West Sussex
Safeguarding Adults Board

Safeguarding Adults Review
In respect of

‘Adult E’

Publication: 6 February 2018

Independent Author

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WEST SUSSEX SAFEGUARDING ADULTS BOARD

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Appendices

1. Introduction

1.01 For the purposes of this SAR Report and in order to protect her identity the subject will be referred to as Adult E.

1.02 It is easy for SARs and Overview Reports to focus on events and the involvement and actions of a number of agencies; it is important that this SAR and this Report recognise that, at their centre, is a human being, who should be treated with the same respect and dignity in her death as she should have been in her life.

1.03 Adult E was 79 years old at the time of her death. She was a divorcee who was living alone in Pulborough, West Sussex at the time of her death, where she had lived for a number of years.

1.04 Adult E had a son, who had died of cancer in 2013.

1.05 Prior to the period of this Review, Adult E had had no contact with West Sussex County Council Adult Social Care Services (ASC).

1.06 On the 18th July 2016, concerned neighbours contacted Sussex Police (the Police) as they had not seen Adult E for a week. The Police attended her bungalow, gained access via an unlocked back door and called an ambulance as they suspected she might have had a stroke. The South East Coast Ambulance NHS Foundation Trust (SECAmb) attended and advised Adult E that she should attend hospital, but she refused to do so. The paramedics therefore arranged for and transported Adult E to see her GP. The Police made a referral to ASC.

1.07 On the 7th August 2016, concerned neighbours contacted the Police again as Adult E had not been seen for two weeks. On this occasion, the Police had to force entry and found Adult E lying on her kitchen floor, where it appeared she had been lying for several days. The Police called an ambulance and Adult E was taken to Worthing Hospital; on her arrival at the Accident and Emergency Department, her presentation was assessed as consistent with having been on the floor for approximately ten days.

1.08 Adult E died during the evening of the 8th August 2016, with the cause of death recorded after a Post Mortem as 'multi-organ failure, dehydration and long-lie and collapse due to underlying co-morbidities'.

1.09 On her admission, staff at Worthing Hospital raised a safeguarding concern with ASC regarding Adult E. At a meeting held under the West Sussex Multi-agency Safeguarding Adults Procedures on the 5th September 2016, it was agreed that a referral for a SAR be made.

1.10 At the SAR Subgroup meeting on the 24 November 2016 it was agreed to recommend to the Independent Chair of the West Sussex Safeguarding Adult

Board (WSSAB) that a SAR be undertaken, an Independent Author commissioned and an agency chronology be prepared and circulated.

1.11 A recommendation was sent on the 12 December 2016, the WSSAB's Independent Chair, who confirmed on the 15 December 2016 that a SAR should be undertaken in accordance with the multi-agency Safeguarding Adults Procedures as below.

1.12 This Report was authored on behalf of the Board by Mr Pete Morgan, an Independent Consultant.

1.13 This Review was commissioned under Section 44 of the Care Act 2014; its commissioning is recorded in the Board's Annual Report for 2016/17 and its findings and their implementation will be reported in the Annual Report for 2017/18 as required by the Act.

1.14 The timetable set out in the original Terms of Reference (ToR) the Review had to be adjusted due to difficulties in arranging meetings of the Panel to undertake the Review and draft this Report for the Board to consider and ratify the Report, the Executive Report and the Action Plan. This is reflected in the final version of the ToR.

1.15 The Report was ratified by the Board at a specially convened meeting held on the 8 November 2017.

2. Sussex Safeguarding Adults Boards Safeguarding Adult Review Protocol

2.01 The Sussex Safeguarding Adults Boards Safeguarding Adult Review Protocol (the Protocol), agreed in May 2017, established the Purpose of a SAR http://www.westsussexsab.org.uk/wp-content/uploads/2017/06/Sussex-SAR-Protocol-FINAL-v1.0-2017-ABS3.pdf and the Criteria for SARs across Sussex.

2.02 The Protocol also established the Procedure for making a referral for a SAR and the Procedure for undertaking a SAR as well as its governance structure and the Timescale within which it should be completed.

2.03 The above Procedures were correctly implemented.

3. Independent Overview Report

3.01 The Protocol does not specifically require an Independent Author to be appointed to write the Overview Report.

3.02 The Board, via its Board Manager, sought expressions of interest in the role through the National Local Safeguarding Adult Board Chairs' Network and appointed Mr Pete Morgan as the Independent Author.

3.03 Mr Pete Morgan has been the Independent Chair of the Worcestershire and Hertfordshire Safeguarding Adults Boards, having retired as the Head of Service – Safeguarding Adults with Birmingham City Council. In the above roles, he has commissioned Serious Case Reviews as well as participated in them and their ratification by the relevant Safeguarding Adults Board.

3.04 He has chaired and co-authored a Domestic Homicide Review for the Safer Wolverhampton Partnership, a Serious Case Review for the Walsall Safeguarding Adults Partnership Board and is currently a member of an Independent Joint Serious Case Review Team for Newcastle Safeguarding Children and Adults Boards and is authoring SAR Overview reports for two other SABs.

3.05 He was a member of the Department of Health's Safeguarding Adults Advisory Group and is the Chair of the Board of Trustees, the Practitioner Alliance for Safeguarding Adults and the Independent Chair of the Safeguarding Panel for Advance, a charity that provides accommodation and support for adults with care and support needs.

3.06 He had had no involvement directly or indirectly with Adult E or any member of her family or the commissioning, delivery or management of any of the services that she either received or were eligible for prior to being commissioned to write this Report.

3.07 He had had no involvement with any of the agencies contributing to this Review prior to being commissioned to write this Report.

4. Media Strategy

4.01 Media contact concerning the Review was the responsibility of the Board's Independent Chair in consultation with the Panel Chair and the Independent Overview Report Author. Overall management was directed through the West Sussex County Council's Communications Team.

5. Liaison with the Police and the Coroner's Office

5.01 There have been no criminal prosecutions arising from Adult E's death and the Coroner's Investigation had been completed before this Review was initiated; there were therefore no issues regarding disclosure arising from the Review. The Police were represented on the Panel.

6. Legal Advice

6.01 Legal advice was available, as and when appropriate, from West Sussex County Council Legal & Democratic Services to ensure the review process and final Overview Report maintained a commitment to safeguard the anonymity of Adult E and complied with current legislation.

7. The Safeguarding Adults Review Panel

7.01 The Safeguarding Adults Review Panel (the Panel) is responsible for ensuring:

- the Review is completed in a timely manner and
- the Overview Report is factually accurate and based on evidence gathered during the process

7.02 The Panel comprised individuals across a range of statutory, independent and voluntary sector agencies as below:

Team Manager, CarePoint 2	West Sussex County Council Adult Social Care
Detective Sergeant, Review Team	Sussex Police
Lead for Safeguarding Adults	Western Sussex Hospitals NHS Foundation Trust
Named GP for Safeguarding Children and Adults	Coastal West Sussex CCG, Crawley CCG, Horsham & Mid Sussex CCG
Designated Nurse; Safeguarding Adults	Coastal West Sussex CCG, Crawley CCG, Horsham & Mid Sussex CCG
Lead for Safeguarding Adults	South East Coast Ambulance NHS Foundation Trust
Named Nurse, Adult Safeguarding	Sussex Community NHS Foundation Trust

7.03 The Panel met on the 17th May 2017, 11th July 2017 and 10th August 2017.

7.04 The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommend appropriate actions to ensure that better outcomes for adults with care and support needs in similar circumstances are more likely to occur as a result of this review having been undertaken.

8 The Safeguarding Adults Review's Terms of Reference

8.01 The meeting of the Panel, held on the 17 May 2017, agreed the Terms of Reference (ToR) for the Review but agreed they would be regularly reviewed as the Review progressed to ensure they remained fit for purpose.

8.02 At each Panel meeting, the ToR were reviewed and revised as appropriate. Any changes were minor and essentially related to the timetable for the completion of the SAR.

8.03 The finalised ToR are to be found in Appendix B.

9 The Scope and purpose of the Safeguarding Adults Review

9.01 The purpose of the SAR was to focus on the events that culminated in the death of Adult E on the 8th August 2016 and on whether her death was predictable and could have been prevented.

9.02 The scope of the SAR was set as the period from the 1st January 2016 until the 8th August 2016.

9.03 The reason for this was that it would focus the Review on a period of time that was both manageable and likely to contain all relevant information rather than including older, historical information of less relevance to Adult E's care and support needs prior to her death.

9.04 However, the Individual Management Review (IMR) authors were asked to include any earlier information held by their agencies that they considered relevant to the purpose of the Review.

10 Independent Management Reviews

10.01 IMRs were requested from the following agencies:

- Pulborough Medical Group
- South East Coast NHS Ambulance Trust
- Sussex Community NHS Foundation Trust
- Sussex Police
- West Sussex County Council Adult Social Care
- Western Sussex Hospitals NHS Foundation Trust

10.02 Agencies were required to make recommendations within their IMRs as to how their own performance and that of partner agencies could be improved. These were accepted and adopted by the agencies concerned. The recommendations are supported by the Independent Author.

10.03 Some of the recommendations did not relate directly to the focus of the Review but to the general service provision provided by the agencies. These are not included within this Report but are supported by the Independent Author and are contained in Appendix C.

10.04 The originally submitted IMRs were of a mixed standard, reflecting the experience and expertise of their authors and their agencies of origin. These were revised after a meeting of the IMR Authors with the Independent Author on the 17th May 2017. The revised IMRs were of a high standard. The IMR authors met again with the Independent Author on the 13th June 2017 to clarify and resolve any outstanding issues from the IMRs.

10.05 A full and comprehensive review of the agencies' involvement and the lessons to be learnt were achieved.

10.06 Additional IMRs could have been requested had the Panel considered it appropriate and necessary; however none were identified.

11. Family liaison and involvement

11.01 Adult E had no surviving family members who could be contacted, despite attempts made via the solicitors who acted as executors for Adult E; there was therefore little information available to the Review about Adult E's life.

11.02 Attempts were also made to contact the neighbour who had had some contact with Adult E and who had been involved in calling the Police on both occasions during the Review period. She was written to twice to offer her the opportunity to meet with the Independent Author in order to contribute to the Review. However, she chose not to reply, and it was considered inappropriate to pursue her further.

12. Sequence of events – 1st January 2016 – 8th August 2016

12.01 On the 15th January 2016, Adult E requested and was provided with repeat prescriptions for medication to treat her diabetes and manage her depression that commenced following her son's death in February 2013.

12.02 On the 25th January 2016, Adult E had sutures removed at the Pulborough Medical Group (PMG) following the removal of a skin lesion.

12.03 On the 11th February 2016, the 15th March 2016, the 11th April 2016 and the 18th May 2016, Adult E requested and was provided with repeat prescriptions as on the 15th January 2016.

12.04 On the 28th June 2016, a letter was sent by the PMG advising Adult E to make an appointment for a diabetes review, but no response was received.

12.05 On the 6th July 2016, a neighbour contacted the PMG concerned that Adult E might have had a stroke; the Duty Doctor advised that Adult E should either come into the Surgery or that an ambulance should be called. Adult E did not attend the Surgery and an ambulance was not called. Staff at the PMG made three unsuccessful attempts during the day to contact Adult E – she did not answer her phone – and it was not possible to get a message to the neighbour until the following day when the Duty Doctor's advice was passed on. No further contact was received by the Surgery.

12.06 On the 8th July 2016, a second letter was sent to Adult E advising her to make an appointment for a diabetes review; again no response was received.

12.07 On the 18th July 2016, the Police were contacted at 14.21 by a neighbour who had not seen Adult E for a week and was concerned that she might be unwell or deceased as she got no reply to knocking on her door or ringing her phone.

12.08 The Police attended at 15.30 and gained access to the property via the back door, which was open. Adult E was in bed and advised the Police that she had not answered the door or her phone for a few days as she had been feeling unwell and had a stomach upset. The Police suspected, from her speech and mobility, that Adult E might have had a stroke and therefore called an ambulance at 15.53.

12.09 The Police stayed with Adult E until the paramedics arrived at 16.06. Adult E advised the Police that she lived alone and had no family or close friends to provide support but that a neighbour assists her with her shopping each week. The bungalow appeared to be clean and tidy and Adult E appeared to look after herself – no suggestion of self-neglect. The neighbour suggested that Adult E had lost a lot of weight recently and they were concerned about her frailty and lack of support. Adult E was advised about key safes (see Glossary) and other options available to her, but she did not want any assistance or support. She was not pleased that an ambulance had been called, did not believe she had had a stroke and wanted to be left alone.

12.10 The Police officers left the bungalow at 16.30, after the paramedic had arrived; before going off duty on the 18th July 2016, they completed and submitted a Single Combined Assessment of Risk Form (SCARF) summarising their involvement to the Specialist Investigations Unit.

12.11 The paramedics advised Adult E that she ought to be transported to hospital for an assessment, but she refused. The paramedics assessed her as having the capacity to make this decision, therefore no formal capacity assessment was necessary or completed. She did, however, agree to be transported to the Pulborough Medical Group (PMG) to see her GP. An appointment was arranged by the paramedics for 17.20 that afternoon and they transported Adult E to the Surgery.

12.12 Adult E was seen by her GP, who assessed her as having the capacity to make an informed decision about her treatment. A stroke was diagnosed as highly probable and she was aware of and accepted the risk of a further stroke and the chance of it causing either her death or disability and the risks inherent in failing to comply with preventative treatment. The GP completed a six item cognitive impairment test (see Glossary), which Adult E answered with two errors. She refused a referral to the memory clinic but did accept medication in the form of statins and aspirin.

12.13 The GP discussed the support that was available for Adult E and she agreed that a referral be made to the Proactive Care Team (PCT) (see Glossary) to offer support and review her situation at home and to review an appointment at the Surgery in a month's time. As she had been transported by the paramedics without any money, the PMG's Receptionist contacted a taxi to transport, which she paid for when she arrived home.

12.14 On the 19th July 2016, the SCARF form was viewed and signed off as complete by a supervisor from the Safeguarding Investigations Unit; before the SCARF form was forwarded to them, the officers tried to raise a verbal concern directly with CarePoint 1 (CP1) and CarePoint 2 (CP2) staff, but were advised by both that a formal referral was required via the SCARF form to CP1. The SCARF form was received from the Police at CP1 at 14.37 and transferred to CP2 for assessment. It was received at CP2 at 8.23 on the 21st July 2016. There is no written record of any triage process in CP2, but a verbal report that it was assessed as requiring a standard response as the bungalow appeared clean and tidy, Adult E appeared to look after herself and did not want any assistance.

12.15 Also on the 21st July 2016, the referral from the GP was received by the Community Nursing Team for Proactive Care support.

12.16 On the 29th July 2016, the referral for Proactive Care support was discussed in the Multi-Disciplinary Team (MDT) meeting, albeit without a GP present as the rostered GP who was unable to attend. It was agreed that the Mental Health Liaison Practitioner would visit Adult E to assess her capacity and to gain her

agreement to the Occupational Therapist visiting to complete an assessment. The Occupational Therapist would also seek Adult E's agreement to speak to ASC. The outcome of both visits would be fed back to the PCT Coordinator.

12.17 On the 2nd August 2016, the Mental Health Liaison Practitioner received the minutes of the MDT meeting and a Problem Based Patient Summary to inform her assessment visit.

12.18 On the 7th August 2016, the Police were contacted at 13.32 by the same neighbour who was concerned once more about Adult E, having not seen her for two weeks, and advised that other neighbours were similarly concerned. Adult E was described as very independent and would normally be seen walking to the local supermarket. The neighbour has closed circuit television installed which had not shown Adult E leaving her bungalow for a week.

12.19 When the Police arrived at 14.20, the property was locked with net curtains blocking the view inside. Flies were seen inside the bungalow and, as all the doors and windows were closed, entry was forced. Adult E was found lying on the kitchen floor.

12.20 Adult E was very disorientated and was unable to explain how she came to be on the floor or how long she had been there. She was covered in her own faeces, which was on her finger as well as in her mouth and on her teeth. There were faeces and vomit in the hallway, bathroom, lounge and bedroom.

12.21 The bungalow was described as cluttered and untidy, with packets and bowls of food in the kitchen and lounge that were covered in mould. It appeared that Adult E was hoarding paperwork. The Police were unable to find any contact details for any family or friends and Adult E was unable to say if she had any family. The Police called an ambulance at 14.28, which arrived at 15.05 and transported Adult E to Western Sussex Hospitals NHS Foundation Trust (WSHFT), leaving at 16.04 and arriving at 16.46.

12.22 Adult E was admitted to the Accident and Emergency Unit and transferred to Resus. Her temperature was low (34.0 C) and she was observed to have/ grazes/pressure areas/sheared skin to her knees, elbows and sacrum. She also had an acute kidney injury secondary to dehydration and sepsis – see Glossary.

12.23 Adult E had a low Glasgow Coma Scale score – see Glossary -, inflammatory markers that might indicate an underlying infection and a CT scan of her head showed no signs of any acute bleeding. Her presentation was consistent with having been on the floor for approximately ten days. She was treated

appropriately but Adult E's condition deteriorated and at 15.42 on the 8th August 2016 it was agreed to stop all active management and to provide palliative care. Adult E died at 18.55 on 8th August 2016.

13. Analysis and Recommendations

13.01 This SAR is focused on the events that culminated in the death of Adult E on 8th August 2016, on whether her death was predictable and could have been prevented.

13.02 Adult E has been described as an independent person who did not want anybody or any agency intruding into her life; she had demonstrated that she was capable of contacting services when she felt she needed to and retained the mental capacity to decide whether or not to agree to medical treatment or social care support.

13.03 The responses of the emergency services on both the 18th July 2016 and the 7th August 2016 incidents were timely, effective and appropriate; likewise the care and treatment provided to Adult E at WSHFT after the second of the above incidents.

13.04 The CT scan undertaken on August 7th 2016 showed no evidence of any acute bleeding on Adult E's brain, although previous TIAs (Transient Ischemic Attacks) or 'mini-strokes' in the past cannot be ruled out.

13.05 Prior to the 6th July 2016, there were no apparent causes for concern over and above those that were being appropriately treated by Adult E's GP. She appeared to be contacting her GP when and if the need arose – seeking treatment for a skin lesion, attending for the removal of the sutures following the treatment and requesting and collecting repeat prescriptions for her chronic health issues, namely diabetes and depression.

13.06 Equally, in this period there were no concerns identified to services by her neighbours as to her social care needs, although it has to be acknowledged that Adult E appears to have been a very private person who kept herself to herself.

13.07 A letter was sent by the PMG on the 28th June 2016 advising Adult E to make an appointment for her annual diabetes review; they received no response but the review was not due until August. It is therefore understandable and appropriate that the PMG did not take any further action on this issue at this time.

13.08 On the 6th July 2016, the PMG was contacted by a neighbour concerned that Adult E might have had a stroke. The advice that the Duty Doctor gave, namely that the neighbour should either call an ambulance or that Adult E should come into the surgery, again appears to be appropriate and proportionate and recognises the need for Adult E's consent to any action

13.09 However, despite it being recorded that 'ask duty doctor if police need to be called to access her home'; there is no record of this happening or of any decision that resulted.

13.10 The information available to any doctor will depend on the IT system used by each practice and the personal configuration used by each doctor. It may have been necessary for the Duty Doctor or Adult E's GP to have actively interrogated the system to discover Adult E's not having requested repeat prescriptions. This situation is further complicated by the number of different routes by which repeat prescriptions can be requested.

Recommendation 1:
The West Sussex SAB raise regionally and nationally their concerns that GP practices should have effective and proportionate processes in place for contacting patients for whom there are active concerns who do not answer phone calls, particularly those living alone or known to be at risk.

Recommendation 2:
The West Sussex SAB raise regionally and nationally their concerns that effective and proportionate multi-agency processes should be in place for monitoring the provision of repeat prescriptions and the flagging of failures to either request, collect or have made up repeat prescriptions, particularly for those living alone or known to be at risk.

13.11 On the 8th July 2016, a second letter was sent to Adult E advising her to make an appointment for her annual diabetes review. They received no response but again, as the review was not due until August, it is understandable and appropriate that the PMG did not take any further action on this issue at this time.

13.12 On the 18th July 2016, the responses of the emergency services appears to be appropriate and effective; in particular, the response of the Police in attempting to engage with Adult E and to get her to consider possible options to support her in the community, such as the use of a key safe. Both the Police and the Paramedics assessed that Adult E had the capacity to make decisions about her safety and need for treatment, respecting her autonomy and wish for privacy.

13.13 No formal assessment of Adult E's mental capacity is recorded as having been carried out; however, the Mental Capacity Act 2005 requires the assumption of an adult's capacity and that the making of 'an unwise decision' is not, in itself, a reason to assess an adult as lacking capacity. Despite her having some difficulty with speaking, a formal assessment of Adult E's mental capacity was not required and could be seen to have been intrusive and disproportionate in the circumstances. It could have further distanced Adult E from accepting support. Not completing such an assessment is therefore to be seen as good practice

13.14 The Paramedics' willingness to both make and transport Adult E to an appointment with her GP should be recognised as good practice in these circumstances.

13.15 The GP also assessed Adult E as having the mental capacity to make decisions about her health and social care needs and the same rationale to not undertaking a formal mental capacity assessment applies as in 13.13 above and, again, this should be seen as good practice. It is recognised that the cognitive impairment test was not carried out as an alternative to a mental capacity assessment, but in response to concerns specific to Adult E's memory. Again, this should be seen as good practice

13.16 As the WSSAB annually seeks assurance on compliance with the Mental Capacity Act 2005, it would not be appropriate or proportionate to recommend further action to seek assurance that the above good practice is embedded in the all partner agencies.

13.17 The GP's diagnosis was that there was a high probability of a stroke having occurred; she advised Adult E that she should go to hospital for assessment and possible treatment, but recognised her right and mental capacity to decline to do so.

13.18 Despite the records showing no explicit discussion of Adult E's social care needs, the GP did refer Adult E to the PCT which would include a referral to physiotherapy, occupational therapy and social care services; the GP's records are not explicit in stating this referral was discussed with Adult E, what any such discussion focused on or whether Adult E agreed to the referral being made, though these issues are clarified in the referral to the PCT.

13.19 It is not clear if the GP had access to information about Adult E's failure to request repeat prescriptions. The prescribing of aspirin and statins to someone

who may have suffered a stroke is standard practice as their benefits outweigh the risks of further bleeds.

13.20 There is a potential inconsistency, in my opinion, between the paramedics and the GP wanting to admit Adult E to hospital and the GP not referring her to the Rapid Assessment and Intervention Team (RAIT), which is a service designed as an alternative to an admission to hospital. However, Adult E's presentation, her assessed capacity, her agreement to be referred to the PCT and her ability to go home by taxi would imply that she would not have met the RAIT's criteria for a service.

13.21 The Police who attended Adult E's bungalow completed a SCARF summarising their involvement before going off duty. The SCARF form was viewed, signed off as complete and forwarded to CP1 the following day. An Officer did try to raise a verbal concern with CP1 before the SCARF was forwarded to them in order to ensure its prioritisation, but this was not accepted on the grounds that CP1 did not accept verbal referrals from the Police at that time except in an extreme emergency.

13.22 While a policy of not accepting verbal referrals is understandable, both on the grounds that doing so may result in written referrals not being submitted and the level of expertise of the staff receiving the referrals, it is of concern that it was not possible in this case to alert CP1 or CP2 in advance of a written referral that a partner agency considers requires prioritisation, as opposed to an immediate response, as is normally the case. This is of particular relevance when there will be a delay in the written referral being received, as was the case here of almost 24 hours.

Recommendation 3:
The West Sussex SAB seek assurance that West Sussex County Council have ensured that CarePoint One and Two have established and implemented procedures whereby partner agencies can highlight referrals that, in their opinion, require prioritisation in the allocation process

13.23 The SCARF form was received at CP1 on the 19th July 2016 at 14.37 but was not transferred to CP2 until 8.23 on the 21st July 2016. There is no evidence or explanation for this delay, which is compounded by the endeavour of the Police to verbally raise the profile of their referral on the 19th July.

13.24 The above concern has now been addressed by West Sussex County Council as a result of its own IMR. It has reviewed and revised its processes, including monitoring and management processes, to ensure referrals are effectively and

efficiently prioritised and transferred to CP2. In particular, referrals from the Police are now triaged via the MASH. The implementation of these revised processes has been reported to and monitored by the WSSAB.

13.25 There is no recording of the processes within CP1 or the triage processes in CP2 that the SCARF form was subjected to but it is assumed that the referral was prioritised on the basis of the information contained in the SCARF form which does not state a need for an urgent response. Revised processes now ensure that such information is recorded appropriately.

13.26 The staffing levels at CP1 and CP2 during the summer of 2016 were below establishment level; this had led to the expected response time to a standard referral being extended from five days to twenty five days. An extension of 500% gives an idea of the stress the Service was under at this time, something that was doubtless compounded by the extension not being communicated to partners who could have signposted referrals elsewhere or adjusted their operating models to allow for the delay in response by ASC.

Recommendation 4:
The West Sussex SAB seek assurance from West Sussex County Council that it has reviewed and revised the operation of CarePoints One and Two to ensure that referrals are responded to in a proportionate timeframe, with the appropriate staffing levels and resources, and that it has initiated a management process to advise partner agencies of response times.

13.27 Also on the 21st July 2016, the referral to the PCT from the GP was received by the Community Nursing Team. The referral did not go to the MDT meeting the following day as there was no indication from the GP that it required additional priority, and the agenda for the meeting was full. It therefore went to the following meeting on the 29th July 2016. The PCT is not an urgent service.

13.28 The MDT meeting on the 29th July 2016 was not attended by a GP – the referring GP would not necessarily attend but one of the GPs would be rostered to attend depending on other work pressures – but the meeting would have had access to the PMGs records. The PCT Coordinator would have read the referral before its consideration on the 29th July 2016; it is of concern that the potential inconsistency identified in 18.20 was not picked upon and queried with the GP, to ensure the referral was appropriate for a ‘non-urgent’ service and whether it should be considered at the earlier meeting or to confirm the appropriateness of waiting a further week before doing so. However, the triage process within the PCT is completed at the MDT meeting, not prior to it.

13.29 The PCT has a local performance target of seeing patients within four-to-six weeks of receipt of a referral; as a non-urgent service, this would appear appropriate for seeing patients. There is, in my opinion, an unnecessary lack of clarity in any target that is a time period as opposed to a point in time: the performance target should be either four or six weeks. However, a performance target is a minimum performance standard, not an aspirational one and does not mean that a patient need not be seen for four-to-six weeks from referral nor that no contact should be made with the patient before they are seen; indeed, it could be argued that, being a non-urgent service makes it even more important to monitor patients for any change in their circumstances. Despite being allocated on the 29th July 2016, no contact had been made with Adult E at the time of her death.

Recommendation 5:
The West Sussex SAB seek assurance from partner agencies that non-urgent referrals for health or social care and support are effectively risk assessed and response times communicated to both the referrer and the service user.

13.30 As stated in 13.03, the responses of the emergency services on the 7th August 2016 were timely, efficient and effective. It could be argued that the response times for SECAmb were outside of their target times and the Trust has accepted this. On the first occasion, this was by 5 minutes but as the ambulance was dispatched within one minute of its being requested, it must be assumed the delay was for reasons outside of the Trust's control. On the second occasion, it was by thirty two minutes but within six minutes of the ambulance being despatched after a second request was received from the Police.

13.31 SECAmb have acknowledged the above in their IMR, which also details how it has reviewed and revised its procedures for receiving, triaging and implementing requests for ambulances and paramedics

Recommendation 6:
The West Sussex SAB seek assurance from South East Coast Ambulance NHS Foundation Trust that its revised procedures for receiving, triaging and implementing requests for ambulances and paramedics are being effectively implemented and monitored.

13.32 It should be acknowledged that the above delays have been accepted as having played no part in Adult E's death and that the performance of Trust staff in their interaction with Adult E was professional and appropriate.

13.33 There is no evidence in the tests carried out at WSHFT on the 10th August 2016, of any acute bleeding on Adult E's brain. This is not the same as there being evidence that she had not had a stroke on any of those occasions or that she had not had one or more TIAs. While her subsequent death was not directly due to a stroke, the cause of her initial fall is not and cannot be known and could have been caused by a stroke or TIA. Her death was as a result of 'multi-organ failure', 'dehydration and long-lie' and 'collapse due to underlying co-morbidities'.

13.34 It can only be surmised, but it appears reasonable to presume that Adult E died as a result of a combination of possible factors, that led to her falling and then being unable to get up and becoming dehydrated and confused, leading to the long-lie and multi-organ failure. There had been no sign of these symptoms when she was seen by the GP on the 18th July 2016.

14. Conclusions

14.01 On the basis of the above, the following conclusions would appear to be appropriately drawn in response to the 'Areas for consideration' contained in the Review's ToR.

14.02 **"Was Adult E's death predictable?"** It would appear that Adult E's death was caused by a combination of factors, of which the major one was her lying on the floor for an estimated ten days. The death certificate cites 'multi-organ failure, dehydration and long-lie and collapse due to underlying co-morbidities': other possible factors might have compounded her situation but couldn't have been predicted to cause her death in the manner it occurred. On balance, it seems reasonable to conclude that Adult E's death was not predictable given the information available to services at the time and, even with hindsight, could not have been predicted.

14.03 **"Was Adult E's death preventable?"** The major factor in Adult E's death was her lying on the floor for an estimated ten days. The cause of her fall is not and cannot be known; it is therefore inappropriate to speculate on whether other factors could have been addressed in a way that would have prevented Adult E's death. It could be argued that, had Adult E been in receipt of support services, she would not have been left on the floor for that length of time; this assumes first of all that she would have accepted any support, which seems unlikely given her responses to the Police and Paramedics and suggestions of support from her neighbours; it also assumes that support would have been provided and provided on a more frequent basis than weekly as it is only an estimate that she had been on the floor for ten days. On balance it seems reasonable to accept that Adult E's death was not preventable given her

previous reluctance to accept support. It also need to be acknowledged that agencies operated within their target response times as they then stood.

14.04 **"How do agencies ensure that frontline workers know the appropriate route of referral of safeguarding concerns."** Within the timeframe of this Review, there was little opportunity for safeguarding concerns to be raised regarding Adult E. Prior to the incident on the 18th July 2016, there were no grounds for raising a safeguarding concern regarding Adult E; indeed, it is arguable whether there were grounds after this incident. However, the two agencies who had direct contact with her at home, raised their concerns appropriately.

14.05 On the 18th July 2016, neither Adult E nor her bungalow were in a state that would suggest that she was self-neglecting; there was certainly no evidence to suggest she was being abused or neglected by another person or persons. Both the Police and the Paramedics assessed her as having the mental capacity to make decisions about her health and social care needs, so even if there had been any evidence to suggest she was self-neglecting, it could be argued that it was as a result of an unwise decision.

14.06 Again, when Adult E was seen by her GP, she was assessed to have the mental capacity to make decisions about her health and social care needs and agreed to a referral being made to the PCT, accepted medication and agreed to a review of her situation in four weeks' time.

14.07 **"Does the Police response desk assure a clear referral process to Adult Social Care?"** The incident on the 18th July 2016 generated a SCARF form that was completed on time – before the officers went off duty – and submitted appropriately internally within the Police. The requirement for the SCARF form to be seen and signed off before forwarding to ASC does provide a degree of quality assurance to the referral process but does also entail a degree of delay.

14.08 **"Do all agencies know that referrals made to CarePoints One and Two are received and acted upon?"** There was no evidence contained in the IMRs commissioned for this Review that there is any formal feed-back loop from ASC that either referrals have been received or as to what decision has been made as to any resulting action. While the provision of such feed-back may appear to be desirable, for reasons of ensuring service users/patients don't 'disappear' and developing inter-agency working amongst others, it would also generate a large amount of work at a time of limited if not reducing resources and increased demand for services.

14.09 It is also the case that the majority of referrals to CP1 and CP2 are not safeguarding concerns and not therefore within the direct remit of the West

Sussex SAB. It would however seem appropriate to develop a process by which agencies are kept informed both of cases that are raised as safeguarding concerns or are identified as such once brought to ASC's attention.

Recommendation 7:
The West Sussex SAB liaise with the West Sussex County Council to develop a proportionate feed-back loop to originating agencies of the receipt and progress of referrals to CarePoint One and Two with particular regard to safeguarding concerns.

14.10 **"Are referrals to responsive services and 'proactive' care triaged for importance and need?"** The referrals relating to Adult E that were generated as a result of the incident on the 18th July 2016 were triaged by the PCT within the MDT meeting and by CP2 respectively for importance and need. What this Review has not seen is evidence of the decision-making process that informed the triage process within CP2, although this has now been rectified and the triage decisions are recorded. Equally, what has also not been seen, in my opinion, is any evidence of 'professional curiosity' forming part of either of the triage processes.

14.11 In Adult E's case, there were several factors that, on their own, might not be considered sufficiently significant as to raise the level of concern about her situation and her mental capacity but, in combination, could have done so: she lived alone; she suffered from depression; she had stopped requesting repeat prescriptions for her anti-depressant and diabetes medication; she had not been seen by neighbours for some time; she was not answering her phone and she had made the decision not to be admitted to hospital for assessment, against the advice of the paramedics and her GP.

14.12 Given that elements of the above represent changes in Adult E's pattern of behaviour, the triage processes at both the PCT and at CP2 should, provided they were in possession of them, have generated 'professional curiosity' to question the level of urgency suggested in the referrals they received, particularly when, in the case of CP1 and CP2, the Police sought to make a verbal referral due to their level of concern about Adult E's situation and the PCT is 'a non-urgent service'.

14.13 Since June 2017, Social Workers from CP2 have attending the Multi-Agency Safeguarding Hub (MASH) (see Glossary) each morning to triage SCARFs on a daily basis, discussing their content with the Police, and where there are domestic abuse issues, and WORTH Services (see Glossary) to agree joint actions where appropriate. This also enables the CP2 Social Worker to add clear directions to the SCARF before it is passed to CP1.

14.14 This process ensures that where a Police Officer at the MASH has concerns about a situation, they are able to discuss it with the Social Worker from CP2 and the SCARF would be prioritised accordingly with a note of the discussion, including any disagreements, retained on the ASC's recording system, Mosaic.

14.15 The Mental Capacity Act 2005 requires an 'assumption of capacity', which is a lower level of knowledge than a 'presumption on capacity', which would require a balance of probability. Only three agencies actually had direct contact with Adult E and were therefore in a position to consider whether or not she retained mental capacity to make certain decisions. All three recorded that Adult E retained the capacity to make decisions about her health and social care needs, having had a number of options – such as the provision of key safes, admission to hospital, etc. – explained to her. These informal assessments are recorded and on the basis that there was no evidence of any lack of capacity, a formal assessment would have been inappropriate.

14.16 The GP also undertook a 'cognitive impairment test'; this was in addition to her assessment that Adult E had capacity to make the decisions regarding her health and social care needs. As the Mental Capacity Act 2005 does not require information to be retained for any specific period of time, just sufficient to be part of the decision-making process, the suggestion that she refer Adult E to the Memory Clinic – a suggestion that Adult E declined – is not indicative of any loss of capacity.

14.17 The difference in response of the Police and the Paramedics on the 7th August 2016 to that on the 18th July 2016 is indicative that their understanding of mental capacity is that it is both time and decision-specific in accordance with the Mental Capacity Act 2005.

14.18 **"Were there other agencies that could have been contacted to make initial contact with Adult E?"** Of the agencies that had direct contact with Adult E, and could therefore have contacted agencies on her behalf, SECAmb did do so – they contacted and transported her to see her GP; the GP referred her on to the PCT and the Police advised her of services they could refer her to, but she declined these.

14.19 The opportunity to refer Adult E to other agencies that could have offered her support – the suspicion remains that she would not have accepted it – occurred after the incident on the 18th July 2016. At this stage, the criteria for the implementation of the safeguarding procedures had not, in my opinion, been met.

14.20 On balance, it would appear that, on the whole, the responses of those agencies and individual professionals who had direct contact with Adult E was

appropriate and proportionate; there were avoidable delays in the internal processes for receiving, triaging and allocation referrals by those agencies to which Adult E was referred for support and in making contact with her. These delays might have been reduced if not prevented by staff exercising a degree of 'professional curiosity'. However, none of the delays can be considered to have played a part in Adult E's fall or subsequent death nor did they prevent the services being on track to meet their performance targets to see Adult E.

15. Recommendations

Recommendation 1:
The West Sussex SAB raise regionally and nationally their concerns that GP practices should have effective and proportionate processes in place for contacting patients for whom there are active concerns who do not answer phone calls, particularly those living alone or known to be at risk.

Recommendation 2:
The West Sussex SAB raise regionally and nationally their concerns that effective and proportionate multi-agency processes should be in place for monitoring the provision of repeat prescriptions and the flagging of failures to either request, collect or have made up repeat prescriptions, particularly for those living alone or known to be at risk.

Recommendation 3:
The West Sussex SAB seek assurance that West Sussex County Council have ensured that CarePoint One and Two have established procedures whereby partner agencies can highlight referrals that, in their opinion, require prioritisation in the allocation process.

Recommendation 4:
The West Sussex SAB seek assurance from West Sussex County Council that it has reviewed and revised the operation of CarePoint One and Two to ensure that concerns are responded to in a proportionate timeframe, with the appropriate staffing levels and resources, and that it has initiated a management process to advise partner agencies of response times.

Recommendation 5:
The West Sussex Board seek assurance from partner agencies that non-urgent referrals for health or social care and support are effectively risk assessed and response times communicated to both the referrer and the service user.

Recommendation 6:
The West Sussex SAB seek assurance from South East Coast Ambulance NHS Foundation Trust that its revised procedures for receiving, triaging and implementing

requests for ambulances and paramedics are being effectively implemented and monitored.

Recommendation 7:
The West Sussex SAB liaise with the West Sussex County Council to develop a proportionate feed-back loop to originating agencies of the receipt and progress of referrals to CarePoint One and Two with particular regard to safeguarding concerns.

Appendices

Appendix A- Sussex Safeguarding Adults Board's Safeguarding Adults Review Protocol

http://www.westsussexsab.org.uk/wp-content/uploads/2017/06/Sussex-SAR-Protocol-FINAL-v1.0-2017-ABS3.pdf

Appendix B – Terms of Reference for Safeguarding Adults Review Case Adult E 2016

1 How are GPs and Primary healthcare made aware of response times/delays due to workload pressures of supporting agencies: i.e. Rapid Assessment Intervention Team (RAIT) and Proactive Care (PAC) Team?

2 How do agencies ensure that frontline workers know the appropriate route of referral between and Safeguarding Adults for CP2 and APT/ MASH for Children/DA) (second police referral not making it to CP2)?

3 What contingencies/systems are in place to ensure delays in contact time are communicated to other agencies for collaborative work to take place (WSCC target time for response following 19th July referral was 5 days – no contact was made up until her hospital admission on 7th August [19 days later]).

4 Were there other agencies that could have been contacted to make initial contact with Adult E?

5 How do all agencies know that referrals made to CP/CP2 are received and acted upon? SECAmb referral following visit on 18th July was never received by Adult services?

6 How do all agencies evidence what professional judgement/steps have been taken when records indicate that the person 'has capacity'? MCA states that 'Capacity should be assumed' – but how do we ensure the topic/question capacity is measured against is appropriate?

7 How are referrals in to 'Rapid' assessment teams, responsive services and 'proactive' care triaged for importance and need?

8 How does the MASH/Police response desk assure a clear reporting structure out to Adult Social Care?

9 Was Adult E's death predictable or preventable?

Appendix C – Findings and recommendations from single agency reports – Taken from individual management reviews received by SAB.

West Sussex County Council

- CP1 – checking inboxes hourly and ensuring that work is moved to CP2 as soon as it is received. - Completed
- CP1 – less rigidity around referral process i.e. accepting of verbal referrals in emergency situations - Completed
- CP2 – case recording of decisions made at triage. - Completed
- CP2 – to give consideration to the impact of waiting times on standard priority cases. A mechanism could be put in place to allocate some cases within a shorter time frame if the waiting list is above the 5 day standard – Completed

SECAmb:

- Mental Capacity Act Training to be delivered for all appropriate staff by 31/03/2018
- MCA Assessment tool to be made available for all staff – COMPLETED

GP:

- No recommendations identified

SCFT:

- No recommendation identified

Sussex Police

- No recommendation identified

WSHT

- No recommendations identified

Appendix D Glossary

ASC	Adult Social Care
CP1	CarePoint 1; this is the initial point of contact for the vast majority of enquiries in relation to Adult Social Care at WSCC. CP1 is staffed by Customer Service Advisors, who provide information and advice to simple queries but forward new requests for social care support or safeguarding concerns to CP2 for further assessment
CP2	CarePoint 2; this undertakes initial assessments of need and information gathering for all referrals including those for assessment and safeguarding concerns received by WSCC. It is staffed by trained Assessment Officers and qualified Social Workers and Occupational Therapists. In relation to safeguarding, its primary function is to ensure immediate actions have been taken to make a person safe where needed and to establish whether concerns are sufficient to require a Safeguarding Enquiry as mandated by Section 42 of the Care Act 2014
Glasgow Coma Scale	This is a scoring system used to describe the level of consciousness in a person
IMR	Individual Management Review
Key safes	an accessible means of securely storing keys to enable care and support staff to gain access to patients/service users
MASH	Multi-Agency Safeguarding Hub; this is a single point of contact for all safeguarding concerns regarding children and young people in West Sussex, bringing together expert professionals from the relevant services, including the Police and the County Council, to safeguard and promote the wellbeing of children and young people It is also the initial point of contact for all concerns raised by the police for both adults and children. CarePoint 2 staff now triage with the police those concerns related to Adults, but this was not the case when this Review was commissioned
MCA	Mental Capacity Act
MDT **Panel**	Multi-disciplinary Team West Sussex Safeguarding Adults Board's Safeguarding Adult Review Panel
PCT	Proactive Care Team – The Proactive Care Team work with people with long term conditions and their carers to actively promote health and wellbeing in the community; and where possible prevent admission to unplanned care/hospital. The team includes a social worker, community matron, prevention and assessment worker, occupational therapist, physiotherapist,

	community psychiatric nurse, coordinator and administrator. The Proactive Care Team is not an urgent response service and does not respond to urgent referrals
PMG	Pulborough Medical Group
RAIT	Rapid Assessment and Intervention Team
SAR	Safeguarding Adult Review
SCARF	Single Combined Assessment of Risk Form
SECAmb	South East Coast Ambulance NHS Foundation Trust
Sepsis	a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs
Six item cognitive impairment test	was designed to assess cognitive status in dementia and comprises 6 questions: one memory (remembering an address), two calculations (recalling numbers and months backward), and three orientations (e.g. time of day, month, and year)
Subgroup	West Sussex Safeguarding Adults Board's Safeguarding Adult Review Subgroup
TIA	Transient ischaemic attack or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain
ToR	Terms of Reference
WORTH Services	WORTH Services is an Independent Domestic Violence Advocacy (IDVA) Service which supports people affected by domestic abuse in West Sussex
WSHFT	Western Sussex Hospitals NHS Foundation Trust
WSSAB	West Sussex Safeguarding Adults Board