West Sussex
Safeguarding Adults
Board
Making Safeguarding Personal

West Sussex Safeguarding Adults Board

Safeguarding Adults Review in respect of MS

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Contents

FOREWORD

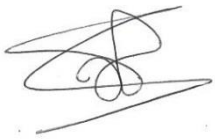
The West Sussex Safeguarding Adults Board has today published the Safeguarding Adults Review in respect of the death of MS; a lady in her nineties who was described by family and those who knew her as a very strong, determined woman with an outgoing personality.

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 Safeguarding Adults Review looks at the incidents leading up to Adult H's death which happened following a fall on Christmas Day; a day that was identified by the Ambulance Service as having exceptional demands on the service.

The review examines the actions of various agencies that had been involved in supporting MS and identified ways of changing and improving current systems across the Health and Social Care sector to reduce the likelihood of a similar event happening again in the future. Recurring themes from other reviews, both locally and nationally around information sharing and the implementation of Mental Capacity assessments, and how professionals respond to issues around falls are identified in this report and have been highlighted as a key issue for action.

This particular Safeguarding Adults Review highlights the need to ensure that agency escalation procedures and risk assessments are undertaken by trained professionals with the right skills and responsibilities to make these decisions. Family have been genuinely surprised at how in-depth the review has been and have felt in control of the Safeguarding Adults Review process. They have made it clear that neither MS, nor her sister wanted to be seen as 'making a fuss' and so did not call services immediately after the fall incident. Recommendations have been made to raise the importance of linking calls together within emergency services, and as a Safeguarding Adults Board in West Sussex, to escalate the ongoing concern about falls management processes and its impact on resource across the sector to implement the recommendations of this and former and future reviews to identify where and how services will improve and to drive that improvement.

The West Sussex Board and the Safeguarding Adults Review subgroup of the Board will monitor progress on implementation of recommendations so the Board is assured services are improving overall.



Annie Callanan, Independent Chair

1. INTRODUCTION

1.1. The West Sussex Safeguarding Adults Board decided on 23/05/18 to commission a Safeguarding Adults Review, following the death of MS at the age of 90 in December 2017. MS, who lived in Kent, and her older sister, JF, had both fallen at the latter's home in Goring, West Sussex on 25/12/17. After many hours waiting on an ambulance which did not arrive, they were supported to their feet by Police Officers who attended the home address. On the following day or shortly after, MS and her sister fell again at the home address, were unable to summon support, and MS had died by the time that she and her sister were found on the floor by a friend on 28/12/17.

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

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

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

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

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

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

1.6. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has chaired an initial professionals meeting to agree the review terms of reference; conducted research by critically analysing Individual Management

Reports, chronologies and relevant records held by involved agencies and by interviewing representatives of agencies; culminating in a planned Safeguarding Adults Review Outcome panel meeting and presentation to the West Sussex Safeguarding Adults Board.

1.7. The review refers to contextual information about the development of physical and mental health concerns and agencies responses from September 2017, and is concentrated on the most relevant period, from 23 to 28 December 2017. This has necessitated the involvement of Health services staff in Kent, outside the remit of the West Sussex Safeguarding Adults Board.

1.8. A contribution by family and friends to the review has been enabled through meetings by the Reviewing Officer with JH (stepdaughter) and JW (friend of sister). Telephone contact has also been completed with BC and MC (niece of MS and husband of niece).

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

- Consultant Nurse – South East Coast Ambulance Service (SECAmb)
- Detective Sergeant – Sussex Police, Strategic Safeguarding Team
- Named Nurse for Safeguarding Adults – Kent Community Health NHS Foundation Trust
- Safeguarding Adults Nurse – West Sussex Clinical Commissioning Group (by telephone)
- Adult Safeguarding Lead – Kent County Council Adult Services (by telephone)
- General Practitioner – Tonbridge Medical Group (by correspondence)

2. CIRCUMSTANCES LEADING TO THE REVIEW

2.1 MS, who had previously been very independent, fell at her home in Kent on 24/09/17 and, following a period in two hospitals, spent the final months of the year recovering at home from surgery to a fractured hip. She stayed with her sister, JF, at her home in Goring, West Sussex from 21 or 22 December 2017, which was an annual occurrence over the Christmas period. Her sister fell at home on 23 December and was assisted to her feet by a friend who responded to a call from the Careline pendant alarm service. Both sisters fell at home on 25 December and, following a period of over seven hours on the floor and almost five hours awaiting an ambulance that did not arrive, they were supported to their feet by attending Police Officers. Both MS and her sister fell again on approximately 26 December and, unable to summons assistance, MS had died by the time that a friend visited on 28 December.

2.2. The West Sussex Safeguarding Adults Board was satisfied that the conditions for a Safeguarding Adults Review were met regarding MS as, at the time of the incident, she was an adult with care and support needs who it is suspected may have died due to neglect, and it is suspected that services should have been more proactive in protecting her, meeting the conditions outlined in The Care Act 2014, Section 44.

2.3. The review has also overlapped with a Coroners' Investigation, commencing on 08/01/18, and an Inquest Hearing was held at Centenary House in Crawley on 11/06/18. The cause of death was recorded as:

(1a) bilateral bronchopneumonia and;

(ii) ischaemic heart disease, hypothermia, chronic obstructive pulmonary disease.

The conclusion of the Coroner was that MS 'died from natural causes following a long lie on the floor where there were missed opportunities of medical action.'

2.4. The Safeguarding Adults Review has been completed by an Independent Reviewer from February to April 2019, following a review panel initial planning meeting to agree terms of reference and initiate Individual Management Report requests in November 2018. The role of the Reviewer incorporates responsibilities as the Safeguarding Adults Review panel meeting chair and the author of an overview report, including a multi-agency action plan and an executive summary report.

It is anticipated that the report will be published on the Safeguarding Adults Board website, as is the standard practice.

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

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

- To consider whether agencies worked together effectively to safeguard and promote the welfare of MS, took action that was necessary and shared information appropriately, including multi-agency risk assessment and management.

- To identify whether any other interventions or processes might have improved the outcomes for MS.

- To review decisions made in respect to the mental health of MS and in the context of the Mental Capacity Act.

- To consider the impact of resources and the environment on decision-making across agencies.

- To consider whether practice was in line with statutory and procedural requirements.

- To consider whether the incident was avoidable or preventable.

3. PEN PICTURE of MS

3.1. MS lived in the Slough area as a child and moved with her parents to live in Tonbridge. She had a twin brother who died some years previously. MS worked in an insurance company in London and she was a practising Methodist. In 1979, MS married and they did not have any children. Her husband died in 1991. JH, her stepdaughter, lived nearby and called in on her regularly. She stayed with her sister in Goring, West Sussex every year, a tradition that had been maintained since her husband died.

3.2. MS is described by her family and friends as a very independent, strong willed and organised person, with a sense of humour. She and her older sister were very close and enjoyed many holidays and outings together. MS was fond of gardening and loved shopping for clothes. She routinely walked every day to a local corner shop for a newspaper, up until falling in September 2017.

4. FACTS

Prior to December 2017

4.1 In approximately 2015 or 2016, MS tripped and fell at the front door of her home and injured her wrist. As a consequence, she lived with upper body weakness and had difficulty or was unable to lift her arm above shoulder height. She continued to be independent in walking and in personal care but, due to this injury, family members believe that she would not have been able to push herself up from the floor in the event of falling. Her family and a family friend who participated in this review do not believe that she experienced any further falls until September 2017.

4.2 On 24/09/17, MS fell at her bungalow in Kent and was admitted to Pembury Hospital with a fractured left neck of femur. This is an acute hospital in Tunbridge Wells, part of the Maidstone and Tunbridge Wells NHS Foundation Trust. It is understood that MS had caught her foot whilst making her bed, although on hospital admission she could not recall how she fell. She received surgery for a fractured left sided neck of femur which was not successful, leading to a further operation.

4.3 On 16/10/17, MS was transferred to Hawkhurst Community Hospital in Kent for rehabilitation following surgery, and her GP surgery received a discharge letter on the date of transfer which recorded a fracture to the left neck of femur. The hospital is part of the Kent Community Health NHS Foundation Trust, which covers community hospitals and community services in the area. It was documented that she 'had capacity' for an admission assessment to be undertaken and this was completed with her consent. A staff nurse recorded on 17/10/17 that MS 'had no difficulties with memory.' Her General Practitioner completed three general ward visits each week and noted on 18/10/17 that MS was 'alert, coherent and orientated.' She scored 0 out of 6 in a cognitive impairment test on 17/10/17 (meaning there were no concerns with recall and short-term memory) but, as this was only one test, a further cognitive test by an Occupational Therapist and a referral to the memory clinic were discussed at a ward MDT meeting on 24/10/17, but MS did not consent to either. A Mental Capacity Assessment had been completed specific to the use of a sensor mat in the hospital and it was decided to complete a further Mental Capacity Assessment with regard to mobility. From 27/10/17 onwards there was documentation that MS was presenting as 'confused' and there were concerns about her memory, which were shared by JH (stepdaughter). On 07/11/17, a Physiotherapist recorded that 'we continue to have grave concerns about (MS's) cognition and that is making discharge planning difficult.' A further CIT scan on the same day again showed a 0 score for cognition,

indicating no concern within the limitations of the test. As part of discharge planning, a Mental Capacity Assessment, formal risk assessment and potential Best Interest Decision were not completed in relation to the safety risks involved in returning home; despite the episodes of 'confusion' and a lack of recall about the use of a wristband before discharge to identify a need for some supervision of mobility, staff concerns about how she would manage at home and MS declining assessment and support in relation to her memory. However, it is understood that staff were satisfied that MS had the mental capacity to make the decision to return home, which she was also determined to do. Also, a Safeguarding Adults concern was not raised through the Kent and Midway Multi-Agency Policy and Procedure for Supporting People who Self-Neglect. In view of concerns about cognition, liaison with a Dementia Specialist Nurse was a further available option and was not considered.

4.4 Whilst in hospital, MS was mobile and partially weight bearing. A Sara steady hoist was used for transfers, enabling walking by standing and pushing the appliance. A Multifactorial Falls Risk Assessment (MFRA) was completed, highlighting that she was at a high risk of falls and noting the following risk factors; two falls requiring hospital admission in the past year, fear of falling, multiple medication use, unsteady on her feet when transferring, hearing impairment, incorrect glasses, difficulty getting up from a fall, lives alone. She was assessed as requiring supervision of mobilisation due to this risk, that she would not benefit from onward referral for falls management but would benefit from a future referral to a falls group. MS understood the risk of falls when the risk factors were explained to her. On 18/10/17, she was incontinent of urine overnight and this was also recorded on 20/10/17 and 24/10/17. She was using the toilet frequently at night, without requesting supervision, but a urine test showed no abnormalities. MS had hearing loss, was able to lip-read, and she wore glasses. She was independent in taking medication. Early pressure damage to her heels was noted, but it is understood that this would not have contributed to her later fall. MS also experienced intermittent left leg pain and subsequently her right leg 'giving out' due to over-use. The Physiotherapist record on 07/11/17 noted that she had improved strength and mobility, but that observation of MS walking safely indoors and outdoors should ideally be completed prior to discharge. Although discharge plans were being made from the start of November 2017, it was considered that she was not yet ready for this step. The left hip wound no longer required dressing.

4.5 MS presented as extremely keen to return home from hospital and the Physiotherapist therefore decided to liaise with Occupational Therapy to plan as safe a discharge as possible. On discharge, her mobility had improved and she required some supervision with walking, as she was

occasionally unsafe on turning and presented with some 'confusion' and short-term memory loss. She also required minimal supervision with personal care. A discharge care plan was formulated. This incorporated the support of two carers with mobility, transfers and personal care; and the provision of Community Services Short-Term Therapy Services at home for rehabilitation. Prior to hospital admission, MS had only received the support of a private cleaner and JH, her stepdaughter, who assisted with domestic tasks and shopping. She had used a pendant alarm since September 2017.

4.6 On 05/11/17, a referral was sent by a staff nurse at Hawkhurst Hospital to Kent County Council Social Services Department to request the provision of a care package. Social Services have a record of receiving a referral on 08/11/17 and an assessment visit was completed on 10/11/17. It was noted that MS 'is normally very independent at home' and has poor memory. A meeting was arranged by the Kent Enablement at Home service, with MS and JH present, and MS reluctantly accepted a package of support on discharge, consisting of morning and evening calls to assist with personal care tasks.

4.7 MS returned home on 16/11/17 and it is unclear whether the Social Services care package was in place on the date of discharge. A delayed referral to the Community Services Short-Term Service (STS) for continued support and rehabilitation was made by an Occupational Therapist on 20/11/17, following a request by JH for an outdoor mobility assessment. The reason for the delay is unclear, but workload and therapists not working at the weekend are suggested in the Community Services IMR report. MS was mobile with a walking frame indoors. There was no medication change that would have presented a risk with regard to mobility or transfers. Her family and JW (friend of sister) noticed that MS was experiencing poor short-term memory and appeared to be 'confused' on returning home, and they question whether she may have had a medical infection at the time. However, the General Practitioner records for this period, on hospital discharge up to leaving on the short break, do not indicate that there was an infection.

4.8 On 27/11/17, Kent Adult Social Services cancelled the care package as MS was assessed by the Kent Enablement at Home Supervisor at a final review meeting to be independent in personal care, including nutritional and medication needs, and was 'managing well. ' MS and he stepdaughter were present at the review. The afternoon visit was stopped and the morning visit continued until 29/11/17, when MS requested cancellation. MS had not fallen since her discharge from hospital. Adult Social Services held minimal information on MS; that she had fallen and had a hip operation, had mental capacity, and had hearing loss. It is apparent that there was not an awareness that she

may be at significant risk of falls. It further appears from information received by the Reviewer that a joint risk assessment by Social Services and Community Services was not undertaken and joint consultation was not evident on the decisions to terminate both services.

4.9 The GP surgery had maintained correspondence with the Community Hospital during November and, on 27/11/17, the GP completed a home visit, during which MS said that she was not in pain. JH raised a concern that MS was not managing as well as prior to hospital admission and the GP agreed to check on progress of the Physiotherapy referral.

4.10 A referral was made to the Kent Community Services Long-Term Service on 28/11/17 and a Community Staff Nurse completed a home visit on 19/12/17 to complete ear syringing. It was noted that MS was going away for Christmas and was mobilising independently with a zimmer frame. MS was discharged from the Long-Term Service caseload and there was no further input after this date.

4.11 A Physiotherapist visited MS at home on 29/11/17 as part of planned weekly visits. An initial outdoor mobility assessment was completed on the request of MS, and a four wheeled walker was ordered. On 4/12/17 the same Physiotherapist visited again, provided support with exercises and agreed to order equipment. JH relayed to the Physiotherapist that MS intended to stay with her sister, aged 97, in Goring, West Sussex over Christmas. The risks involved were discussed and were noted as the risk of a further fall and injury due to stairs in the property, an upstairs bathroom, no carers and that her sister is frail. The Physiotherapist considered that MS would manage despite the additional risk factors and documented that MS understood the risks, despite mild cognitive impairment, and MS remained determined to continue with her plan as she felt that the benefits outweighed the risks. She advised that MS should obtain a commode and an extra frame for upstairs at her sister's property. A formal Mental Capacity Assessment was not completed.

4.12. On 04/12/17, the GP surgery completed a urine dipstick test, and the result on 07/12/17 was normal with no action needed. On 08/12/17, in a telephone conversation with the GP, JH said that MS has been 'a little confused on discharge from hospital' and that she seems a little better in herself on having just taken pain relief. It was agreed to monitor how MS was feeling over the weekend. In a follow up GP consultation on 13/12/17, JH explained that MS is experiencing low mood, is taking time to rehabilitate and needs encouragement. It was noted that MS would have increased social contact in the next few weeks. A medication review of the medical notes on the following day was the last involvement by the GP surgery before MS embarked on her short break.

4.13 On 19/12/17, the Physiotherapist made a further home visit. At this time MS was feeling well, had enjoyed visits to church on two occasions and managed transfers outdoors, and had managed to wash, dress and prepare meals. The plan was for therapy support with exercises over the Christmas period, subject to staff availability, and there was no further discussion about the planned visit to her sister. A referral was not made to the West Sussex Short Term Service and it is understood that a referral would not have been the standard practice for a one week break. There was no further input from the Short-Term Service.

23 to 28 December 2017

4.14 A question was raised by the review panel as to whether MS may have been treated by her General Practitioner on approximately 19 or 20 December for a urinary tract infection. The GP practice has confirmed that there is no record of an infection or related treatment at this time.

4.15 MS decided to spend Christmas with JF, her older sister who was aged 97, as she did every year, despite family members and a family friend advising her that she should stay at home due to safety concerns. On approximately 21 or 22 December, MS was driven by a friend to her sister's house in Goring, West Sussex. The friend observed that she was able to manage the stairs before he left.

4.16 On 23/12/17, at 14.04, Careline made a third party 999 telephone call to the South East Coast Ambulance NHS Trust (SECAmb), following contact by JF who had experienced a non- injury fall at her home address, in the doorway to her upstairs bedroom. SECAmb is a stand-alone Foundation Trust and is commissioned by the North East Surrey Clinical Commissioning Group (CCG), solely to provide an ambulance service in Kent, Sussex and Surrey. It is dual regulated by the Care Quality Commission (CQC) and the National Health Service Improvement (NHSI) bodies. Calls are received by an Emergency Medical Advisor (EMA, call handler without medical expertise) in the Emergency Operations Centre (EOC). The EMA assessed the urgency at this triage stage to warrant a category 3 response, which meant that an ambulance was required within two hours. A two-hour response time continues to be the likely target for calls relating to people who have fallen, if there are no further complications such as the patient presenting as unconscious, heavy bleeding or breathing difficulties.

4.17 At 15.30, a SECAmb Support Call Taker in the EOC made a welfare phone call to JF to advise that an ambulance was not yet available and to ask if there was any change in her condition. At the time, the SECAmb procedure was that a Support Call Taker (without medical

expertise) would make welfare calls and the EMA would then call to re-triage if the patient's condition had worsened. It continues to be the procedure to provide a welfare call within 90 minutes of a category 3 call. By this time, JW (nurse, carer, close family friend of JF) had visited the home and assisted JF to her feet. JF had received no injuries and worsening care advice was provided by the call handler, which involves checking on any changes in the patient's condition. The ambulance was cancelled as it was no longer required and the contact was closed down. It is notable that JW also assisted MS, who was experiencing considerable difficulty in rising to her feet whilst seated on her bed.

4.18 On 25/12/17, at approximately 16.00, MS and her sister returned to the home address in Goring, having visited a friend since the morning. JF had removed her Careline pendant alarm on leaving and did not put it back on when she returned home. At approximately 16.30, both MS and her sister fell onto the kitchen floor. It appears that MS fell and her sister then also fell in attempting to support her to her feet. Without access to her Careline pendant alarm, which she had left upstairs, JF was unable to summon help. The kitchen is a rectangular room to the side of the house, with one window at the head and one at the side. The kitchen connects with the hall and front door in one direction and with the living room and dining area in another.

4.19 At 18.26, on accessing her landline telephone, JF rang the Police Control Centre via the 101 non-emergency line to state that both she and MS had fallen, were flat on their backs on the floor and were unable to get up. She said that they were worn out and injured as a consequence of trying to get to their feet for two hours. Additional information was provided that MS was recovering from a hip operation, was breathing and conscious, and neither of them were bleeding. Sussex Police had no involvement with MS prior to this date. The Police Control Centre made a 999 phone call to SECAmb to state that MS and her sister had fallen at home. This was the first involvement of SECAmb in relation to MS. At this point the Trust was at level 3 on the Demand Management Plan (DMP), which has subsequently been replaced with a new operating system, named SURGE. The previous and current systems were set up to review demand on the ambulance service at any one time and level 3 meant that the service was under severe pressure. The Police requested an ambulance and were advised that there would be a quick response, but an estimated time of arrival was not provided. At this point the Police took no further action. A minute later, SECAmb Control Centre completed a triage assessment of the risk to MS, under the Trust Ambulance Response Programme (ARP), and established a category 3 response. There is not a direct link between the DMP service monitoring level and the individual risk category, but the level will impact on the prioritisation of individual grade responses during pressure periods and

a decision may be taken not to respond to lower grade calls until pressure is relieved. An Emergency Medical Advisor (EMA) may answer between 60 and 70 calls per hour and may not have the time or awareness to link a subsequent call to a previous call, although the system does have the facility to link calls.

4.20 At 19.10, the SECAmb Emergency Operations Centre (EOC) Manager escalated a concern that DMP level 5 had been triggered as there were 150 outstanding (welfare) calls. This led to a conference call at 19.30 between strategic and tactical commanders to discuss the demand. It was noted that DMP level 4 triggers were met but a decision was taken that the level would remain at 3. A raised DMP level may have further reduced the response times for category 3 patients.

4.21 At 19.56, JF made a second call to the Police Control Centre via 101 to state that they were both still on the floor, now sitting, and that no-one had been as yet. The call handler agreed to contact SECAmb to enquire about the ambulance arrival time. The Police Control Centre made a second phone call to SECAmb, received by a different call handler. Information was relayed by the Police that both sisters were in greater pain, were feeling sore and were becoming colder. The response provided by SECAmb was that there was no ambulance availability and that a crew had not been assigned, adding that the service is very, very busy. The SECAmb Control Centre call handler agreed to ring JF and the Police did not take any further action at this point. The Police call handler made a decision not to send a Police unit to the address at this point, as they considered the issue to be medical and requiring an ambulance response. Also, the Police call handler and supervisor did not make a link with the earlier call in order to prompt this potential decision. The grading under the Sussex Police Call Grades and Deployment Policy was recorded as 4 (low level) for both calls.

4.22 At 20.56, the Ambulance Control Centre, Support Call Taker (SCT) made a welfare call to JF, who said that they were still on the floor and in increased pain. This was not addressed as a worsening condition and was not escalated for senior operational or clinical oversight.

4.23 At 22.00, a second conference call between all SECAmb strategic and tactical commanders was held, as the number of outstanding welfare calls was 147, and a decision was taken to raise the DMP level to 4.

4.24 At 22.46, JF made a third call to the Police Control Centre via 101 to state that the ambulance had not arrived and that they had been on the floor since 16.30. She said that they were a bit cold and that the room was not heated. The Police call handler responded that they would ring SECAmb and would arrange for a Police visit to the home address if the

ambulance did not arrive soon. This led to the Police contacting SECAmb for a third time (a different SECAmb EMA received the call again) to request the estimated arrival time of an ambulance. Information was relayed that MS and her sister had been on the floor for over 5 hours, were complaining of increasing pain and were becoming very sore and cold. There were no new breathing difficulties and they were not bleeding. The Police call handler indicated that Police attendance would be arranged if an ambulance was not available soon. The SECAmb EMA responded that a unit had not been assigned and that they were second in the queue for an ambulance, but that this would be dependent on whether further higher graded calls were received. The EMA receiving the call suggested escalation to others in the control room to discuss if anything else could be done to support MS and her sister. The circumstances may therefore have been raised with the EMA Team Leader or Dispatch, but not with a clinician. The Police call handler referred the circumstances to the Control Centre Supervisor, who escalated the call to a higher grade 2 priority response. The Police call handler later rang JF to advise that the Police would attend. JF said that she was beginning to hurt and that MS was in great pain.

4.25 At 23.10, the SECAmb EMA Team Leader received an internal phone call to advise that MS and her sister were not experiencing breathing difficulties or bleeding. There were 13 welfare calls pending and therefore no further welfare calls would be made to anyone at that time.

4.26 At 23.15, two Police Officers attended the home address. They found MS and her sister to be uncomfortable, cold and asking to be supported to their feet. There were no signs of significant injury and both sisters said that they were not injured, but MS had a minor cut to her hand or wrist. MS and her sister were supported into chairs and were made comfortable with a blanket, hot drinks and an offer of food. At one point JF stood up and walked upstairs to the bathroom.

4.27 At 23.49, the Police rang SECAmb for a fourth time, received by a different call handler again, to request the estimated time of arrival and to confirm that an ambulance was still needed. The response of the SECAmb EMA was that an ambulance would be at the address 'as quickly as we possibly can' and that the 'ambulance service is under exceptional demand at the moment.' A Module 0 assessment (under NHS Pathways procedure) indicated that both MS and her sister were breathing and conscious and there was no heavy blood loss. The SECAmb EMA spoke with the Police on the scene and asked them to put a hand on the chests of the two sisters to see if they were cold, which they did and their temperatures were deemed to be normal. On the request of the sisters, the Police did not contact relatives or friends. It was noted that MS was occasionally 'confused' but that both had the

mental capacity to make the decision about the Police support with lifting. The Police Officers left the address at 23.59. They did not notice the careline alarm control box in the kitchen or the one pendant alarm which was downstairs, and would not have noticed JF's pendant alarm, as she had left this upstairs.

4.28 On 26/12/17, at 01.59 or 02.06, the SECAmb Control Centre SCT made a welfare phone call to JF, who said that they had been waiting on an ambulance since 18.00, had received Police help, and she had helped MS to bed (in a recliner chair downstairs). MS was not injured. JF said that she was now going to bed herself (or was in bed). She stated that they are 'okay' and that an ambulance was not needed. JF would see how MS was in the morning and attend the GP surgery if necessary. There was no further probing into what was meant by 'okay', which fell short of the SECAmb call compliance expectation. The SCT passed the information to Dispatch to stand the ambulance down, without either seeking clinical or senior operational oversight. Based on the decision to end involvement at this point, SECAmb would not have had cause to make further contact in subsequent days and were not further involved until 28/12/17.

4.29 On the night of 26 December into 27 December, JF's next door neighbours thought that they could hear banging on pipes and a crashing sound from JF's property. They went round and found the house in darkness, looked through the windows and could not see anything out of place. A family member attempted to ring the home on 26 December.

4.30 On 27/12/17, friends from Kent visited the address to provide MS with transport to her home. There was no response and they looked through the windows. As they could not see anything out of place, they decided to leave and return on the following day.

4.31 On 28/12/17, at 12.02, JW (family friend) made a 999 phone call to SECAmb to report that she had entered JF's property, as she had not received a reply to her phone call. She said that she had found MS and her sister on the kitchen floor. MS was identified as unconscious and not breathing, there was evidence of rigor mortis and she was described as beyond help. Her sister was conscious, talking, and had a graze to her leg. At 12.06, an ambulance crew arrived on the scene. The Police were contacted at 12.09 as, due to a disturbed scene, it was initially thought that there may have been a break-in. A Police CID unit attended the scene and, on investigating, found no foul play. It appeared that the sisters may have pulled items onto the floor whilst trying to get to their feet. Two telecare pendants were found, one upstairs and one on the lounge sofa downstairs. At 12.10, on examination, an entry was made

on the SECAmb Patient Care Record that MS was 'lying on floor in kitchen, rigor mortis, cold and stiff.' At 13.01, JF was transported by ambulance to Worthing Hospital with dehydration and hypothermia, to be discharged some weeks later. She could not remember any details of her sister and herself falling.

5. CRITICAL ANALYSIS OF FACTS

5.1. The effectiveness of multi-agency needs and risk assessments

SECAmb clinical oversight: It is a concern that the Ambulance Service, whilst applying the Ambulance Response Programme grading procedure on worsening conditions, did not recognise or take into account the increasing risk factors that were presented after MS and her sister had fallen and did not at any time escalate the circumstances for clinical or senior operational oversight. Although the Emergency Medical Advisor (EMA) was not present with the patient to make a decision based on observation, the Police, on receiving a series of telephone calls from JF, relayed clear information on each of four telephone calls to the SECAmb Emergency Operations Centre (EOC); received by four different EMAs, who are call handlers without medical expertise. It is understood that the EMAs did not link the calls which, had they done so, may have raised the level of concern. Although the operating system includes this function, they were dealing with a large volume of calls.

By the time the Police made the initial call at 18.41 on 25/12/17, MS and her sister had been on the floor for over two hours. A triage assessment resulted in a category 3 grading, requiring an ambulance within two hours, which remains the standard response if a patient has fallen, is conscious, there are no breathing difficulties and there is no heavy loss of blood.

The Police made a second call to the EOC at 19.56, when MS and her sister had been on the floor for about three and a half hours. On this call, it was conveyed that the sisters were experiencing increasing pain and were feeling colder. This was followed by a standard Support Call Taker welfare call at 20.56 to check on worsening conditions and JF advised that they were experiencing increasing pain. The Trust's Serious Incident report, dated 20/03/18, identified that the SCTs were not trained to detect changes in a patient's condition that required escalation, followed a pre-determined script, and key triggers were missed. It is acknowledged by SECAmb that worsening conditions should have been recognised and escalated at this point.

The Police made a third call at 22.46, when the sisters had been on the floor for over five hours, and relayed that they were experiencing increasing pain and were cold, but had no breathing difficulties and were not bleeding. This was followed by an EMA Team Leader appraisal of the circumstances, in which the absence of the 'scripted' factors were noted. It is also acknowledged by SECAmb that discussion with a clinician at this time 'would probably' have raised the priority level and shortened the response time.

After supporting the sisters up from the floor, the Police made a fourth call at 23.49 to state that an ambulance was still needed. The EMA confirmed with the Police that the sisters were not cold, were conscious, had no breathing difficulties and were not bleeding. At 01.59, an EMA made a welfare call to JF and stood down the ambulance on the basis that JF stated they were both 'okay.' If clinical oversight had been sought at this time, it is not known whether this would have led to further probing and the dispatch of an ambulance. SECAmb now provide training to Support Call Takers on welfare calls and escalation. Welfare calls are now always made by a registered nurse or paramedic from within the EOC and, if a worsening condition, the circumstances are triaged again.

Police risk assessment: Overall, the Sussex Police Control Centre call handlers and the Police officers who attended the address provided an attentive service and mitigated the difficulties experienced by the Ambulance Service.

The Police Control Centre received an initial call from JF at 18.26 and promptly relayed the incident and risk factors to SECAmb on requesting the dispatch of an ambulance. A further call was received from JF at 19.56 and the deteriorating circumstances were relayed to the Ambulance Service in a prompt and comprehensive manner. Although the risk circumstances were discussed with a senior officer, a link between the two calls was not made, which meant that the deterioration was not recognised and this may have had a bearing on the decision to maintain the risk level at 4 (low risk) and not to assign a Police unit to visit the address at that time. Whilst the Police call handler and senior officer were entitled to make the judgement that the sisters required a specialist Ambulance service due to medical needs, the absence of this service at the time would seem to indicate that a Police response was warranted. The Police staffing levels would have been at a minimum due to the holiday period, but this does not appear to have been a factor in the decision not to deploy a unit to the address at this point. A third call from JF was also promptly and comprehensively relayed. The lack of Ambulance Service provision on this occasion led to a decision to deploy a Police unit to the address and two officers arrived at 23.15. The officers completed a risk assessment before supporting them to chairs and making them comfortable. A further call was made to the Ambulance Service to update on the situation and request an ambulance. These actions by the Police Officers were efficient, sensitive and personalised. However, the officers did not recognise the Careline control box which was situated in the kitchen and one of the two pendant alarms which was downstairs, and therefore missed an opportunity to remind JF to wear the appliance. It is not known

whether, had they done so, JF would have been wearing the pendant alarm and have been able to summon support when the sisters fell again on 26 or 27/12/17.

Kent Community Health risk assessment: MS was an inpatient at Hawkhurst Community Hospital for a month of rehabilitation, following surgery to her left hip, and received Physiotherapy and Occupational Therapy Support at home in the period of over a month between hospital discharge and staying with her sister in Goring. There is clear evidence that hospital and community services staff at were attentive, caring and sensitive in their approach to and communication with MS. Whilst in hospital, she received comprehensive assessments and support in relation to mobility, transfers, the risk of falls and personal care. A Physiotherapist at the hospital considered that MS was not ready for discharge. However, she was determined to return home and her functional abilities were clearly improving prior to discharge. As MS was potentially putting herself at significant risk of falls through early discharge, a safeguarding adults concern should have been raised in accordance with the Care Act 2014 and the Multi-Agency Policy and Procedure for Supporting People who Self-Neglect. Continued support was provided at home and, on MS stating her intention to stay with her sister over the Christmas period, risks were discussed and advice given on equipment to address her needs and safety.

Kent Adult Social Services risk management: Following discharge from hospital on 16/11/17, the Kent Enablement at Home service provided twice daily personal care support to MS, which she reluctantly accepted. This service was cancelled on 29/11/17 on the basis of a review meeting two days earlier, as MS was independent in personal care and did not wish the service to continue. Whilst this was undoubtedly a needs-led and personalised decision, as a secondary concern, there appear to have been grounds for Social Services to have worked closely with Community Services in assessment, intervention and the decision to terminate involvement. On this basis, Kent Social Services may wish to consider a review of training provision available to Adult Social Care staff, relating to risk assessment and management.

MS, family and family friend on risk: Despite concerns about mild cognitive impairment and short-term memory loss, MS seemed to understand and have the ability to weigh up the risks involved in hospital discharge and in staying with her sister, and she asserted her independence. Her family and a family friend were very concerned about the wisdom of a holiday break with her sister, in view of the risk of falling, but respected her right to make this decision. It may be that, on ringing the non-emergency service line when they fell, MS and her sister were minimising their anxiety and discomfort to avoid impacting

on emergency services. Whilst this cannot be established, it seems appropriate for services to bear this possibility in mind when assessing risk.

5.2. The effectiveness of multi-agency interventions and information-sharing

SECAmb estimated time of arrival: Whilst it is clear that EMAs and Support Call Takers endeavoured to provide a professional service during a very demanding period, with obvious difficulty in predicting accurate response times, it is a concern that the Police and the sisters were not provided with an estimated time of arrival during contact on 25/12/17, beyond an initial commitment to a two hour waiting period that was not met.

Sussex Police information sharing: The Police Control Centre and the attending Police unit relayed prompt and comprehensive risk information to SECAmb that demonstrated an apparent deterioration in the condition of the two sisters. Although it is not clear that Police call handlers had linked the calls to recognise that the updated information amounted to deterioration, this was the primary role of the Ambulance Service to assess.

Kent Community Health hospital discharge: MS was discharged from hospital on 16/11/17 and a referral to the Short-Term Service was made by an Occupational Therapist on 20/11/17, after the weekend. Whilst this represented a short delay and support was on a weekly basis, it is a concern that arrangements were not fully in place as part of hospital discharge planning. Also, at the time MS went to stay with her sister, there was a recognised risk of falling in an environment which presented increased challenges and, whilst it is not standard practice to refer to a host authority during short holiday breaks (particularly for a weekly service when MS was planning to stay for one week only), it may have been appropriate to have considered requesting a needs and risk assessment by West Sussex Community Services.

5.3 The consideration of mental health and mental capacity

SECAmb: The Ambulance Service did not have grounds during telephone contact to be concerned about the mental health or mental capacity of MS.

Police: The Police Officers who attended the home address carried out a risk assessment and made a judgement on assumed mental capacity, before supporting the sisters from the floor into chairs, which was

appropriate and proportionate in view of the risk of remaining on the floor.

Kent Community Health: Whilst in hospital, MS presented with periods of 'confusion' and short-term memory loss, declined remaining in hospital for longer and a referral to the memory clinic, and there were concerns about how she would manage at home. On this basis, a formal Mental Capacity Assessment specific to discharge needs, aligned to a risk assessment and possibly a Best Interest decision regarding returning home before rehabilitation in hospital had run its course, should have been undertaken prior to discharge to determine if MS really had the cognitive ability to understand the consequences and potential safety risks of returning home. It should be noted, however, that MS was improving in her physical health and understood the risk of falls when the risk factors were discussed with her, and respecting her wishes to return home seems to have been proportionate in the circumstances.

On hospital discharge, when MS stated her intention to stay with her sister, there were again grounds to undertake a Mental Capacity Assessment and potentially a Best Interest decision, in view of the risks involved and concerns about mild cognitive impairment. However, MS was very clear in her wish to stay with her sister and seemed able to weigh up the benefits and risks in this decision. Her voice was listened to and it seems unlikely that her wishes for independence and companionship would have been curtailed if a Mental Capacity Assessment had been undertaken. However, an assessment may have presented grounds to trigger a needs and risk assessment in her temporary surroundings.

5.4 The impact of resources and the environment on the responses and actions of agencies and professionals

SECAmb availability of ambulances and ambulance crews: It is a concern that there was a lack of available ambulances and crew to meet the exceptional demands on the service on 25/12/17. When the initial call was received by SECAmb from the Police at 18.41, there was a level 3 rating under the Trust's Demand Management Plan (now SURGE), which meant that the service was under severe pressure. This service risk rating was raised in contact between strategic and tactical commanders at 22.00 to level 4, which was evidence of senior management oversight but reflected a demand and supply situation that excluded patients in the risk category of MS and her sister from timely intervention.

The difficulty in the service responding to demand is reflected in the Ambulance Service responses to Police contact. There was no availability to dispatch an ambulance and crew at any time during the afternoon and evening of the fall. At 19.56, the service was described as very, very busy and at 23.44 the service was described as under exceptional demand. The demand on the service over Christmas Day in 2017 was described as considerable in a Trust Serious Incident Report, dated 20/03/18. At 19.10 there were over 150 calls awaiting a response and, although forecast demand for the whole day was 18% higher than actual demand, 'at the time of the call and up until the ambulance attendance was stood down demand was significantly higher than the resources available.' A SECAmb graph of demand versus available delivery demonstrates that the peak was between about 14.00 and 18.00, before reducing in the evening when it is assumed that the service will have been dealing with a backlog of calls from the peak period.

There is evidence of the Trust endeavouring to increase the capacity for provision of ambulances and ambulance crews since this incident. A SECAmb Demand and Capacity Review has been held to address the resource gap, with investment in the EMA service, additional paramedics, and an agreed timeline to purchase second-hand ambulances. The West Sussex Gazette on 28/11/18, reported that the Trust had recruited additional clinical staff from abroad in order to 'improve the safety of all patients waiting for an ambulance response, especially lower priority category three and four patients.'

Police deployment of unit to the home address: There is no indication that the Police decision not to attend following the second contact was due to resources, although Police staffing levels would have been low on 25/12/17. Sussex Police report a continued significant impact on their resources due to SECAmb not having the capacity to manage medical calls and asking the Police to attend instead. Consequently, the Police capability to answer other policing matters is diminished and staff have to make difficult medical decisions without appropriate training, due to a primary purpose to save life. Sussex Police comment that SECAmb are engaging at a local and regional level, including the development of a memorandum of understanding with Fire and Rescue services to provide additional services.

5.5 The compliance of agencies and professionals with statutory and procedural requirements

SECAmb: The relevant procedures are the Demand Management Plan and the Ambulance Response Programme. The procedures in place for assessment and monitoring of service demand and patients risks were

in part followed, but they did not provide the flexibility to consider wider worsening factors, the application of the ARP was not subject to clinical oversight, and worsening conditions were not recognised or escalated.

Sussex Police: The relevant policy is the Sussex Police Call Grades and Deployment Policy. The risk grading remained at a low level, despite deteriorating conditions, and was then increased on further contact and consideration.

Kent Community Health: The relevant policies, procedures and guidance are the Kent Community Health NHS Foundation Trust Safeguarding Operational Manual; Kent Community Health NHS Foundation Trust Mental Capacity Act Policy; Kent and Medway Multi-Agency Self-Neglect Policy and Procedure for Supporting People who Self-Neglect; and the Kent and Medway Multi-Agency Policy, Procedure and Practice Guidance. The concerns about a potential lack of mental capacity to make risk decisions about hospital discharge and a holiday break did not lead to formal Mental Capacity Assessments or raising a Safeguarding Adults concern.

6. FINDINGS

6.1 **Overview:** It is clear that staff in all services who were directly involved in the period leading up to and during this incident endeavoured to provide an attentive, caring and professional service to MS, at times in the context of extremely demanding resource considerations. Both individual and systems errors should be viewed in this context in terms of learning, in order to avoid a repeat incident.

It should also be noted that MS had a very independent and determined mind and appears to have been aware of the risks involved in staying with her sister for a short break.

The primary findings relate to the performance of SECAmb, with secondary findings relating to the performance of the other involved agencies.

6.2 **Finding 1 - SECAmb clinical oversight:** As a primary concern, the Ambulance Service did not recognise or take account of worsening conditions and did not escalate concerns for clinical and senior operational oversight, thereby creating a lower response priority and contributing to the service not responding. An estimated time of arrival was not provided, beyond an initial commitment of two hours waiting time, which was not met.

6.3 **Finding 2 - SECAmb availability of ambulances and ambulance crews:** As a primary concern, the Ambulance Service had availability of an insufficient provision of ambulances and ambulance crews to meet the exceptional demands on the service throughout 25/12/17, which led to delays and, in the case of MS and her sister, non-attendance.

6.4 **Finding 3 - Sussex Police risk assessment:** As a secondary concern, Sussex Police missed an opportunity to deploy a unit to the address at an earlier point on not linking the two calls to recognise a deterioration in risk circumstances, although the primary responsibility was for an Ambulance Service response to a medical concern.

6.5 **Finding 4 – Sussex Police awareness of pendant alarms:** As a secondary concern, an opportunity was also missed to encourage JF to wear her pendant alarm, which may have enabled her to summon help when the sisters fell again within the following two days.

6.6 **Finding 5 – Kent Community Health Trust:** As a secondary concern, during rehabilitation in hospital and in the community, one or possibly two Mental Health Assessments should have been undertaken. There should also have been a Safeguarding Adults referral due to potential

self-neglect. There was a short delay in a referral for Community Services, which did not have an impact on MS managing at home, and there may have been merit in considering a referral to West Sussex Community Services for a falls risk assessment on the holiday break. However, MS seemed to understand and to be able to weigh up the benefits and risks of returning home and later staying with her sister. It seems to have been both proportionate and personalised to have respected her wishes to exercise her independence in these decisions.

6.7 **Finding 6 – Kent Adult Social Services risk management:** As a secondary concern, the Kent Enablement at Home service could have worked closely with Community Services on assessment, intervention and termination of the service, in view of the risk of falls. However, the service was clearly responsive and the decision to terminate the service was both needs-led and personalised.

6.8 **Finding 7 - Conclusion:** The incident in which MS lay on the floor for many hours on 25/12/17 was both avoidable and preventable; had an ambulance been dispatched promptly and possibly if clinical oversight was in place.

It is not possible to conclude whether the incident of a further fall and MS passing away was avoidable or preventable, as there are a range potentially contributing conditions relating to health, resources and levels of awareness.

7. RECOMMENDATIONS TO IMPROVE SERVICES AND REDUCE RISK

7.1 **Recommendation 1:** SECAmb to review changes introduced as a result of the incident, to ensure that EMA's link sequential calls and that there is clinical and senior management oversight and flexibility involved in decisions about worsening conditions; and staff training and supervision on risk assessment to be provided at appropriate levels.

7.2 **Recommendation 2:** SECAmb to provide assurance of sufficient availability of ambulances and ambulance crews to meet forecasted exceptional demands at peak times.

7.3 **Recommendation 3:** Sussex Police to review the Police Control Centre risk assessment arrangements, including the linking of calls to recognise deteriorating conditions.

7.4 **Recommendation 4:** Sussex Police to provide training to operational staff on the recognition of pendant alarms and on encouraging vulnerable adults to wear the appliances when these are made available.

7.5 **Recommendation 5:** Kent Community Health Trust to provide assurance of training to appropriate staff on Mental Capacity Assessment and Safeguarding Adults training. Also to monitor that hospital discharge arrangements are timely (including over weekends) and to consider whether there are circumstances in which it may be appropriate to refer across County boundaries for assessment and intervention during short holiday breaks.

8. ADDENDUM – FAMILY REFLECTION ON THE SAFEGUARDING ADULTS REVIEW

A Draft copy of this review was sent to the relatives of MS for their input and feedback about the review.

Feedback from MS's Stepdaughter included the following (amended for confidentiality):

'I have received and read the Safeguarding report on the events leading to the death of my step-mother, MS. Thank you.

Although I visited her on most days at the hospital I was not aware of the various tests carried out by the staff there, nor of their concerns about her discharge or her mental capacity. Her hearing impairment meant communication latterly was often through pencil and paper (but it did mean she had it for reference) but her precise medical condition was not conveyed to me.

I believe MS expected to be able to go back to living her normal independent life (going to church meetings, collecting her pension, shopping...), once she returned home from hospital. When this didn't happen her confidence suffered and she was even more determined to make her annual Christmas visit to her sister.

Consequently she didn't fully consider the associated difficulties of two 90 year olds in a house with stairs (MS lived in a bungalow), one of whom was not fully mobile. I specifically asked the Physio (as a medical person and not a family member) to explain all the difficulties that may arise which she did, but said the final decision was MS's.

Although I wasn't happy I was aware that MS would have been devastated if she hadn't gone. Instead she had a lovely final Christmas lunch with her sister and friends.

Please thank the police for their assistance during the evening of Christmas Day.

JH

The Author would like to thank and acknowledge the invaluable contribution from friends and family at this time – whose input helped to shape the entire review process.