches to long term planning.
- To consider looking at structures and processes. Best practice would have been for the OALPS to have reviewed James immediately prior to his discharge and referred to OAHTT and they should have also reviewed him immediately prior to discharge to clarify that he still required their acute input.
- Professionals should call LAS immediately if there are serious concerns towards patients' mental and physical wellbeing and to ensure Datix is completed.
- Hospital and Adult Social Care discharge care plan was not communicated to other agencies.
- Medication administration issues and prescription and the need for immediate escalation.
- Deterioration significantly of physical health escalated to the GP, Safeguarding lead or senior management team.
- Communication with family members.

b) **Adult Social Care**:

Areas of good practice:

- A mental capacity assessment was completed by hospital based social worker and signed off by team manager.
- A best interests meeting was held, with involvement from family, nursing staff, ward medical staff and senior discharge co-ordinator.
- An assessment of care and support needs was completed in a timely manner with a plan to review in two weeks, and the required onward referrals were made.

Areas for consideration:

- The minutes of the best interests meeting were brief and lacked detail. There was a short explanation as to how the decision was reached by the Decision Maker, but the notes did not fully reflect the discussions regarding risks and concerns.
- The names of family members were not recorded in full on LAS.
- In LAS case notes there is no record of communication to the LIFE social worker from any provider agency. No records were made from the 17/05/2022 to 13/6/2022.
- Professionals and family do not appear to have been advised as to further actions they could take regarding the outcome of the best interest meeting if they were not in agreement with the decision reached, even though the family made it clear they were not.

c) **Croydon Health Services**:

Good practice:

- There was evidence of good multi-professional working and communication between services with James and his nephew, and the niece was also involved in the best interest meeting.
- There was expected practice around application of the Mental Capacity Act (2005), however there wasn't evidence of consideration for application of Deprivation of Liberty Safeguards (DoLs).
- James wasn't discharged with a blister pack this however didn't affect his care as the DNs attended and administered until this was available for the care workers to use.

Areas for consideration:

- Where a person lacks mental capacity regarding hospital stay, care and treatment the ward doctors and nurses should have consideration to the Deprivation of Liberty Safeguards (DoLS) and make application where required.

6. Themes from previous SARs

CSAB have undertaken several SARs which have included recommendations covering similar issues to this SAR. CSAB will review its SAR Action Plan and the updates provided by partners /agencies on those recommendations in light of the learning from this SAR.

7 Recommendations

The table below sets out the recommendations from this Safeguarding Adults Review. The named agencies will be expected to provide evidence to Croydon SAB on how they have assured themselves they have put this learning into practice.

The right-hand column identifies where there may be learning for other agencies. They will have the opportunity to share with the Board any actions they take to act on this learning, but this will be at their discretion rather than an expectation that they do so.

No.	Recommendation	SLaM	Adult Social Care	Croydon Health Services	Action for other CSAB Members (specify which)	Potential learning for other CSAB members
1	To ensure that risks are recognised, and that this leads to incident reporting and / or escalation processes being followed so senior managers, safeguarding lead and, where needed, the GP are made aware of these issues. This includes • Issues relating to medication and prescription issues • Significant deterioration of physical health	✓				✓
2	Where a person lacks mental capacity regarding hospital stay, care and treatment the ward doctors / nurses should have consideration to the Deprivation of Liberty Safeguards (DoLS) and make application where required.			✓		✓
3	To ensure that discharge planning is communicated across all agencies that need to be informed, and that records are made of that communication.	✓	✓	✓		✓
4	To ensure that best interest decisions made under section 4 the Mental Capacity Act 2005 meet the requirements of the Act and of the MCA Code of Practice.		✓			✓

	Where there is a dispute over what is in a person's best interests then this must be responded to in line with the expectations set out in pages 88 – 91 of the Mental Capacity Act Code of Practice.					
5	To ensure that records are kept in line with expectations. In particular: • That the names and details of family members names are fully recorded • Minutes of best interest meetings should include sufficient detail to explain how decisions were reached and the rationale for them.		✓			

Appendix 1

Chronology - JAMES

29/12/21	James admitted to CUH. James attended Croydon University Hospital (CUH) Emergency Department (ED) on 29th of December 2021 at 12:39, he presented following a fall and injury to head. James had contacted the London Ambulance Service, he explained he was sat on his bed, felt 'giddy' and fell forwards, and he had fallen 3-4 times in the last few weeks. The ED assessment indicated James may have Cardiac syncope triggered by infection and dehydration, fall and head injury and right elbow inflammation. Required assessments were completed (x-ray, CT head, bloods, observations).
30/12/21	James was transferred from the Emergency Department (ED) to the Acute Medical Unit (AMU) on the 30th of December for onward care and assessment. On admission James was noted as being confused to time and place, he was also observed to have a category 2 pressure area to the sacrum (incident report completed). A medical review took place on the 30th December which indicated sepsis, low blood pressure, and possible subdural haematoma. The Cardiology team reviewed James on the 30th of December, the plan of care was to treat infection and once medically stable further cardiology investigations to be completed.
04/01/22	It was explained to James on the 4th of January that he may have experienced a heart attack and had been found to have heart failure (HF). The HF Nurse met with James, he was provided education around the condition, lifestyle choices, medication and provided a booklet. Plan for community HF team to review on discharge.
10/01/22	On the 10th of January James was transferred from the Acute Medical Unit to ACE ward (Acute Care of Elderly) for onward care, he was provided a Baywatch bed (provided to patients at high risk of falls). The Occupational Therapist met with James on the 12th of January to obtain some background information, he declined to engage. The OT completed assessment with his nephew, prior to admission James was described as being quite independent, he found personal care difficult and required Nephew's support with shopping. Nephew explained James had become paranoid about Covid-19, isolating himself from family after the death of his sister. His Nephew felt James would benefit from a package of care and ongoing therapy.
13/01/22	On the 13th of January the records detail JAMES was low in mood and was reported he wanted to die. There were cognitive concerns as he believed he was 41 years old and was unable to recall why he is in hospital. 4AT – 8. James reported as not feeling 'bothered' about his reduced nutritional intake, that he doesn't like being at home as he lives alone.
14/01/22	First SLaM contact, discharged from Working Age Psychiatric Liaison Service to Older Adult Service. Ward Doctor documented a discussion with Nephew, he explained James had experienced low mood since both his sisters had passed away and became isolated. It was agreed that a referral would be made to the psychiatric team for review and support of low mood, and to start Mirtazapine (antidepressant).
17/01/22	Psychiatric Team met with James, a follow up contact was completed on the 18th, he didn't engage on either stating "leave me alone". It is documented that James may have delirium or deteriorating in regard to his mood (depression).
18/01/22	Further attempt to review James's mental state – postponed while information sought, and mirtazapine prescribed

19/01/22	SLaM full psychiatric assessment undertaken – James engaged and much improved in mental state – medication remained the same and no indication for regular psych review but to review before discharge. Psychiatric Team met with James, it is documented that he engaged well with the assessment, was orientated and aware of why he was in hospital, he was reporting as feeling better with no suicidal ideation. The risk summary identified high risk of self-neglect and falls, low risk of self-harm. Diagnosed as resoling delirium and moderate depressive episode, plan to review again prior to discharge.
20/01/22	OT review on 20th of January indicated that James requires transfer with sara steady and two staff support, unable to mobilise with frame due to reduced strength. Suggested micro set up at home with sara steady and 4 times a day package of care.
24/01/22	Review Standard Mini-mental State Examination (SMMSE) – no change to care plan
25/01/22	Multidisciplinary team meeting – no change to plan
26/01/22	Doctor discussed an update with Nephew, James is now medically fit, is showing improvement with mobility which would benefit onward therapy. Liam informed James's home has been refurbished and is suitable for his return.
27/01/22	He was able to walk 8 meters with zimmer frame and supervision of 1 staff, requires prompts to support safe transfers, sit to stand with support of 2 staff, unsafe sit to chair requires assistance of 1 staff.
28/01/22	MDT Meeting – no change to care plan
31/01/22	Tested positive for Covid-19
01/02/22	MDT Meeting – no change to care plan. Doctor contacted Nephew to provide update that James has tested positive for Covid-19 and will be monitored and supported. Discussed discharge plan, records detail Doctor and his view is a step-down rehabilitation bed would be beneficial.
03/02/22	Contact with nephew on the ward and information shared although nephew incorrected identified as 'son' on ePJS. James had a fall, he had been provided a urine bottle to use, he put down the side rails and fell from bed. All required actions to review and document upon fall completed at time. James supported with low profile bed in Baywatch area of ward. A Mental Capacity Assessment was completed by the ward staff regarding the decision of hospital stay/care and treatment, this deemed James lacked mental capacity, it referenced confusion.
04/02/22	MDT meeting no change to care plan. The Psychiatric team completed a review on James reported as 'okay', no concerns relating to suicidal ideation, plan to review prior to discharge.
09/02/22	The OT completed a review on the 9th of February; James didn't engage however agreed for an environmental visit to consider options of equipment at home. Discussion held with Nephew, shared update that James isn't engaging in OT/Physiotherapy. He expressed continued wish for step down bed (CICS) and onward therapy, OT explained CICS currently closed due to Covid-19 with no plans for reopening, also not a suitable placement due to James's functional level.
10/02/22	Nephew agreed to and attended hospital to support the OT assessment and encouraging James to engage. The OT advised James and his nephew the safest discharge option available is home with sara steady and double handed package of care 4 times a day with LIFE therapy input.
16/02/22	Psychiatric team reviewed, James declined to engage in memory assessment, continued evidence of cognitive change as he reports poor memory and unable to inform of year and place. Plan for Mental Health Home Treatment Team on discharge,

	moderate risk of suicide as continued thoughts reported. Moderately high risk of suicide. Reviews continued with concern of increasingly confused and secondary delirium.
18/02/22	OT completed a home assessment, suitable for equipment required Nephew informed. the ward Doctor informed Nephew that James had raised inflammatory markers and an infection (being investigated) leading to periods of confusion, prescribed antibiotics and for monitoring.
02/03/22	A referral was made to the Speech and Language Team for possible silent aspiration (related to post-polio syndrome). SALT completed a review on the 10th of March which informed at risk of aspiration, recommendation of a thicker fluid would support swallow.
07/03/22	Further contact with nephew and James appeared bright and cheerful in mood. The Psychiatric team reviewed JAMES, he engaged well and informed he wasn't having thoughts of suicide as often, that he was looking forward to going home. Still presenting with some confusion and disorientation.
14/03/22	Family contact helpful and nephew provided lots of information. Since Covid James was depressed during isolation and had become confused over the past year.
18/03/22	Nephew contacted re imminent discharge plans. The Psychiatric team reviewed James, he was sat in the chair, observed to be in good mood, engaged well, was interactive and reported happy to be going home.
21/03/22	Psychiatric review on the ward – expresses suicidal thoughts and hopelessness since the loss of his sister. Referred to HTT who will review James. Wandle ward in process of discharging, left a message on nephew's phone. Clear risk guidance documented regarding suicide risk and access to medication if at home. James was currently bed bound, drugs to be locked away and care workers to administer. SMMSE unable to complete as James not engaging – suggested this could be completed in the community if discharged. A Mental Capacity Assessment was completed by ward staff regarding care and treatment; outcome was had capacity.
23/03/22	Discharge plan postponed and HTT to await next discharge date. It is noted that James was refusing to return home, on exploration this was due to confusion and believing he had been offered a place to stay 'here' (in hospital). It was identified that James had a high temperature.
24/03/22	James continued to experience high temperatures, he was provided IV antibiotics, fluids, paracetamol and bloods were taken. Receiving treatment for hospital acquired pneumonia.
26/03/22	James's temperature and observations had stabilised.
04/04/22	James wanted to go home but then saying he doesn't want to go home - saying 'he wants to die'. He thought the hospital was his home. Capacity to make a decision on where he lives. Nephew not aware of plans to discharge. All observations in normal range. The OT met with James and discussed the discharge plans, James presented as confused at times in conversation. Discussed with James the plan for him to return home with hospital bed, and care to be provided in bed. Discharged from Physiotherapy with plan for LIFE therapy team to support on discharge.
05/04/22	Referral from Discharge Team to Hospital Social Work team.

	OT discussed with Nephew discharge plans, he reports concern that James will not manage even with package of care. OT handed this over to discharge co-ordinator who made a referral to Social Services for support.
06/04/22	Blood sugars were low at 3.8 and glucogel given. AMTS score was 4/10. James' discharge preference is documented as home, that he would need help, that he would like to try, and that he would 'think twice about a care home'. A Mental Capacity Assessment was completed regarding discharge destination, this determined that James lacked mental capacity, the plan was for the social worker to lead a best interest meeting, and a referral to made for memory assessment on discharge.
07/04/22	A further SALT assessment was completed which concluded Pharyngeal dysphasia characterised by a delayed cough. Slightly delayed hyo-laryngeal movement likely results in reduced airway protection and increased risk of penetration/aspiration. Recommendation; Slightly thickened fluids (level 1), independent eating/drinking with supervision, slow pace.
08/04/22	A chest x-ray was completed which indicated on the right lung some likely infective changes. James was treated with antibiotics.
11/04/22	Unclear if CPN, HTT and Ward are communicating with family. No details of social worker or the BIA meeting plan.
11/04/22	Mental Capacity Assessment completed and signed off states that James lacks capacity to make a decision regarding his discharge/accommodation.
12/04/22	Social Worker attended and completed a Mental Capacity Assessment regarding discharge destination, this concluded that he doesn't have mental capacity regarding this decision. James was able to understand the decision, retain and communicate but unable to recognise his support needs and weigh the risks/benefits. Plan; Best Interest Meeting required.
13/04/22	James declined some food, and on the 14th, he declined medication. Doctor was informed who reviewed, observations in range, James reporting as well, he expressed he would like to go to a care home.
18/04/22	blood sugars low, glucogel given.
20/04/22	BIM held - decision maker states JAMES to be discharged to his home address with a plan in place for continued support in the community. This includes four daily care input, careline and equipment.
25/04/22	First ePJS documenting of disability (polio) and need to mobilise with a leg brace. No mention of the family in care plan. Visit once daily to monitor transition from hospital to home, monitor mental state and any other risks.
27/04/22	James is documented as being medically fit for discharge, awaiting equipment and services to be in place.
05/05/22	SALT team completed a review as it was reported that JAMES drink less due to the thickened fluids. Recommendation to continue with level 1 fluids.
06/05/22	D2A completed. Identifies double handed care support required 4 x daily plus OT and physiotherapy input.
09/05/22	Medical review indicates that James was well in himself, no pain, no shortness of breath, and observations in range. Nephew shared continued concern regarding the plan for James to be discharged home and shared an image of the hospital bed placement and limited space, this was shared with OT for review and feedback.
10/05/22	James discharged from CUH, HTT informed. Careline installed on site.

	James was discharged with a package of care in place, including key safe, district nurse referral, red cross, home treatment team referral, pendant. A discharge letter was sent to the GP, and nephew was informed. Referral made to the District Nursing Team Requires support with pressure area (category 2 on sacrum) and equipment check. Tissue Viability Nurse completed a review of equipment at James's home. Care workers noted as unable to provide James with medication and eye drops, TVN provided to him with consent, he declined pain relief reporting not in pain. James declined his sacral area being checked, heels were checked.
11/05/22	A bag of medication found on the chair next to his bed, home care workers not recorded medication information. DNAR letter was found in his medication bag and copy taken. District Nurse (DN) attended James's home at 16:35. James was sitting on the floor next to his bed, he said he had fallen from his bed at 15.45 and was unable to get up, he denied any injury or pain, observations taken and in range. James was wearing his pendant alarm, pressed to inform Careline, care workers attended and helped James to bed. Pressure areas checked, no pressure area noted on sacrum. Care workers reported unable to support medication as these are in packets not blister packs. Evening medication given by DN.
12/05/22	HTT meeting, plan accepted by HTT remain in red zone and daily visits. Home visit took place, and James says he fell out of bed the day before and care workers called LAS. SLaM not informed about fall and don't follow up details, care workers say they are unable to give medication. District Nurse (DN) attended James' home at 09:50. James documented as being 'bright and alert' on arrival, medication provided as prescribed. DN attended James home at 16:45, he declined medications as reported he had already had these. D2A received, allocated to LIFE team Social Worker to complete a post discharge home visit/assessment for James Part B
13/05/22	Home visit and James in stable mood and moved to amber zone, still confusion regarding the taking of medication and to whether care workers had been in that morning. Social Worker completes Part B home visit/assessment. Identifies goals and refers to physiotherapy. Note to review in two weeks. Occupational therapist attempted to call James on landline and mobile, a voicemail was letter and letter sent. Documented if no response by 3/6/22 James will be discharged
14/05/22	Home visit and still no clarity on medication or dietary intake, no record of attempts to contact nephew. No record of manager escalation.
15/05/22	Amber zone. Home visit and noticed he had a cough but not drinking or eating, house was cold and had to boil the kettle to wash him and he was soaked in urine. He struggled with fluids due to choking but was this reported? No manager escalation.
16/05/22	Home visit and James lying on mattress on the floor in the lounge. The District Nursing care plan identified Wednesday visits to provide James with pain patch.
17/05/22	Detailed recording by support worker with multiple concerns identified (good practice) Concerns raised with the HTT team manager after the visit. HTT worker could see red sore on buttocks and asked care workers to inform DNs. James was in pain and distressed and couldn't tolerate being washed.
17/05/22	Visited by Careline staff to sign relevant documents and uploaded to LAS.
18/05/22	MDT meeting and may return to hospital. Home visit Nurse met care workers at the door and James lying in bed with lots of blankets, he was not responding well and decision to call 999. No record of nephew being called and no escalation to Clinical Service Lead or Safeguarding Lead.

18/05/22	The District Nursing team attended James' home at 11:50 and found him to be presenting as unwell, ambulance was called, he was transferred to hospital. GP Duty Doctor consultation with paramedic – sepsis identified needs hospitalisation and taken to hospital
20/05/22	HTT discharged James as he is in hospital and James died in CUH with Aspiration Pneumonia.
13/06/22	Social worker attempts to make telephone call to James and his NOK to make arrangements for a review as planned. SW speaks to Care Provider (All for Care) who advised James passed away.