West Sussex Safeguarding Adults Board

Review in Rapid Time

Author: Patrick Hopkinson
Date: 16/03/2021

Patrick Hopkinson
Version 2 | 16/03/2021

Contents

Patrick Hopkinson

Version 2 | 16/03/2021

1. Foreword

1.1 West Sussex Safeguarding Adults Board (the Board) has today published a Review in Rapid Time in respect of Darlington Court. This Review looked into the circumstances of the deaths of 13 people and the wider COVID-19 outbreak and its management, which impacted on over 70% of Residents in the service.

1.2 The Board wishes to extend its sincere condolences to the families, friends and carers of the people who died as a result of COVID-19 and to ensure that lessons have been learned and systems have changed and improved because of this Review.

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

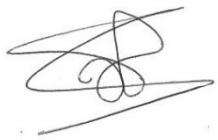
1.4 This last year has required fast acting and reactive responses by agencies to adapt their ways of working, whilst being under unprecedented pressures. However, while this Review reflects a point in time during the second wave of COVID-19 it does not detract from the significant circumstances of this case and the important learning required.

1.5 The Review highlights eight questions for The Board to take forward under four key finding areas; accuracy of information, leadership and responsibility, resources, including operational pressures and the national context and safeguarding concerns that may have been avoidable or preventable.

1.6 The Board will, without delay, establish a multi-agency action plan in response to the report so that assurance is provided that all changes required are implemented.

1.7 The Board will monitor progress of this action plan to minimise the risk of a repetition.

1.8 The Board will also ensure that the learning from this review is widely disseminated locally and nationally to support minimising risk at this unprecedented time.



Annie Callanan, Independent Chair

Patrick Hopkinson

Version 2 | 16/03/2021

2. Background & Methodology for Review

2.1 A referral was made by West Sussex County Council (WSCC), on the 30/12/2020. The referral detailed that 13 residents at Darlington Court, Littlehampton, had died as a result of Covid-19 and several others had contracted the virus. At the time of the referral there were 7 open safeguarding enquiries in relation to concerns regarding the Covid-19 outbreak and how this was assessed and managed. The Covid-19 outbreak impacted over 70% of Residents and a significant proportion of the staff team. Infections continued to spread from the first case in October 2020 up until the date of referral.

2.2 There were several professionals involved, however, there were concerns regarding mixed messaging, no face-to-face oversight, potential false sense of assurance and confused communications across the system which led to the placement of people at Darlington Court during outbreaks and after a number of residents who had tested positive for Covid-19 had died.

2.3 The scoping period for this Review was from 28/10/20 (date Covid-19 infections were confirmed) to present (this is an ongoing and developing situation, information will be requested up until current date).

2.4 Safeguarding Adults Review Subgroup members from WSCC, Police and CCG agreed that the criteria had been met, and Review in Rapid Time should be progressed. Independent Chair, Annie Callanan approved this decision on 09/02/2021.

2.5 This Review in Rapid Time, completed within three weeks, provides systems findings that have been identified from documents and information shared by involved agencies, and during discussions from a Multi-Agency Meeting.

2.6 The findings focus on organisational and systemic factors that impacted on practice and provide learning about issues, in order to provide a timely and effective partnership response, to prevent/reduce the risk of similar situations occurring in the future. Each finding will be listed individually, followed by questions which will enable The West Sussex Safeguarding Adults Board and Partners to review practice.

2.7 It is acknowledged that the constraints of a Review in Rapid Time learning captured in this report cannot be comprehensive, however, is to be used to implement change and improvement in services across the Partnership.

3. Engagement with Family or Representatives

3.1 As part of a Review process it is important to seek the views of involved individuals and/or family members. It is acknowledged that in a Review of this

kind, where learning is required in rapid time, the timescales do not allow for full consultation with all involved individuals and family members.

3.2 In the case of this Review, the original referral was made on behalf of one individual who died as a result of contracting Covid-19 Darlington Court, and linked to the wider concerns and management of the outbreak.

3.3 The original referral raised by WSCC was linked to an individual at Darlington Court, who passed away as a result of contracting Covid-19. Prior to the referral a Safeguarding concern had been raised by the Individuals Granddaughter. The Granddaughter was informed by WSCC that a referral had been made to the WSSAB for consideration as to whether the referral met the criteria for a SAR.

3.4 Following the decision to proceed with a Review in Rapid Time the Granddaughter was contacted by the WSSAB to advise that a Review in Rapid Time was being undertaken and offering the opportunity to have a conversation with the Reviewer to contribute to the Review. On this occasion the family chose not to participate in the Review.

4. Summary Chronology

Rather than a descriptive chronology, the following timeline sets out the main events in the period covered by this Rapid Review.

4.1 27/10/20: One member of staff and one resident tested positive for Covid-19.

4.2 02/11/20: A new resident was admitted to the ground floor at Darlington Court which was Covid-19 free at the time.

4.3 18/11/20: Test results showed that eight staff and four residents had tested positive for Covid-19 at Darlington Court.

4.4 20/11/20: First Covid-19 Response Meeting held.

4.5 26/11/20: The infection prevention and control team provided advice to Darlington Court.

4.6 04/12/20: A new resident was admitted.

4.7 05/12/20: Eleven residents at Darlington Court had tested positive for Covid-19 and there had been two deaths

4.8 (Week beginning) 07/12/20: A further three residents were admitted.

4.9 09/12/20: Darlington Court was described as "fully locked down" (according to the undated root-cause analysis, which due to its contents, could not have been written any earlier than the end of January 2021. There are no contemporary records showing when Darlington Court was "locked down").

4.10 10/12/20: Second Covid-19 Response meeting held.

4.11 11/12/20: Sussex Community Foundation Trust staff witnessed that IPC (Infection Prevention and Control) measures were not being followed at Darlington Court and reported this to their safeguarding team.

4.12 11/12/20: By this time, 37 Darlington Court residents had tested positive and Darlington Court's Covid Positive Timeline suggests that there had been at least six deaths.

4.13 14/12/20: Third Covid-19 response meeting held.

4.14 15/12/20: Sussex Community Foundation Trust safeguarding team reported that IPC measures were not being followed at Darlington Court to the Sussex NHS Commissioners safeguarding team.

4.15 18/12/20: Fourth Covid-19 response meeting held.

4.16 23/12/20: Fifth Covid-19 response meeting held.

4.17 27/12/20: By this time, 42 Darlington Court residents had tested positive and there had been thirteen deaths (of which two appear to have occurred after 28 days from testing positive for Covid-19).

4.18 29/01/21: End of outbreak declared at Darlington Court and Darlington Court reopened.

5. Systems Findings and Questions for the SAB

5.1 **Finding One: Ambiguous, inconsistent and inaccurate information was not always clarified.**

The records reviewed showed that there was frequent confusion about the extent of the infection at Darlington Court, (which was operated by Care UK) the consistency and effectiveness of infection prevention and control measures and whether or not new admissions could be made.

Despite extensive email contact and five Covid Response meetings, ambiguous, inconsistent and inaccurate information was not always clarified. There were

multiple sources of information, which were held by multiple partners and were unreliably updated with the latest information from Darlington Court and not always shared with the agencies or teams who needed them. As examples, one agency staff member was only made aware upon arrival at Darlington Court that there were Covid positive residents there and the Care Quality Commission had not been given an accurate figure for how many residents and staff had tested positive.

The CCG was not aware of which NHS commissioners were responsible for contracting beds at Darlington Court nor was it aware of whether or not the commissioners knew of the concerns there. The NEC tracker was not updated accurately and in a timely manner and there was frequent uncertainty about how many residents and staff had tested positive for Covid-19.

The impact of this was that uncertainty persisted in, amongst others, the shared understanding of following:

5.2 Whether or not Darlington Court was open or closed to new admissions

The Safeguarding Response document dated 10/02/21 states that Darlington Court closed to admissions on 9/12/20. However, nothing made available to the Rapid Time Reviewer contained a contemporary note that the home had closed on 9/12/20. The Minutes of the Covid Response meeting held on 10/12/20 state that the home had now closed to admissions, but do not specify when it had closed. There should have been clarity at the time, and there did not appear to have been.

The West Sussex County Council placement team informally stopped making admissions on or around 28/10/20, but subsequently understood that Darlington Court was open and made placements there again. There is a report that the home was closed as of 20/11/20 but whether or not the home was closed was still being raised at the Covid Response Meeting on 14/12/20.

5.3 The accuracy of risk assessments at Darlington Court

A blank template rather than a risk assessment to support the decision for Darlington Court to remain open was provided to West Sussex County Council and a completed risk assessment still had not been provided by 14/12/20. According to the minutes of the Covid Response Meeting on 18/12/20, when a risk assessment was provided, it appeared to be out of date since it stated that Darlington Court was Covid free.

A challenge for this rapid review was the inconsistent and inaccurate information available. For example, the Covid Positive Timeline supplied by Care UK was contradicted by Care UK's later submissions.

In the dynamic and challenging context of the response to the Covid-19 infection, it is inevitable that there will be confusion, that there will be frequent change and that information will become out of date. Situations like this require careful attention to accuracy and the rapid updating and distribution of key data so that effective decisions can be made.

5.4 **Theme One Questions:**

Are there barriers to information sharing?

What actions need to be taken to ensure that information is accurate, regularly updated across multiple information systems and is shared with those who need it?

5.5 **Finding Two: Leadership and responsibility for obtaining accurate information, and for making decisions based on it, was diffuse and insufficiently authoritative.**

The records showed that no one person took responsibility for clarifying information, for obtaining the right advice at the right time, and for taking timely action. There was an insufficient grasp of details and of the need for prioritisation of actions. This was exacerbated by diffuse and uncertain leadership across multiple agencies with unclear authority and precedence over decision making and for setting or enacting actions. This manifested itself in, amongst others, the following areas

5.6 **Whether or not Darlington Court should be closed to new admissions and who could make a decision about this**

On 18/11/20, four residents and eight staff members had tested positive for Covid-19, but Darlington Court remained open to admissions. Upon discovering this on 10/12/20, West Sussex County Council identified that this had placed people at Darlington Court at risk. Public Health guidance was noted to be that homes should close to admission for 28 days from the date of the last positive test result. This Public Health guidance, however, was subsequently understood to allow homes to make their own decision based on an assessment of risk.

Whilst the Public Health guidance was advisory, it was believed that there was a national expectation that homes should close if there had been a "significant" outbreak of Covid-19 infections. The definition of "significant", given in the records, was that 15% of the number of residents had tested positive with Covid-19. Given that the occupancy at Darlington Court was 46 residents, this meant that a significant outbreak had occurred if 7 residents had tested positive. Subsequent clarification from the West Sussex Public Health team, obtained for this review, was that there is no technical definition of "significant".

5.7 Lack of assurance that infection prevention and control processes were followed and were not deviated from.

There were a number of concerns about the extent to which the infection prevention and control processes were being consistently applied at Darlington Court. These were recorded in the minutes of the Covid Response Meeting on 14/12/20 and included staff not complying with the processes; the difficulty of cohorting when staff sickness levels were high (although there were no concerns about low staffing levels) and the physical practicality of separating sections of the building. None of these concerns appear to have been resolved.

Whilst there were concerns about the extent to which infection prevention and control processes had been implemented, these did not lead to assertive action. For example, poor infection prevention and control practice was reported by SCFT staff on 11/12/20, which included at least one member of staff not wearing full PPE, the police and ambulance service staff who had entered Darlington Court not being notified that residents there had Covid-19 and that the bedroom door of a resident with Covid-19 had not been kept closed.

An accident report provided for the purposes of the Rapid Review by Care UK stated that the paramedics had been informed of the Covid status of Darlington Court. Care UK also stated that the resident's door was kept open because the occupant had dementia. This practice does not appear to have been discussed with infection prevention and control specialists at the time nor was a risk assessment provided to support this decision. No action to enforce correct infection prevention and control practice was taken.

There were also concerns about the practicality of, and adherence to, cohorting of residents and staff but there was a reliance on verbal assurance from Darlington Court rather than on visits to inspect that infection prevention and control processes were being followed. Even on 18/01/21, when it was clear that 13 residents had died, a telephone check on the infection prevention and control measures would only be made if the manager of Darlington Court accepted the request for the call. Care UK has subsequently confirmed that the call would have been taken.

Despite the ambiguous and sometimes contradictory information available, there was evidence in the records that the extent of the infection at Darlington Court and its impact on residents and staff was escalating and that the efforts to control it were ineffective. This did not appear to have led to a reformulation of the multi-agency response or an escalation in the urgency and assertiveness of action. Insufficient attention was paid to outcomes.

When responding to significant concerns and crises, allocation of responsibility for decision making and for giving instructions needs to be agreed as soon as possible so that grip and control can be exercised. This can be a challenge across multiple organisations from different sectors with different responsibilities, priorities and

pressures but is essential to ensure that situations like that at Darlington Court are comprehended and acted upon.

5.8 Finding Two Questions

How can multiple agencies identify escalating concerns and events, and create a shared understanding of them and respond collectively?

When crises emerge, how can agencies rapidly appoint one person between them with the authority to make decisions for all agencies and to lead the response, making sure that all relevant information is collected, updated, distributed and acted upon?

Should onsite infection prevention and control visits (as opposed to telephone and video) be required to ensure effective IPC guidance and monitoring?

5.9 Finding Three: Resources, including operational pressures and the national context, are likely to have impacted on decision-making processes and practice but these should not have prevented a more decisive and effective response to the situation at Darlington Court.

Covid-19, and the response to it, placed a significant demand on health and social care sector resources and operations and required reprioritisation over an extended time period. During the first wave, organisations had to urgently readjust to the presence of a previously unknown infection; the methods of transmission, the virulence and seriousness of which were uncertain and against which protections were being devised and tested. The events covered by this Rapid Review took place during the second wave by which time there was greater awareness of methods of transmission and of protection, but the impact of the infection was reportedly greater than before.

The peak of the second wave of the pandemic covered the three-month period November 2020 to January 2021. In mid-November 2020, there were between 50 to 100 daily reported cases of COVID-19 in the Arun District (the location of Darlington Court) and 25 to 50 daily cases in the Worthing area. These numbers peaked in December 2020 with between 300 to 350 daily cases in the Arun District and 150 to 175 in the Worthing area. The reported daily cases dropped by the end of January 2021 with daily reported cases between 50 to 100 in the Arun District and 25 to 50 in the Worthing area. The number of reported deaths in care homes attributed to COVID-19 for the month of January 2021 total 568 in the whole of West Sussex, with Arun at 119 deaths and 72 in Worthing.

The records do not explicitly state the system wide pressures that commissioners and providers faced in West Sussex as a result of this, but some indication of these can be gleaned from the existence of a Covid funding pathway contract and that a number of referrals for placements were made to Darlington Court during the period of this Rapid Review. According to West Sussex Public Health, which provided comments to support

this review, the majority of care homes followed guidance to close to new admissions as soon as there was an outbreak of Covid-19 (defined as two or more cases).

This may have restricted the options for commissioners when identifying placements to relieve pressure on hospitals. Despite these pressures, however, placements at Darlington Court should not have been inevitable and there was insufficient concern or curiosity to recognise that referrals could be refused or even contested. This manifested itself in, amongst others, the following areas:

5.10 Perceived contractual requirements were not discussed or clarified

The minutes of the Covid Response Meeting on 18/12/20 record a concern about Darlington Court's individual risk assessments, which had referenced a requirement "to admit people due to Covid funding pathway contract" to CCG block funded beds. This was judged to have overruled the risk to "customers" whilst West Sussex County Council had similar block funded beds but expected the home to close to admissions. The status of block funded beds should have been reviewed throughout the Covid response process and clarified as the situation developed.

5.11 Over-reliance on and deferment to local and national guidance rather than to responding to the situation at Darlington Court

The manager of Darlington Court did not realise that referrals for admission could be refused, believing that she was obligated to accept them. It is unclear whether or not any guidance had been provided by Care UK to its individual care homes on this. The Covid planning and response by West Sussex County Council and the CCG should have clarified the status of Covid pathway beds when a home had residents and staff who tested positive.

On 18/12/20 the winter plan was reported to require that all staff should be tested twice a week for Covid-19 infection. Darlington Court awaited written confirmation before doing this and by 23/12/20 still had not implemented this change in the testing regime since written confirmation had not be received. Subsequent information provided in support of this review suggests that Care UK had issued a requirement to its services not to use lateral flow testing kits until a strategy was in place. There was an expectation that guidance would come from the Department of Health. No responsibility was taken to find out more about this change in the frequency of testing or to act on it despite the number of infections and resultant fatalities at Darlington Court.

On 29/01/21, the coronavirus outbreak at Darlington Court was noted as officially over and Darlington Court was open to admissions. Darlington Court was in the provider concern process by this time. The normal protocol for this process was to focus on individual risk assessments prior to making any further placements in a care home rather than on topics that affected all residents such as the effectiveness of infection prevention and control measures. Consequently, there was a risk that by focusing only on individual risks, the bigger picture might be missed.

5.12 **Finding Three questions**

How should multi-agency processes be halted when there are concerns that they are ineffective or are exacerbating risks?

How can multiple agencies develop a shared understanding of their pressures, priorities and capabilities so that they can recognise how these might conflict with each other and identify how they can work together collaboratively?

5.13 **Finding Four: The safeguarding concerns may have been avoidable and preventable.**

Efforts were made to manage the spread of Covid-19 infection at Darlington Court, but the landscape was rapidly changing and there were still factors in transmission and infection that were unknown. As set out in the previous findings, there was a lack of clarity, a lack of accuracy and precision, an excessive tolerance of ambiguity, a lack of decisive action and a lack of accountability. All these factors may have contributed to the spread of Covid-19 within Darlington Court. There were, however, opportunities for concerted multiagency action.

Consequently, the safeguarding concerns may have been avoidable, but it is difficult to judge whether they were preventable: the nature of the second wave of Covid-19 infections and its means of transmission were too unpredictable. In the documents made available to the Reviewer, however, there was no reference to alternative placements being sought, required or available. There were no references to needing to halt the placements process on a system wide rather than on an individual agency basis.

5.14 **Finding Four questions**

How can multiple agencies place the needs of people who use services first during times of pressure and crisis?

6. Summary of questions for the Safeguarding Adults Board to consider

6.1 Are there barriers to information sharing?

6.2 What actions need to be taken to ensure that information is accurate, regularly updated across multiple information systems and is shared with those who need it?

6.3 How can multiple agencies identify escalating concerns and events, and create a shared understanding of them and respond collectively?

Patrick Hopkinson

Version 2 | 16/03/2021

6.4 When crises emerge, how can agencies rapidly appoint one person between them with the authority to make decisions for all agencies and to lead the response, making sure that all relevant information is collected, updated, distributed and acted upon?

6.5 Should onsite infection prevention and control visits (as opposed to telephone and video) be required to ensure effective IPC guidance and monitoring?

6.6 How should multi-agency processes be halted when there are concerns that they are ineffective or are exacerbating risks?

6.7 How can multiple agencies develop a shared understanding of their pressures, priorities and capabilities so that they can recognise how these might conflict with each other and identify how they can work together collaboratively?

6.8 How can multiple agencies place the needs of people who use services first during times of pressure and crisis?