West Sussex Safeguarding Adults Board

TD Safeguarding Adults Desktop Review:

Overview Report

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Foreword

The West Sussex Safeguarding Adults Board (the Board) has published a Safeguarding Adults Review (SAR) that looked into the circumstances in the lead up to the death of TD. The Board and the Independent Reviewer express their sincere condolences to the family and friends of TD.

The purpose of a Safeguarding Adults Review is not to reinvestigate or to apportion blame but to establish where and, how lessons can be learned, and services improved for all those who use them and, for their families and carers.

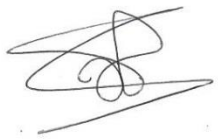
This Review looks at the circumstances and the support offered in the lead up to TD's death and, examines the actions of various agencies that were involved in order to reduce the likelihood of similar events happening again, in the future.

Recommendations have been made as a result of this Review, which will enable lessons to be learned and will contribute to service development and improvement.

The Review identified key findings in relation to; professional curiosity, multi-agency risk management, effective safeguarding adults' decisions and actions, and fulfilment of TD's wishes. The Reviewer made a recommendations under 5 key areas; planned and completed actions, multi-agency risk management, safeguarding thresholds and enquiries, Mental Capacity Act training and recording and, the service user voice.

The Board and the SAR Subgroup, which reports to the Board, will monitor progress on the implementation of all recommendations through receiving reports from all agencies involved in working TD, that reflect progress on their continued action plan to reduce risk and ensure that the necessary development of systems and procedures continue to improve practice.

The Board will also ensure that the learning from this Review is widely disseminated and that the outcomes of the learning will lead to improved services in West Sussex.



Annie Callanan, Independent Chair

1. Introduction

1.1. The West Sussex Safeguarding Adults Board (WSSAB) decided in January 2021 that the criteria to undertake a Safeguarding Adults Review were met. A desktop review was considered to be proportionate, to build on individual agency reviews and already agreed upon improvements, and this was commissioned to commence in May 2021.

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

- When an adult has died and abuse or neglect has been a contributory factor, or has not died but has 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 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 TD and a comfort to his 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), an analysis of the facts with findings (so what), recommendations to improve services and to reduce the risk of repeat circumstances and a shared action plan to implement these recommendations (what now). It is important that the actions are monitored by the WSSAB to ensure that the review makes a positive difference in the lives of adults at risk.

1.6. It is not the purpose of the review to re-investigate suspected abuse or neglect, or to apportion blame to any party, and strengths are identified alongside failings to ensure a rounded learning experience.

1.7. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has critically analysed relevant agencies records and interviewed representatives; leading to a presentation of the overview report and action plan to the WSSAB SAR panel and full board for endorsement; and culminating in a learning event and a Quality & Performance Sub-Group responsibility to seek assurance that the action plan is progressed across agencies.

1.8. The review concentrates on the most relevant period, from 01/03/19 when the initial safeguarding concern arose to 31/10/19 when TD died.

1.9. The review overlaps with a Coroner's Inquest, held on 02 and 03/06/21, and the findings are incorporated within this review. In conclusion, the coroner found that Adult G died from pneumonia, caused by his Chronic Obstructive Pulmonary Disease (COPD), despite appropriate treatment. His decline was accelerated by his mental health. The coroner concluded that deficits found in interventions by agencies did not amount to neglect or contribute in any significant way to TD's death.

1.10. The Independent Reviewer acknowledges that significant improvements have already been made in areas identified within this review, under the auspices of the WSSAB, and continued progress should be monitored by the Board.

1.11. A contribution by family to the review has been enabled by a telephone interview with AD (brother), in which he provided a pen picture of TD and a perspective on the care received from agencies. Following consultation with a relative, Care Home and CMHT professional, contact has not been made with TD's partner, MM, to discuss the review. This is due to her vulnerability. However, a summary of the findings may subsequently be shared with her by the Independent Reviewer and a relative.

1.12. Representatives of agencies contributing to the review, through panel attendance or online interviews with the Independent Reviewer (unless otherwise stated), are listed below (titles are those which applied during the reporting period):

- Assistant Director, Safeguarding, Planning & Performance – West Sussex County Council (WSCC), Adult Social Care
- Adult Safeguarding Service Manager – WSCC, Adult Social Care
- Tissue Viability Nurse Lead – Western Sussex Hospitals
- Deputy Director of Social Work – Sussex Partnership Foundation Trust
- Social Worker (AMHP, Placement Review Officer) – Berkshire Mental Health Services, Windsor & Maidenhead Community Mental Health Team (WAM CMHT)
- Team Leader – Berkshire Mental health Services, WAM CMHT
- Director – Abbots Lawn Nursing Home (Ashton Care)
- Home Manager – Abbots Lawn Nursing Home (Ashton Care)
- Sussex NHS Commissioners (CCG) – Designated Nurse Adult Safeguarding
- West Meads Surgery – Practice Manager
- SECAmb – Safeguarding Nurse Consultant
- Detective Sergeant – Sussex Police (via email)
- Representative – CQC (via email)

2. Circumstances leading to the review

2.1. TD died in St Richards Hospital on 31/10/19 and, in the eight months prior to his death, there had been six known contacts by agencies with West Sussex County Council (WSCC) about possible abuse and neglect. These are detailed in this report as significant events.

2.2. In preparing for the Inquest, WSCC found internal systemic and operational practice concerns, specifically relating to risk management and safeguarding decisions and actions.

2.3. The analysis in this review has focused on key themes, as agreed at an initial SAR planning meeting on 28/05/21, which are outlined in the Terms of Reference:

- How effective was multi-agency needs and risk assessment and communication?
- How effectively was mental capacity and the person's voice addressed?
- How effective were Safeguarding Adults responses in reducing the risk of abuse and neglect?
- What was the impact of resource and environmental issues on
- the decisions and actions of agencies?
- How compliant were agencies in meeting statutory and procedural requirements?
- Could the suspected neglect have been prevented?
- What concerns were raised by the Coroner's Enquiry?

3. Pen picture of TD

3.1. Safeguarding Adults Reviews (SARs) should provide a window into the lived experience of adults at risk.

3.2. TD is described by his brother (AD) as very caring, but that he was also prone to violent mood swings when not corrected by medication. They grew up together with their parents and grandparents and his brother recalls that TD had a difficult childhood. He had a speech difficulty, which meant that he received unkind comments from some peers. His schizophrenia began to manifest itself in his early teenage years and subsequently worsened. By his early twenties, TD was working as an apprentice joiner in a factory, before losing this job. He was later diagnosed with Asbestosis. TD was regularly in and out of Wexham Park Psychiatric Unit in Slough around this time and his brother feels that the stress on their parents was a contributory factor in their separation, after which TD continued to live at home with his mother. He met MM at Wexham Park Hospital Psychiatric Unit and she became his life-long partner. They lived in a Council flat in Maidenhead and then moved to sheltered accommodation in Bognor Regis. Subsequently they 'were split up' and TD experienced a couple of moves, before residing at Abbots Lawn Nursing Home (owned by Ashton Care) in Bognor Regis from May 2018, a couple of streets away from MM's residential care home.

3.3. It is unclear whether TD experienced the loss of a child to a road traffic accident whilst living in Berkshire and, if so, the significance to his mental health deterioration. The Berkshire Mental Health Services Social Worker, who was assigned to TD, is aware of this and believes it is accurate. TD's brother is aware of this possibility, but believes that it is probably not accurate as it was not relayed to him by TD, their mother or MM. He also feels that, if TD did experience such a loss, it would have been some time after his mental health had significantly deteriorated.

3.4. TD lived with acute mental health needs, including a diagnosis of paranoid schizophrenia, was not compliant with medication, and presented with challenging behaviour. GP records in November 2014 refer to delusional health beliefs and aggression. The GP surgery confirm, in contributing to this review, that they considered TD to have a learning disability and that he was on the learning disability register, but that he was not considered to be living with dementia and this is not referenced in his clinical records. There is a record of drug overdoses in 1979 due to depression, in 1985 as suicidal and in 2008 as feeling 'fed up'. His brother recalls that TD received ECT treatment whilst at Wexham Park, but he feels that this did not improve his mental health condition.

3.5. TD also had complex physical health needs; including chronic obstructive lung disease, microcytic anaemia, diabetes mellitus, chronic kidney disease, acquired hypothyroidism, and developed pressure ulcers to his sacrum and heels. His compliance with care was variable and full assistance was required whilst resident at the Nursing Home.

4. Facts

4.1. Prior to March 2019

4.2. The assigned Windsor & Maidenhead Social Worker (Approved Mental Health Practitioner and Placement Review Officer) began working with TD in April 2017. She completed her initial, introductory visit to him on 09/05/17. At this time, he had been in St Richard's Hospital for about 2 years, under Section 3 of the Mental Health Act, and discharge was planned back to Albany House Care Home. The Social Worker visited again on 09/06/17, joint with the Review Officer for TD's partner, MM, and the manager of the Care Home. Discharge was discussed and TD's partner had indicated a wish for them to move to a placement in Berkshire that had been identified by a previous Review Officer. She was concerned about possibly being separated from TD, who wished to be discharged to a low security unit. TD had presented at times as aggressive towards staff.

4.3. TD was discharged to Abbots Lawn Nursing Home on 04/05/18, with information provided by the Hospital and Social Worker on his presenting needs and an assessment completed by the placement whilst TD was in hospital. The Nursing Home is registered to meet the needs of up to 37 residents who are living with dementia or other mental health concerns. The area was chosen to enable TD to be close to his partner (resident in a Care Home nearby) and other potential placements in the Bognor Regis area had not progressed due to his challenging behaviour.

4.4. The Social Worker visited TD at Abbots Lawn Nursing Home on 25/07/18 to review the placement.

4.5. TD was admitted to the Harold Kidd Unit, Orchard Ward, under section 3 of the Mental Health Act, due to not taking medication. He was also presenting as aggressive to staff, putting himself on the floor, not eating and drinking sufficiently, was deteriorating in his physical health and had developed a Urinary

Tract Infection (UTI). A Discharge Planning Meeting was held on 02/10/18. Abbots Lawn Nursing Home affirmed that they could meet TD's needs with support and provided feedback that he would only accept medication of a certain colour. TD's brother, AD, was present and confirmed that he had held Lasting Power of Attorney (LPA) responsibility for TD's health and welfare and finances since 15/08/18.

4.6. On 22/08/18, the GP records refer to a Nursing Home request for a 'covert medication letter', which the surgery considered to be appropriate. It was also noted that it was unclear if the Mental Health Team were actively involved with TD. On 24/08/18, the Surgery and Nursing Home had requested that the Mental Health Team complete a Mental Health assessment as TD was not compliant with medication (as he felt that tablets were poisoned) and that his paranoid delusions were increasing. The GP surgery confirms that a temporary covert medication certificate was signed by the paramedic practitioner at the surgery on 22/08/18, following discussion with Nursing Home staff. The surgery has recorded a request to the local Mental Health Team on 23/08/18 to complete a mental health assessment, due to challenging behaviour and declining care, leading to hospital admission from 31/08/18 to 08/10/18.

4.7. The GP records on 05/11/18 refer to TD having received a letter from the Mental Health Team, explaining that covert medication was being applied, as he is refusing medication. He was under a Mental Health Act s17 Community Treatment Order.

4.8. The Social Worker contacted Abbot's Lawn Nursing Home on 26/11/18 and was informed that TD was still presenting as aggressive at times towards staff.

4.9. A Psychiatrist prescribed anti-psychotic depot medication on 03/12/18, under the Community Treatment Order; Anxiolytic (Clonazepam), Antiepileptic (Sodium Valproate), Antimuscarinic (Procyclidine). The medication was to be administered covertly within BNF limits. This was superseded by a Community Treatment order, signed by a second opinion appointed doctor. Other medication was not administered if refused.

4.10. CQC published an inspection report on Abbots Lawn Nursing Home on 13/12/18, with a rating of 'Good'.

4.11. On 05/02/19, the Social Worker visited TD at the Nursing Home, joint with the Clinical Commissioning Group (CCG) Review Officer, to complete a placement review. The CCG attendance had been arranged as TD was presenting as physically aggressive at times and was consistently asking to move to North Berkshire. The focus of the review was to consider TD's needs and potential transfer to his area of choice. During the review, the Social Worker witnessed TD punching his key worker twice. Staff at the Nursing Home managed his aggression by giving him time to calm down. TD required two staff to support him with a daily wash. At times he would put himself on the floor from his wheelchair. TD said that he wished to move to Berkshire to be near to his brother. His partner, MM, had spent most of her life with him. He visited her residential care home weekly, also to see his parrot, whilst she visited him every day at his Nursing Home and in hospital. She had complained to staff that he

was spending most of his time in his room. A strong smell of urine was noticed in TD's room during the review and laminate flooring was planned by the Nursing Home. The Social Worker, as part of the Safeguarding Adults Review, recalls that she had planned to look at potential placements in Berkshire but that it was difficult as he and his partner wished to move together, and they had different levels of need to each other.

4.12. March to October 2019

4.13. **Significant event 1:** TD was visited by a GP on 19/03/19, requested by the Nursing Home due to a slight swelling to his face and eye, with no acute cause found. It is understood that this was corrected by steroids on the same day. The GP advised that staff should provide monitoring and hospital admission was not considered to be necessary. TD had been observed on the bedroom floor by staff at 6am, helped back to bed, and observed on the floor again at 9.30 am. The Nursing Home representatives confirm that he was often found in this position. He would at times roll himself from his bed onto the floor and remain there for hours, at times covering himself in faeces (often shortly before his partner visited in the afternoon), and a mattress was therefore placed on the floor. A hoist was not safe to use, as he was at risk of throwing himself backwards. Shortly after support with dressing, he tended to strip off his clothes again. Staff would check in on TD at 8am and 8 pm. He was not routinely taking his prescribed medication, which the GP and Psychiatrist felt was affecting his physical and mental health. Despite administration of tablets in accordance with his colour preferences, he would still sometimes refuse to take tablets and staff would try again later. He received Sodium Valproate for paranoid schizophrenia, Clonazepam and a depot injection that was administered every two weeks by the local Mental Health Hub. The Nursing Home representatives state that they would administer the medication covertly as a last resort and had GP and Pharmacy permission for this. As the home is registered to cover mental health needs, including dementia, they have a Mental Capacity Assessment for every resident in respect to medication. The GP surgery confirm that mental capacity was correctly assessed and recorded in regard to taking medication on each GP visit to TD; that 'sometimes it was felt he had capacity to decline his medication and at others he did not seem to have capacity to decide'. It was not felt essential for him to take his psychiatric medication every day and he did take it intermittently. When he did not take medication, he became more paranoid, suspicious of staff, more intolerant and likely to present challenging behaviour. TD required two carers to assist with washing and dressing and presented as aggressive to staff at times, hitting or presenting as about to hit. This behaviour is described as unpredictable, as he could also present as amiable and 'very nice' and there was no clear pattern. Although there was also no clear trigger to his aggression, he presented certain motivations, such as racial prejudice and changeable food obsessions. The care plan was reviewed and, although unclear, this was not a care management review and was probably undertaken by a nurse at the home. Checks were increased to half-hourly, which the Nursing Home representatives confirm did happen. He would spend most of the time in his bedroom and would be supported or make his own way downstairs at times. A DoLS authorisation was in place since 12/5/2019, and an Independent Mental Capacity Advocate (IMCA) was involved, who supported his wish to move. TD had wished throughout his stay to move to Maidenhead, which the

representatives feel became increasingly significant to his emotional wellbeing, but do not know if this impacted on his behaviour. They do not recall a care management review, but that there were regular discussions about moving which they feel should have been more proactively pursued, and that the Social Worker did not visit regularly. The Social Worker was aware of the incident in March 2019. WSCC representatives would occasionally visit unannounced to check on TD, seeing him directly. The incident reported by the Nursing Home to WSCC did not meet the Care Act s42 criteria as there were no grounds to suspect neglect. This was a reasonable decision, but there is no record of a medication review by the Nursing Home and the GP, or of other action taken to address risk aside from increased checks.

4.14. A further GP visit was requested on 21/03/19 at 10.13. TD was seen at 15.41, had developed blisters on his hands and arms and was diagnosed with Bullous Pemphigoid and treated with steroids. This was reviewed by the GP on 05/06/19, who found that it had resolved. There is a GP record on 20/03/19 of covert medication. The Nursing Home representatives add that he did not have pressure ulcers at this point, but had blisters on his hands due to diabetes, which the GP was treating with steroids since around 13/03/19.

4.15. On 04/06/19, 18/06/19 and 21/06/19, the Social Worker contacted the Mental Health Team in Bognor Regis to request information on his needs. This was received and provided to two prospective Nursing Homes in Berkshire.

4.16. The Nursing Home requested a medication review in July or August 2019, due to a deterioration in TD's physical health, and Temazepam was reduced in the same month. There had been active communication between the Nursing Home with the GP surgery, with 3 requests for visits to TD in June 2019, none in July 2019 and 4 in August 2019.

4.17. SECAmb received 16 calls from the Nursing Home regarding residents between July and October 2019 (4-month period), including 4 or 5 duplicate or cancelled calls. An ambulance crew attended on 11 occasions, which the SECAmb representative in this review does not consider to have been exceptional, considering the dependency levels of residents.

4.18. **Significant event 2:** An incident was reported by TD's partner on 01/07/19 to the local Mental Health Hub, that TD had alleged a physical assault by staff; specifically, that he was punched on the nose and his eye was cut. Staff checked and found no cuts, bruises or other injuries. The GP surgery was not contacted in relation to this incident. Mental Health staff visited promptly, and no injuries were observed. There was unclear recording and action by the Mental Health Hub and there was no recording of the incident by the Nursing Home. The Nursing Home representatives state that recording has improved since this time. They state that it was not unusual for TD's partner to report allegations, including assault and neglect, following comments from TD; but that there was never any indication of assault and carers attended in pairs. Also, on no occasion where they asked to complete a Safeguarding Adults form in relation to TD. The incident was not reported to West Sussex County Council as a safeguarding concern or shared with Berkshire, although the Care Act s42 criteria was clearly met.

4.19. **Significant event 3:** TD was admitted to St Richard's Hospital on 11/08/19, due to sepsis. The SECAmb Ambulance Service has a record of providing transport to hospital; that sepsis was queried, he was receiving antibiotics for a chest infection, there were concerns about his nutrition and there was nothing untoward in this or in either of the other 2 ambulance callouts to TD. SECAmb did not have a responsibility to provide transport for the return journeys. The Hospital reported unstageable pressure ulcers to his sacrum and heels on 14/08/19. The development and care of these is unclear. The Nursing Home representatives state that TD had two diabetic blisters on each foot, which was known to the GP, and also had a moisture blister to his sacrum on 10/08/19, which they state turned into a pressure ulcer; that hospital admission was due to a concern about his chest and possible sepsis. They state that staff supported TD with repositioning, but that he would always lie on his back. A propad mattress was also placed on the floor when his skin integrity became a concern. TD was discharged on 15/08/19 and referred for assessment of the pressure ulcers. The discharge summary was received by the GP surgery without mention of the pressure ulcers. A Hospital Senior Social Work Practitioner passed a safeguarding concern to the local Mental Health Team in Bognor on 14/08/19 and then closed the concern as the s42 threshold was not met. The Nursing Home record of the pressure ulcers is unclear. WSCC Adult Social Care planned to visit on 20/08/19, but he had been readmitted to hospital. They closed the Safeguarding Adults concern two months later in October 2019 as not meeting the safeguarding adult's threshold. There was no line manager recording within this two-month period to explain the rationale for closing or to monitor whether actions were taking place.

4.20. **Significant event 4:** The Nursing Home representatives state that a nurse at the home remained concerned that TD was still unwell when discharged on 15/08/19. A GP visited on 16/08/19 (also viewing the blisters) and TD was readmitted to hospital on the same day, accompanied by his partner, due to a GP concern about pressure ulcers. SECAmb provided ambulance transport to hospital and their records show that TD had not had any oral intake since the previous day. Pressure ulcers were not indicated in the handover information from the Nursing Home. St Richard's Hospital reported unstageable deep tissue pressure ulcers to the heel and ankle, alongside a lesion to TD's ribs, as a safeguarding concern to WSCC on 19/08/19 (recorded as received on 20/08/19). Also, TD's partner expressed concern about general care of TD at the Nursing Home and his sleeping on a mattress on the floor. As referred to in the previous paragraph, a Hospital Social Worker considered that a s42 enquiry was appropriate on the basis that the threshold was met. WSCC closed the concern two months later, not progressing to enquiry as it duplicated an open enquiry, but it was not recognised that there had been no action taken on the open enquiry and line management monitoring is not clear. A WSCC Adult Social Care Senior Social Work Practitioner spoke with the Hospital Ward Sister on 22/08/19, prior to discharge on the same day, and confirmed agreement that TD should be discharged to the Nursing Home. A discharge summary was forwarded to the GP surgery. This noted diagnoses of sepsis, frailty and pressure sores to his sacrum and heel, with no follow-up actions detailed.

4.21. TD was readmitted to hospital on 27/08/19, due to respiratory failure, the third admission in the same month, with no change in the presentation of pressure ulcers. A TVN completed a physical examination/review on 30/08/19, recording a large sacral sore and category 3 bilateral blisters to heels, and there was a full care plan relating to the wounds. The TVN, in the coroner's enquiry states that these did not present as definitely diabetic blisters. On discharge to the nursing home on 31/08/19, there is no record of written documentation about wound care advice. A GP record on 28/08/19 referred to TD as being under a Community Treatment Order, MHA s17, and that he lacked the capacity to make independent decisions.

4.22. TD's brother, who supported transfer, rang the Social Worker on 30/08/19 to confirm that a Berkshire placement would accept him and that he had been placed on their waiting list. He relayed his concern that Abbots Lawn may not be meeting TD's needs, that his partner would need to move with him, and that he was finding the journey to Bognor Regis difficult. At the same time, the Social Worker had made a referral to another Nursing Home in Berkshire.

4.23. A Multi-Disciplinary Team (MDT) meeting was held on 04/09/19. This was attended by the Psychiatrist, Social Worker and Support Workers. The discussion included that Nursing Homes in Berkshire were being contacted with a view to possible transfer. The Nursing Home contacted the GP Surgery on 18/09/19 and reported that TD's sacral sores had been improving in the home but had deteriorated in hospital. A TVN with Sussex Community NHS visited on 24/09/19 and found an unstageable sacral sore and bilateral heel damage, recommending two hourly turns as much as he would comply but not recording this in her report. It was noted that his partner, who was present, was often removing his boots. A further review was not planned and the TVN recognised in the coroner's enquiry that a review after 4 weeks would have been appropriate.

4.24. CQC received one notification in relation to a pressure ulcer during the period covered in this review, on 20/09/19. This was reviewed by the allocated inspector for the service and closed as appropriate action had been taken. There were no further contacts with CQC to register concerns.

4.25. The Social Worker contacted Abbots Lawn Nursing Home on 01/10/19 for an update on TD's care plan. She was informed that he had developed blisters on his hands and had been seen by the GP.

4.26. On 07/10/19, TD was readmitted to hospital, due to an infection. A GP had visited him at the Nursing Home on the same day and considered that he was deteriorating, experiencing difficulty in swallowing and not eating well; in bed all the time, but was regularly falling out of bed. The pressure ulcers were noted, and a wound assessment completed on admission, with no mention of the previous safeguarding alerts. TD's brother emailed the Social Worker on 08/10/19 to convey that he had been advised by the Nursing Home that TD had been permanently discharged and was in Hospital. The Social Worker rang the Nursing Home and was informed that TD had been admitted to hospital due to a chest infection but had returned to the Nursing Home on 08/10/19; that they would not agree to a return to the Home if admitted to Hospital again, as family were requesting a Home in Berkshire. She rang TD's brother to relay this

information and to update him on Nursing Homes that she had contacted. Of these, some were pending a response, or she had concerns, or Homes had said that they could not manage his needs.

4.27. A GP visited TD at the Nursing Home on 14/10/19. TD was lying in bed, not engaging and was eating small amounts. He nodded when asked if he wished to move to Berkshire and if he wished Hospital admission if unwell, with the GP considering that he appeared to have capacity to make these decisions.

4.28. On 15/10/19, the Social Worker visited TD at Abbots Lawn Nursing Home, joint with the CCG Review Officer. TD had been prescribed steroids due to bruising on his hands, had a recent chest infection, and had sores on his bottom that the Home Manager had said were not pressure ulcers. A Tissue Viability Nurse (TVN) was advising the Home on care of the sores. It was further reported that TD was staying in bed and would only lie on his back. He was not taking himself to the floor. TD required two carers to support him with personal care, he was no longer aggressive as he was frail and lacked the physical strength, was not engaging, had lost his voice and was referred to the Speech and Language Team (SALT). The Nursing Home were giving consideration to issuing a notice for TD to leave. The Social Worker asked the Home to raise a Safeguarding Adults concern regarding the pressure ulcer, and to refer for Physiotherapy and a Psychiatric review. In contributing to this review, the Social Worker recalls that she was considering a professionals meeting at the time to address issues that had been raised; to include the Nursing Home, partner and possibly the local Mental Health Team in Bognor Regis. However, she states that her recording was not clear on this point. Aside from this concern and the concern raised on 01/07/19 regarding suspected assault, the Social Worker states that she was unaware of the other Safeguarding Adults concerns that had been raised.

4.29. TD was readmitted to hospital on 15/10/19, due to an infection, and discharged on the following day. A GP record on 17/10/19, notes that TD had 'moisture lesions to sacrum and sore heels (historical and has been seen by TVN)'. On 24/10/19, the record refers to a Surgery representative speaking with a Consultant at the Bedale Centre. It is noted that the Consultant seemed to consider that TD's decline, in terms of not engaging and reduced self-care, was medical rather than behavioural/mental health related, and that medical admission was not necessary; although it is commented that the Consultant had relayed these opinions without having seen TD. The Surgery also recorded that the Consultant felt that TD did not have capacity to make decisions regarding medication, but that the GP had felt in reviewing TD during the previous month that he did have capacity in this regard.

4.30. **Significant event 5:** On 16/10/19, the Nursing Home reported pressure ulcers as safeguarding, related to the previous two concerns, and did not receive feedback. The Sussex Partnership Mental Health Team had visited; as had the TVN, advising dressings. The wound was due to moisture rather than a pressure area and was closed as duplicating the previous two open safeguarding enquiries. This was appropriate as the concerns duplicated open enquiries, but no work was being completed on the previous two concerns and this was not flagged up. It was closed with no action and no line manager record of the rationale for this decision. There was no discussion of any of the safeguarding

concerns with TD or family. On 17/10/19, TD was seen at the Nursing Home by a Sussex Community NHS primary care nurse. He had a profiling bed with an air mattress, his boots were on, he had recently been seen by a TVN and his wounds were managed. His almost blank care plan was not updated.

4.31. **Significant event 6:** TD's partner contacted Mental Health Services on 22/10/19 to raise a concern about the Nursing Home and TD's physical and mental health deterioration; stating that he was losing weight, was being targeted by Nursing Home staff and that his health improves in hospital. The concern was forwarded by email to Berkshire Mental Health Services but was not raised as a safeguarding adults concern with WSCC, although the s42 criteria appears to have been met.

4.32. TD was readmitted to hospital on 24/10/19, due to double pneumonia, sepsis and a severe sacral ulcer that had deteriorated to grade 4. SECAmb records indicate that he had experienced recurrent chest infections, the home rang for an ambulance as he presented as less responsive, there were signs of sepsis, and observations taken by the ambulance crew showed that he was in very poor health. A TVN completed a review on 24/10/19 and 25/10/19, observing a category 4 sacral pressure ulcer, a category 2 pressure ulcer to the left heel and also to the right ankle, a category 3 or 4 deep tissue injury to his shoulder, and a full care plan was in place. TD was cared for on a pressure mattress and his heels were rested on pillows. He had not eaten for 2 days. A referral was made by the Nursing Home to Berkshire Mental Health Services on 25/10/19 for a Mental Health Act Assessment and s3 detention or recall to Hospital under a Community Treatment Order (CTO). The Nursing Home contacted the Hospital to state that TD would be discharged to a new placement.

4.33. The Social Worker contacted Brokerage on 30/10/19 for an update on available Nursing Homes. She had now expanded her search within Berkshire. On the same day, TD's brother rang the Social Worker to inform her that TD was receiving palliative care.

4.34. On 04/11/19, the Social Worker was informed by St Richards Hospital that TD had died on 31/10/19 and it was confirmed that he had a pressure ulcer.

4.35. Sussex Police received a report from WSCC Adult Social Care of TD's death and that there were potential concerns about care received whilst a resident at the Nursing Home. This was recorded as an Adult Safeguarding referral and closed as not a Police matter. There is no other record of TD held by Sussex Police from 2017 (the starting point for the check). This seems to have been appropriate on the basis of information known to the Police. However, the alleged physical assault in July 2019 should have been reported to the Police, despite the unreliability of the allegation.

4.36. On 07/11/19, CQC received notification of TD's death and closed involvement after a review. An inspection of Abbots Lawn Nursing Home was completed on 02/12/19 (published on 14/02/20), with a rating of 'Requires Improvement'. It was considered that staff were kind and caring, protected residents' dignity, encouraged independence and had a good understanding of safeguarding adults.

However, records did not clearly demonstrate how Mental Capacity Act principles were followed and recording of medication needed to be improved.

5. Critical analysis

5.1. General overview

5.1.1. There is evidence of a commitment by individual professionals and agencies to address TD's complex needs in an effective and personalised manner, including by the Nursing Home, and it is notable that neglect was not found by the coroner.

5.1.2. However, there were clear deficits in agencies providing comprehensive and coordinated oversight of health and social care provision, both individually and collectively. These are addressed in detail within the remainder of this section and summarised in the subsequent section on findings.

5.2. How effective was needs and risk assessment and communication?

5.2.1. **Family overview:** TD's brother, AD, considers that Abbots Lawn Nursing Home were 'not geared up' to meet his complex needs. He considers that TD developed pressure ulcers because the provision of a pressure relieving mattress was delayed. He also feels that hospital discharge was rushed, that 'systems let him down', and that agencies could have communicated more effectively.

5.2.2. **West Sussex County Council, Adult Social Care:** West Sussex County Council had Care Act Section 42 Safeguarding Adults responsibility, which was delegated to the Sussex Partnership Foundation Trust (local Mental Health Hub) within the Section 75 partnership agreement, with staff seconded to the Trust. The Coastal West Sussex Clinical Commissioning Group (CCG) held Section 117 responsibility, which was also delegated to the Trust.

5.2.3. Whilst WSCC had delegated the Care Act responsibility to assess and meet needs to a third party, there remained a responsibility to oversee the working of this arrangement in respect to TD. This oversight was not apparent and, although there was good practice through occasional visits to see TD, there was insufficient follow-up of care needs and risks in the aftermath of safeguarding decisions. The Section 75 arrangement ended in April 2021.

5.2.4. **Berkshire Mental Health Services, CMHT:** The level of Social Work contact between April 2017 and October 2019 does not appear to have been sufficient to provide oversight and coordination. However, there had been joint reviews, an MDT, and the urgency of contact and reassessment increased considerably in the two months prior to TD's death; including involvement in the decision-making that surrounded readmission to hospital in October 2019. Social Work reviews were held in July 2018, February 2019 and October 2019, as well as a Hospital Multi-Disciplinary Team Meeting in September 2019 regarding transfer and repositioning. The service notes that

the local CMHT in Bognor Regis held delegated care management responsibility, whilst Berkshire CMHT held review responsibility; that for most of the period of the Social Worker involvement, TD was in hospital, and she was involved in all hospital discharge meetings and identifying adequate alternative placements. Whilst the Independent Reviewer acknowledges this clarification, the point remains that a more intensive input over a prolonged period to locate an alternative placement would seem to have been appropriate; particularly in view of the complex circumstances.

5.2.5. The assigned Social Worker acknowledges, on reflection, that it would have been appropriate to have convened a multi-agency review meeting around May 2018, possibly taking the form of a West Sussex risk framework meeting, and that further clarity on cross-border risk management options would be helpful to practitioners. She recalls consideration of a multi-agency risk management meeting in October 2019. An earlier multi-agency review (which could have been triggered by any of the involved agencies) might have presented an opportunity for a more comprehensive and coordinated approach; particularly in view of the range of agencies involved across borders.

5.2.6. Also, locating an alternative placement was not proactively followed up, notwithstanding the difficulty in finding an appropriate placement due to TD's challenging behaviour, frequent hospital admissions and differing needs to his partner.

5.2.7. The assigned Social Worker states that she was very clear about her care management review responsibility to ensure that the placement was meeting TD's needs. However, she feels that communication with the Sussex Partnership Foundation Trust was not adequate, and she experienced a delay in receiving a copy of the up-to-date care plan; contact with the Nursing Home was prompt but she feels that views expressed tended to be subjective and a more accurate picture was found when she visited; and she had limited communication with WSCC. It is noted that the search for an alternative placement in Berkshire, in line with TD's wishes, was complicated by a necessity to balance this right with his Article 8 human right (Human Rights Act 1998) to private and family life; meaning that his partner was also a consideration in the move, and she had different needs. The Independent Reviewer has acknowledged the complexity of the circumstances and considers that this was further reason for a more concentrated input over a prolonged period.

5.2.8. **Sussex Partnership Foundation Trust:** The Trust held delegated Care Act s42 responsibility and the Bognor Recovery and Wellbeing Mental Health Team, with an allocated Mental Health practitioner (a Nurse; a Social Worker was not assigned in view of the Berkshire Mental Health Services Statutory Social Care responsibility), held an over-arching responsibility to review TD's mental health and medication needs. Whilst there had been attentive support in terms of medication and prompt responses to safeguarding concerns, there was insufficient evidence of close communication with other agencies; most significantly with Berkshire Mental Health Services, Windsor and Maidenhead Community Mental Health Team (CMHT).

5.2.9. **Western Sussex Hospitals:** Following a safeguarding concern raised by the hospital on 14/08/19 in relation to pressure ulcer care, the hospital discharge plan included a request for TVN support as a protective measure, but there is no further reference to the safeguarding concern in the two further hospital admissions during the same month. When TD was discharged on 31/08/19, there was no evidence of wound care advice to the nursing home. This demonstrated a shortfall in effective hospital discharge planning to meet identified risks; with a pattern of admissions followed by swift discharges (and one readmission a day after discharge), without triggering a comprehensive review of whether TD's needs and risks were met at the Nursing Home.

5.2.10. An investigation report was completed by the Trust in May 2020, considering whether guidelines were correctly followed on the patient journey. This includes a joint reflection with a WSCC Senior Social Worker that discharges to the Nursing Home were appropriate 'as the community social and mental health services were fully involved in trying to formulate a plan for this gentleman who had complex needs. Whilst acknowledging this perspective, the Independent Reviewer considers that readmission within a few days with the same presentation, the absence of information on wound care and the overall admissions in circumstances of complex needs, should have triggered a multi-agency review before discharge.

5.2.11. **Abbots Lawn Nursing Home:** It is clear that the Nursing Home endeavoured to meet TD's complex mental and physical health needs, including challenging behaviour. They seemed to be aware of his declining physical health and to have maintained close contact with the GP. However, there were deficits in recording and care plan records. TD would on occasions roll onto the floor, take off his clothes and cover himself in faeces. He was resistant to medication unless provided in particular colours. Two carers attended to TD in view of his aggressive presentation at times. There were concerns about his non-compliance with repositioning and with his nutritional intake. In these circumstances, the Nursing Home clearly endeavoured to be attentive, but should have actively sought multi-agency coordination and support in responding to TD's needs.

5.2.12. The Nursing Home representatives state that, on referring for TVN support, the initial TVN visit was completed 3 weeks later, but that communication was positive thereafter. They consider that communication with the Hospital was not adequate, including Hospital staff losing forms and not actively listening, but that the Hospital Discharge Team communicated well. They consider that communication and visiting by WSCC was very positive. The Community Psychiatric Nurse also visited fortnightly.

5.2.13. The representatives consider that the main deficit in support was that agencies were working alongside each other to support TD, with overall positive communication, but were not 'joined up'. On reflection, they consider that they should have been more proactive in challenging the delay in arranging a transfer to a Nursing Home in Berkshire. Also, they acknowledge that a multi-agency meeting should have been held to ensure a

joined-up approach to meeting TD's needs and addressing risks; that they had requested this since August 2019 without success.

5.2.14. The GP surgery representative confirms that there would not have been an expectation of contact by the Nursing Home following the alleged assault on 01/07/19, as the nursing team at the home had not observed any injuries. Whilst acknowledging this point, the Independent Reviewer considers that an independent medical examination and record by the GP would have been beneficial in terms of medical evidence as part of an enquiry. However, the surgery was not contacted, and a safeguarding adults enquiry was not conducted, notwithstanding the apparent lack of evidence to suggest assault.

5.2.15. **Sussex Community NHS Trust, Community Nursing:** A Tissue Viability Nurse (TVN) should have been requested earlier to provide the Nursing Home with specialist support and there was a three-week delay in provision of the service when this was requested.

5.2.16. A TVN recommendation of two-hourly turning in October 2019 was not clearly recorded and not subject to a prompt review, as acknowledged in the Inquest.

5.2.17. Community Nursing had no safeguarding concerns and felt that the Nursing Home understood and were managing his complex needs. It is a home that is highly regarded by Community Nursing for complex care.

5.2.18. West Meads Surgery: The surgery states that TD's circumstances were discussed at meetings with the Admissions Avoidance Matrons (now Care Home Matrons) and staff at the Nursing Home. There were no concerns raised by the GP about the care provided to TD by the Nursing Home and involved agencies.

5.3. How effectively was mental capacity and the person's voice addressed?

5.3.1. **Family overview:** TD wished to move to Berkshire and, whilst his brother acknowledges that the Windsor & Maidenhead CMHT were finding it difficult to find a suitable placement, he feels that this was an unmet need, and that transfer would have made visiting easier. He believes that this should have been more proactively followed up. TD was aware that medication was administered covertly at times and feels that this was necessary for his needs and risks to be addressed.

5.3.2. **WSCC, Adult Social Care:** Whilst responsibility for TD's reviews was delegated, there should have been a recognition that his wish to move had not been proactively followed up, with escalation of this concern with Berkshire Mental Health Services. As addressed in the next section, none of the safeguarding concerns were discussed with TD or his brother, who held Lasting Power of Attorney (LPA) for health and welfare and finance.

5.3.3. **Berkshire Mental Health Services:** It was clear that TD wished to move to a Nursing Home in Berkshire, joint with his partner, to live closer to his brother. He had expressed this view consistently from around May 2018 (or

before) until his death in October 2019. Whilst the very changeable and challenging care needs and risks presented a considerable difficulty in finding an appropriate placement and TD spent long periods in hospital, it does seem that transfer may have significantly improved TD's sense of wellbeing and greater urgency should have been afforded to seeking an appropriate placement in Berkshire, which is acknowledged by the agency as a learning point.

5.3.4. **Sussex Partnership Foundation Trust:** It is not evident that agencies, including the Mental Health Trust, had a focus on understanding the underlying causes of Adult G's mental health and behavioural concerns, towards a recovery model approach. This may have complimented the efforts to maintain a consistent medical approach.

5.3.5. Covert medication was administered at times, and it seems that this was necessary, given the risk of non-compliance with care and of challenging behaviour. It is understood that Mental Capacity Assessments were completed when this intervention was required, although evidence of recorded assessments has not been available to the Independent Reviewer.

5.3.6. **Abbots Lawn Nursing Home:** As the agency providing consistent daily support to TD, the Nursing Home has acknowledged that there should have been a greater focus on requesting transfer in support of his wishes.

5.3.7. The Nursing Home used covert medication at times, as recommended by medical practitioners. The Independent Reviewer has not received evidence of recorded Mental Capacity Assessments or Best Interest Decisions.

5.3.8. **West Mead Surgery:** The Surgery states that mental capacity was assessed on each visit to TD with regard to taking medication, always completed correctly and recorded. The Independent Reviewer has not had evidence of these assessments and TD's brother, whilst supportive of covert medication when it was necessary, confirms that he was not party to these. This responsibility was shared with Sussex Partnership Foundation Trust and the Nursing Home. Sometimes it was felt that he had capacity to decline his medication and at other times he did not seem to have capacity to decide. It was not felt to be essential for him to take his psychiatric medication every day and he did take it intermittently. When he refused antibiotics for an infection, he was admitted to hospital for IV fluids, as it was felt that he could come to harm without this intervention.

5.4. How effective were Safeguarding Adults responses in reducing the risk of abuse and neglect?

5.4.1. **Family overview:** TD's brother states that MM had been raising concerns about physical abuse of TD by staff at the Nursing Home. He would discuss these concerns directly with the Nursing Home but, in view of their mental health conditions, he did not and still does not believe that his brother was physically abused or neglected.

5.4.2. **WSCC, Adult Social Care:** WSCC had lead coordinating responsibility for safeguarding adults, notwithstanding delegated responsibility. There were five safeguarding concerns (within six contacts), some regarding the same or similar circumstances, between March and October 2019. These concerns were not addressed in accordance with statutory requirements or good practice requirements: or were not reported to WSCC; or were not progressed to enquiry when the Care Act s42 threshold was met; or were correctly not addressed as safeguarding, but with needs and risks not followed up. There was an absence of line management oversight and there were deficits in recording on the Mosaic system. None of the concerns were discussed with TD or his family, so responses were not personalised. The practice shortfalls were recognised in a WSCC, Adult Social Care review of safeguarding responses.

5.4.3. TD's partner and brother had raised concerns about support received, without these leading to safeguarding referrals and plans or to a comprehensive, multi-agency review.

5.4.4. The presentation of a grade 4 pressure ulcer in the days preceding TD's death, alongside concerns about how his needs and risks were being addressed, presented grounds for raising a further safeguarding adults concern.

5.4.5. Specific concerns are summarised below:

5.4.6. **Concern 1:** March 2019; swelling to eye due to rolling out of bed; reported by the Nursing Home to WSCC; led to a correct decision that this did not meet the Care Act s42 threshold. There were immediate actions taken, including increased regularity of checks, but a Social Work or multi-agency review was not triggered and there was no evidence of a medication review.

5.4.7. **Concern 2:** July 2019; disclosure by TD that he had been assaulted by Nursing Home staff; whilst the local Mental Health Team visited promptly and there were no marks to indicate assault, an unreliable disclosure should progress to enquiry, and this did not happen. The GP was not contacted for a medical examination and a safeguarding concern was not raised with WSCC or Berkshire Mental Health Services.

5.4.8. **Concern 3:** August 2019; pressure ulcers were observed on admission to Hospital from the Nursing Home; these were reported by the Hospital to WSCC and closed two months later as not meeting the safeguarding threshold, without a clear line management rationale for this decision or the delay.

5.4.9. August 2019; pressure ulcers were observed again on Hospital readmission, alongside a concern raised by his partner about the mattress on the floor; reported by the Hospital to WSCC and closed two months later as a duplicate concern, again without a clear line management rationale for the decision. As the pressure ulcers were unstageable and the standard of pressure ulcer care was unclear, the Independent Reviewer considers that this concern should have progressed to an enquiry.

5.4.10. **Concern 4:** October 2019; pressure ulcers were reported by the Nursing Home (on Social Worker advice) to WSCC as safeguarding concerns.

5.4.11. October 2019 – pressure ulcers were reported again by the Nursing Home to WSCC, without receiving feedback; TD was visited by the local Mental health Hub and closed by WSCC as a duplicate concern, without a clear line management rationale for the decision and without recognition that there had not been follow-up action in response to previous concerns. It was appropriate to close this as a duplicate concern that was open, but the previous concern was closed around this time without progressing to enquiry, even though the Care Act s42 threshold appeared to have been met.

5.4.12. **Concern 5:** October 2019; TD's partner raised a concern about the quality of care provided at the Nursing Home, leading to a Mental Health Act Assessment request to Berkshire Mental Health Services but was incorrectly not raised as a safeguarding adults concern with WSCC.

5.4.13. **Berkshire Mental Health Services:** The assigned Social Worker was aware of only two of the safeguarding adults' concerns and acknowledged that there should have been closer communication with WSCC on the concerns that had been shared.

5.4.14. **Sussex Partnership Foundation Trust:** The alleged assault disclosure by TD in July 2019 was responded to promptly by the Mental Health Hub, quickly establishing that there were no markings to his skin. However, the incident should have been reported to WSCC as a safeguarding concern, and to Berkshire Mental Health Services, and these reports were not made. This was a further example of agencies not always working together in a coherent manner to promote TD's safety and wellbeing.

5.4.15. **Western Sussex Hospital Trust:** The aforementioned Trust investigation report considered whether guidelines were correctly followed in regard to raising safeguarding concerns.

5.4.16. The Trust pressure ulcers guidance states that raising safeguarding concerns should be considered for patients with a category 3 or 4 pressure ulcer, or patients with multiple category 2 pressure ulcers. This complies with national guidelines and, as stated in the report, appears to have been applied correctly.

5.4.17. There were two safeguarding concerns raised by Trust staff. On 14/08/19 a concern was raised regarding the development of pressure ulcers on the sacrum and heel. A referral was made before discharge on One Call to request TVN input to the home regarding wound care. The investigation report concludes that this concern was raised and documented correctly. Also, the discharging nurse requested specialist input in the Nursing Home from the community TVN service on discharge.

5.4.18. There was a further safeguarding concern raised on 19/08/19, following a review of the pressure ulcers, and the concerns raised by his partner regarding the standard of care at the Nursing Home. It was noted on the safeguarding form that TD would remain in Hospital for end-of-life care. The investigation report concluded that the concern was raised and documented correctly, although it is not clear in the documentation whether the Ward staff were aware of the previous safeguarding concern.

5.4.19. The MDT discharge transfer summary on 22/08/19 requested that the GP review TD in the community as soon as possible after discharge but does not mention the safeguarding concern.

5.4.20. The Trust report acknowledges that there was a lack of written documentation about TD's safeguarding concerns in the MDT discharge planner and the nursing and medical notes, aside from the actual alerts. Also, there was no flagging system to raise awareness of open safeguarding adult cases.

5.4.21. **Abbots Lawn Nursing Home:** It is unclear whether TD's pressure ulcers deteriorated due to the care provided by the Nursing Home, as safeguarding concerns were not followed up, but it is known that the home staff were unable to manage regular repositioning in view of his presentation. The alleged assault in July 2019 should have led to a safeguarding adults plan on the part of the Nursing Home.

5.5. What was the impact of resource and environmental issues on the decisions and actions of agencies?

5.5.1. Whilst the Independent Reviewer acknowledges that there is a considerable strain on Health and Social Care resources, there is no evidence that actions or decisions by agencies were directly impacted by resource levels.

5.6. How compliant were agencies in meeting statutory and procedural requirements?

5.6.1. All agencies had a responsibility to comply with the Care Act and Mental Capacity Act. WSCC and Berkshire Mental Health Services, in particular, did not fully meet the requirements of the Care Act, sections 9 (assessing needs) and 42 (safeguarding enquiries).

5.7. Coroner findings

5.7.1. The coroner found that there were deficits in care standards, but that these did not amount to neglect and did not significantly contribute to TD's death.

5.7.2. It was found that Abbots Lawn Nursing Home had inadequate recording in place (including nutrition and wound care plan), whilst acknowledging that this had improved, and had not met repositioning requirements (every two hours) for TD.

5.7.3. It was also found that WSCC did not respond appropriately to safeguarding concerns that had been raised.

6. Findings

6.1. **Overview:** Whilst there is evidence of professionals and agencies endeavouring to improve TD's safety and wellbeing, individually and collectively, there were significant deficits in the support provided. These most significantly concerned professional curiosity, multi-agency risk management, effective safeguarding adults' decisions and actions, and active fulfilment of his expressed wishes. As the Coroner concluded, there is no evidence that the deficits contributed in any significant way to TD's death. However, they clearly did have a significant impact on the quality of his life.

6.2. The following findings relate to the analysis provided in the previous section.

6.3. **Finding 1: Multi-agency risk management**

6.4. The coroner was critical of the lack of multi-agency information sharing and joint decision-making. The presenting complex mental and physical health needs, alongside the consideration of a transfer and the complicated inter-agency and cross-border responsibilities, warranted a multi-agency risk management meeting to provide an effective and coordinated pathway. This did not happen and the response to TD's needs was more fragmented than it should have been. Whilst Berkshire Mental Health Services were in a pivotal position to have scheduled a meeting, WSCC and all agencies shared in this responsibility.

6.5. There were some reviews and multi-agency meetings, but these were not sufficiently holistic and there was not a sense of coordinated risk management, information sharing and comprehensive oversight of the intervention strands by Berkshire Mental Health Services and a range of involved agencies across borders.

6.6. **Finding 2: Safeguarding Adults thresholds and enquiries**

6.7. The coroner found that none of the Safeguarding Adults concerns raised with WSCC were dealt with appropriately (including the decision not to progress to an enquiry in August 2019) and that statutory obligations were therefore not met; but that, as the ulcers contributed to but did not cause TD's death, this did not impact on the outcome.

6.8. There were five safeguarding adults' concerns (six contacts) in the eight months prior to TD's death, concerning alleged physical abuse and neglect of pressure ulcers and general care. Some concerns were not raised with WSCC as the lead coordinating agency, some not progressed by WSCC as safeguarding when the Care Act s42 threshold appeared to be met, there was a lack of action to address risk factors through safeguarding enquiries or risk management responses, and there was a lack of line management oversight and recording. A further safeguarding adults concern should have been raised in the days preceding TD's death when a grade 4 pressure ulcer was observed in the context of concerns

around care standards. It is recognised that tis responsibility was also held by the Sussex Partnership Foundation Trust in view of the delegated arrangement.

6.9. **Finding 3: Mental Capacity Act training and recording**

6.10. Whilst it is understood that there appears to have been a need for covert medication at times and medical authorisation was obtained, evidence of recorded Mental Capacity Assessments and Best Interest Decisions have not been forthcoming as evidence within this review. It is noted that this responsibility primarily relates to the Sussex Partnership Foundation Trust, GP Surgery and Nursing Home.

6.11. **Finding 4: Service User Voice**

6.12. The voice of TD, his partner and family were not actively listened to. In particular, there was a lack of urgency by Berkshire Mental Health Services in responding to TD's clearly expressed wish to move to a familiar area, notwithstanding the obvious difficulty in securing an appropriate placement due to his challenging behaviour, hospital admissions and having different placement needs to his partner. TD and his brother, who had Lasting Power of Attorney, were not informed by WSCC or other agencies about safeguarding concerns; or involved in decisions about these concerns. There was insufficient evidence of agencies attempting to explore the underlying causes of TD's mental illness and potential recovery (including possible childhood trauma and later loss & bereavement), with an apparent focus on medical intervention. There is a concern that his partner, MM, was removing his pressure relieving boots, without evidence of an attempt to work with her in appropriately participating in care.

6.13. **Finding 5: Berkshire Mental Health Services –** Whilst acknowledging the considerable difficulty in locating an appropriate placement, there was insufficient urgency in searching for a Nursing Home in Berkshire, in accordance with the wishes of TD and his partner.

6.14. **Finding 6: Abbots Lawn Nursing Home –** The Nursing Home was understandably experiencing difficulty in meeting TD's complex mental and physical health needs; including pressure ulcer care, repositioning, nutrition, medication and challenging behaviour. Shortfalls in recording impair a clear understanding of the extent of this difficulty and there was a reluctance to escalate concerns about the difficulty in managing TD's needs and in advocating for him regarding the need for a transfer. The coroner found that the difficulty with repositioning meant that the pressure ulcers did not heal and that this contributed to his overall decline in health but did not amount to neglect. There does not appear to have been sufficient scrutiny of the permission gained for covert medication and there was a shortfall in reporting safeguarding concerns to the CQC.

6.15. **Finding 7: Sussex Partnership Foundation Trust –** The alleged assault in July 2019 should have been raised as a safeguarding adults concern and the Trust had delegated responsibility for safeguarding concerns, so has some responsibility for learning in this area alongside WSCC. Communication with Berkshire Mental Health Services should have been more robust and there

should be clearer evidence of Mental Capacity Assessments. The coroner found that the Admission Avoidance Matron should have been involved a month or two sooner than mid-October 2019.

6.16. **Finding 8: West Sussex Hospitals –** The Coroner found that appropriate safeguarding concerns were raised by the hospital. He was critical of the discharge processes and lack of information regarding the pressure ulcers. There should have been a more robust flagging of safeguarding concerns in records.

6.17. There were multiple hospital admissions and swift discharges without a multi-agency review of whether TD's needs could be met on returning to the Nursing Home and without an effective communication of needs to be met by the Nursing Home and community services; in particular, without pressure ulcer care guidelines, as in the August 2019 discharges, when TD was readmitted within a few days for the same condition.

6.18. **Finding 9: Sussex Community NHS Trust –** There was a delay of three weeks in the provision of the TVN service, although the service thereafter appears to have been attentive.

6.19. A TVN recommendation of two-hourly turning in October 2019 was not clearly recorded and not subject to a prompt review, as acknowledged to the Inquest.

6.20. The coroner acknowledged that actions have been taken by WSCC to improve safeguarding adults' arrangements; specifically concerning management oversight, a streamlined Mosaic recording system and appropriate training to staff.

6.21. Mosaic recording has been updated, with recording on a stand-alone form. Also, as a temporary arrangement since March 2020 until formal changes are made, working age mental health referrals have been triaged by the Safeguarding hub. It is believed that this has improved the consistency of decision-making and management oversight.

6.22. Safeguarding training is to be undertaken at regular intervals by relevant Adult Social Care staff, including reporting responsibility.

6.23. Regular audits of safeguarding enquiries are to be undertaken, to include a personalised and holistic approach, timely responses, clearly documented safeguarding plans (linked to risk, with a clear allocation of tasks), and a review of circumstances with a line manager before closure.

6.24. WSCC Adult Social Care staff are to receive regular training on the Mental Capacity Act and Deprivation of Liberty Safeguards (Liberty Protection Safeguards All). The intention is to target residents in residential and nursing Homes; to encourage DoLS referrals by providers, if appropriate; and to prompt Mental Capacity Assessments and Best Interest Meetings if there is a concern about capacity and a consideration of covert medication.

7. Planned or completed actions

7.1. **Action 1: WSSAB & West Sussex County Council - Safeguarding Adults thresholds and enquiries**

7.2. **Action 2: WSSAB - Mental Capacity Act training and recording**

7.3. **Action 3: West Sussex County Council, Adult Social Care –** WSCC developed an action plan in the aftermath of TD's death. This made a commitment to regular DoLS training audits completed with mental health staff and feedback to managers, and a Multi-Agency Safeguarding Hub (MASH) has been introduced as a front door service to receive and make threshold decisions on concerns.

7.4. The Section 75 arrangement has ended, which may offer the opportunity for a more seamless service.

7.5. **Action 4: Abbots Lawn Care Home** – The Nursing Home representatives point to improvements that have been made. A new 'Access' electronic recording system has been installed. This incorporates tasks such as setting up care plans and monitoring completion of tasks (including medication administration and repositioning). Audits on quality standards are completed; covering pressure ulcer care and safeguarding. Annual training to staff is provided on areas including pressure ulcer care, recording, medication and safeguarding.

7.6. **Action 5: Sussex Partnership Foundation Trust** – Safeguarding audits have been completed within the Mental Health Service, with feedback provided to senior staff and training arranged.

7.7. **Action 6: West Sussex Hospitals –** The Sussex University Trust (now merged with Brighton) has developed improvements, following the investigation report. This includes a review of the One Call system to streamline recording of communication with nursing colleagues; a section for historical safeguarding concerns that have been raised; level 3 training completed in 2020 by Tissue Viability Clinical Nurse Specialists to increase confidence in assessing safeguarding concerns; to provide level 2 safeguarding training for band 2 nurses (including specialist nurses and sisters); the wound care plan has been adapted to include a discharge plan page, in order to improve wound care information on admission and discharge; a Quality leads safeguarding & safe discharge meeting between the Trust and community has been established to discuss concerns and proactively learn from incidents; a flagging system to identify open safeguarding cases to providers; and work around improving general discharge planning is ongoing, including a review of electronic discharge summary information (to include key information such as safeguarding) and a quality audit of transfer and discharge documents.

7.8. **Action 7: Sussex Community NHS Trust, Community Nursing -** There is now an Admission Avoidance Matron Team, as part of a Care Homes programme in primary care; which will provide input to Care Homes, complete weekly Ward rounds and flag multiple discharges.

7.9. Further developments include a discharge hub for patients with complex needs; a wound care plan that includes hospital discharge; closer communication with Hospital Wards on discharge arrangements to ensure that a sensible package is put in place; an electronic discharge letter; an audit of discharges; safeguarding awareness training; and a safeguarding flag on the Evolve recording system.

7.10. The TVN stated in the Inquest that she had received safeguarding adults training and is more confident in recognising and reporting suspected abuse. Also, the TVN is planning a weekly meeting between the Hospital and Community teams; towards improved communication and discussion of safeguarding adults' concerns.

8. Recommendations to improve services and reduce risk

8.1. **Overview:** The recommendations in this section are presented as additional to the improvements already planned or implemented, towards further advancement of the safety and wellbeing of adults at risk.

8.2. **Family overview:** TD's brother considers that the following broad recommendations, as outlined by the Independent Reviewer, are appropriate measures to reduce the risk of similar circumstances arising in future.

8.2.1. A multi-agency risk management meeting, leading to a coordinated response, 'could have helped'; particularly as transfer was not sufficiently prioritised.

8.2.2. Increased prioritisation of TD's wishes in respect to transfer would have been beneficial, as he does not consider that the Nursing Home was appropriate to meet his needs.

8.2.3. TD's brother is not concerned about the decision-making regarding covert medication and, having Lasting Power of Attorney responsibility for health & welfare and finances, he was aware of and supportive of this practice when necessary. He was not aware of a Mental Capacity Assessment having been undertaken at any time.

8.2.4. He was not aware of any Safeguarding Adults considerations and agrees that this may have been a potential vehicle to a more effective care management response.

8.2.5. TD's brother considers that improved communication between agencies would be beneficial in meeting the needs of people in future.

8.3. The following recommendations are intended to build on recognised multi-agency and individual agency improvements.

8.4. **Recommendation 1: Planned and completed actions**

8.4.1. WSSAB to monitor progress in implementing actions already planned or taken after TD's death.

8.5. Recommendation 2: Multi-agency risk management

8.5.1. WSCC to agree and embed across agencies an enhanced risk management framework for high-risk cases, building on the current Multi-Agency Risk Management (MARM) process.

8.5.2. To agree a multi-agency contract review and quality improvement framework, coordinated by WSCC; including (i) regular provider monitoring visit outcomes shared with CQC, and (ii) monthly quality improvement meetings for oversight and scrutiny of safeguarding adults and quality concerns (hard and soft data).

8.5.3. West Sussex Hospitals to review and audit discharge planning procedures and compliance, particularly related to comprehensive discharge summaries.

8.5.4. Sussex Partnership Foundation Trust and Berkshire Mental Health Services to review the effectiveness of information-sharing on service users when there is joint responsibility.

8.5.5. Abbots Lawn Nursing Home to provide assurance of improved procedures and practice concerning escalation of care and safeguarding concerns and recording.

8.5.6. Sussex Community NHS Trust to review the effectiveness of TVN engagement timescales, recording and reviews.

8.5.7. Berkshire Mental Health Services to review the effectiveness of care management oversight, risk management escalation and communication.

8.6. Recommendation 3: Safeguarding Adults thresholds and enquiries

8.6.1. WSSAB to gain assurance of awareness across agencies of the responsibility to report safeguarding concerns to WSCC.

8.6.2. WSCC to further enhance and provide assurance of proportionate, personalised and outcome-focused Safeguarding Adults Enquiries.

8.6.3. WSCC to agree senior line management oversight of complex cases, aligned to a new framework for complex cases that is being developed and an Escalation and Resolution Protocol that is in place.

8.6.4. WSCC to audit safeguarding adult's threshold decisions at the Adult Safeguarding Hub and also Safeguarding enquiries; with a focus online management oversight, proportionality, personalisation, family involvement and outcomes. This aligns to existing safeguarding audits concerning transition, self-neglect, mental health and homelessness.

8.6.5. WSCC to develop an arrangement of cross-border peer review (with a focus as above), towards consistent high standards of practice and communication; in line with ADSS requirements on safeguarding across borders.

8.6.6. WSSAB to monitor compliance with training attendance and continuous professional development.

8.6.7. West Sussex Hospitals to review whether a more robust system of flagging safeguarding adults' concerns is required.

8.7. Recommendation 4: Mental Capacity Act training and recording

8.7.1. WSCC to gain assurance of clear policy, procedures, guidance and accessible recording forms across agencies (including Sussex Partnership Foundation Trust, West Meads Surgery and the Nursing Home) on Mental Capacity Act requirements; incorporating case law and expectations in regard to covert medication.

8.7.2. WSSAB to gain assurance that Mental Capacity Act and Deprivation of Liberty Safeguards (Liberty Protection Safeguards) training occurs across agencies and is embedded in practice, including the requirement of recorded Mental Capacity Assessments and Best Interest Decisions.

8.8. Recommendation 5: Service user voice

8.8.1. WSSAB to gain assurance of the involvement of service users and families in needs assessments, reviews and safeguarding enquiries.

8.8.2. To develop poster and leaflet displays, particularly in care and nursing home reception areas, on how to raise safeguarding adults and quality concerns.